

**A QUALITATIVE INQUIRY INTO THE EXPERIENCE OF LESBIAN,  
GAY, BISEXUAL, TRANSGENDER AND INTERSEXED STUDENTS IN  
ACCESSING HEALTHCARE IN A CONTACT HIGHER EDUCATION  
INSTITUTION**

by

**ATHOLL VALDON KLEINHANS**

submitted in accordance with the requirements  
for the degree of

**MASTER OF ARTS IN SOCIAL BEHAVIOUR STUDIES IN HIV-AIDS**

at the

**UNIVERSITY OF SOUTH AFRICA**

**SUPERVISOR: MR HJL ROETS**

**FEBRUARY 2018**

## ACKNOWLEDGEMENTS

It is with sincere gratitude that I wish to acknowledge the many people and institutions that played a vital role in assisting me to develop this thesis:

My son, Antonio Rivaldo Kleinhans, this thesis is dedicated to you, my boy. It was having you in my life that kept me motivated and grounded to complete this journey. The long battle for the two of us to be a family took its toll but failed to break the ever strengthening bond between a father and his son. The sheer tenacity to complete this thesis was a direct product of the journey of discovery we shared. Your love and affection is what keeps me going and I promised “to always love you without condition”.

My supervisor, Mr Leon Roets, thank you for your guidance and support.

Thank you to all the participants who so graciously devoted their time to participate in this study. I am humbled by the confidence and trust you instilled in me by sharing your stories. It is through your voices and stories that we wish to bring about change in the campus environment.

The organisations and individuals who helped me in my recruitment endeavours, including the Institutional Officer for HIV/AIDS, Sr Rainny, thank you very much for your support during the entire research process. Liberati – thank you for allowing me into your spaces and to access your LGBTI membership. Without you this study would not have been possible.

## **DECLARATION**

I declare that the work I am submitting for assessment contains no section copied in whole or in part from any other source unless explicitly identified in quotation marks and with detailed, complete and accurate referencing.

..... (Signature)

## **ABSTRACT**

South African institutions of higher learning remain unfriendly and hostile environments for queer students who reportedly continue to experience homophobia, biphobia and transphobia in these spaces. This qualitative enquiry explored the experiences of Lesbian, Gay, Bisexual, Transgender, and Intersexed (LGBTI) students in accessing healthcare in a contact higher education institution. The findings suggest that LGBTI issues are silenced within the university spaces and this blocks the availability of a targeted and strategic approach to deal with the healthcare issues of queer students. Furthermore, it was found that the healthcare services are heterocentric in nature, mainly targeting heterosexual students and deliberately excluding LGBTI students from accessing these services. In addition, the heteronormative attitudes held by healthcare professionals create added barriers for LGBTI students to access healthcare services. Religiously motivated stigma and discrimination prevented healthcare professionals from providing culturally appropriate healthcare services to LGBTI students, thereby excluding them from accessing these services. This research concludes that university management should take decisive action in supporting a human rights framework in order to protect the rights of LGBTI students. Sensitization training as well as the training curriculum of healthcare professionals should include aspects of sexual orientation and gender identity.

Key words: Healthcare, access, HIV/AIDS, gender and sexuality, LGBTI

## **LIST OF COMMONLY USED ABBREVIATED ACRONYMS**

AIDS	Acquired Immune Deficiency Syndrome
HBM	Health Belief Model
HEAIDS	Higher Education and Training HIV/AIDS Programme
HEIs	Higher Education Institutions
HIV	Human immunodeficiency virus
HCT	HIV Counselling and Testing
IDU	Intravenous Drug Use
IOM	Institute of Medicine
LGBTI	Lesbian, Gay, Bisexual, Transgender, Intersex
MSM	Men who have sex with men
NSP	National Strategic Plan for HIV, STIs and TB
SA	South Africa
SANAC	South African National AIDS Council
STIs	Sexual transmitted infections
TB	Tuberculosis
UAI	Unprotected Anal Intercourse
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNISA	University of South Africa
USAID	United States Agency for International Development
YKP	Young Key Populations

## TABLE OF CONTENTS

<b>ACKNOWLEDGEMENTS</b>	ii
<b>DECLARATION</b>	iii
<b>ABSTRACT</b>	iv
<b>LIST OF COMMONLY USED ABBREVIATED ACRONYMS</b>	v
<b>TABLE OF CONTENTS</b>	vi
<b>LIST OF TABLES</b>	x
<b>LIST OF FIGURES</b>	x
<b>LIST OF APPENDICES</b>	x
<b>CHAPTER 1: CONCEPTUALISATION OF THE PROBLEM</b>	<b>1</b>
1.1 Introduction	1
1.2 Background	2
1.3 Research Problem	5
1.4 Purpose for the study	6
1.5 The Objectives of the study	6
1.6 Research questions	6
1.7 Brief description of the research process	6
1.8 Operational definitions of key concepts	7
1.9 Conclusion and outline of the chapters	8
1.10 Outline of chapters	10

## **CHAPTER 2: LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK**

2.1	Introduction	10
2.2	Health, Healthcare and healthcare experience as defined in this study	10
2.3	Access to healthcare	12
2.4	Stigma, discrimination and the health of LGBTI students	13
2.4.1	Individual level factor	14
2.4.2	Interpersonal level factors	15
2.4.3	Structural level factors	16
2.4	A Rights-based approach to healthcare	19
2.5	Sexual orientation and gender identity as determinants of health	20
2.6	Gender-responsive health policies and programmes	22
2.7	Healthcare preference held by LGBTI students	24
2.8	Theoretical and conceptual framework	25
2.8.1	The Health Belief Model	25
2.8.2	The Minority Stress Theory	29
2.9	Conclusion	32

## **CHAPTER 3: METHODOLOGY**

3.1	Introduction	33
3.2	Research process	33
3.3	Key Informant Interviews	35
3.4	Focus Group Discussion	36
3.5	Field notes	37
3.6	Data Analysis	37
3.7	Validity of the study	38
3.8	Ethical considerations	39
3.9	Conclusion	41

## **CHAPTER 4: FINDINGS**

4.1	Introduction	42
4.2	Profile of participants	42
4.3	Key findings	43
4.3.1	Section 1: The experience of LGBTI students	44
4.3.1.1	Structural barriers impede access to health services	45
4.3.1.2	The discriminatory structure of the campus health system	53
4.3.1.3	Mental health stigma as barrier to accessing healthcare	58
4.3.2	Section 2: Healthcare needs of LGBTI students	59
4.3.3	Section 3: Perceptions and preferences of healthcare services	62
4.3.4	Section 4: Suggestions on how healthcare services can be improved	68
4.4	Application of the theoretical frameworks	71
4.5	Conclusion	74

## **CHAPTER 5: RECOMMENDATIONS AND CONCLUSION**

5.1	Introduction	75
5.2	Summary of key findings	75
5.2.1	The experience of LGBTI students in accessing healthcare	76
5.2.1.1	Structural barriers impede access to health services for LGBTI students	76
5.2.1.2	A heteronormative campus healthcare system blocks LGBTI students from accessing healthcare services	78
5.2.1.3	Religion and perceptions of homosexuality	79
5.2.1.4	Mental health stigma and discrimination in the campus healthcare system	79
5.2.2	Healthcare needs of LGBTI students	80
5.2.2.1	LGBTI students lack awareness of own healthcare needs	80
5.2.3	Perceptions and preferences of healthcare services	80
5.2.3.1	LGBTI services are fragmented and uncoordinated	80
5.2.3.2	Healthcare services are heteronormative, inequitable and	



discriminates against LGBTI students	81
5.2.3.3 Discomfort with healthcare provider and provider stigma and insensitivity as barriers to accessing healthcare	81
5.2.4 Suggestions of how healthcare services can be improved	82
5.2.4.1 Decisive action and support from university management	82
5.2.4.2 LGBTI friendly healthcare services and LGBTI specific healthcare providers	83
5.3 Limitations of the study	83
5.4 Recommendations for policy and practice	84
5.5 Recommendations for future research	84
5.6 Conclusion	85
<b>LIST OF REFERENCES</b>	<b>86</b>

## LIST OF TABLES

TABLE		PAGE
Table 2.1:	Summary of gender responsive scale	23
Table 4.1:	Profile of key informants	43
Table 4.2:	Profile of focus group participants	43

## LIST OF FIGURES

Figure 3.1:	Data collection cycle	34
-------------	-----------------------	----

## LIST OF APPENDICES

APPENDIX	DESCRIPTION	PAGE
Appendix A	Information sheet	97
Appendix B	Informed consent	101
Appendix C	Focus group guide	102
Appendix D	Permission letter (LGBTI group)	104
Appendix E	Permission letter (study site)	107
Appendix F	Field notes guide	109
Appendix G	Ethical clearance form	110

# CHAPTER 1

## CONCEPTUALISATION OF THE PROBLEM

### 1.1 Introduction

This is a qualitative study which explored and described the experience of Lesbian, Gay, Bisexual, Transgender and Intersexed (LGBTI) students in accessing healthcare in a contact higher education institution. United under the umbrella of LGBTI, lesbians, gays, bisexuals, transgender and intersexed communities are often presented or described as one group by many researcher, health professionals and many others and these hold important health and healthcare related implications (Muller 2017:2). Muller (2017:2) further argues that it is through their communal experiences of stigma, discrimination and differential treatment within the healthcare system that unifies them as one group, but each group has a unique set of health and healthcare needs, critical information needed by healthcare providers to offer culturally appropriate healthcare. Not enough research is being conducted in South Africa to assess the magnitude and impact of the health disparities prevalent among this group.

The LGBTI communities, including students, continue to suffer physical health inequalities as opposed to their heterosexual counterparts (Lick, Durso and Johnson 2013: 521) despite the many advances made with regards to legal protection for LGBTI communities. It has been reported that LGBTI individuals experience a higher susceptibility to depression, anxiety, eating disorders, and suicidality compared to heterosexual individuals (Stover 2011:2). Research conducted by Lane, Fisher, Dladla, Rasethe, Struthers, McFarland & McIntyre (2011), specifically among gay men and men who have sex with men, reported that the HIV prevalence among this group is between 34-50% in Johannesburg and Durban and this is significantly higher than the national HIV prevalence of 11% among the adult population (Rispel, Metcalf, Cloete, Reddy, Lombard 2011). Given these statistics, it is important that culturally competent healthcare services be made available for sexual minority youth in order to address the huge health disparities present among LGBTI groups. Unfortunately, these groups continue to experience barriers

to accessing healthcare, especially so in the higher education sector (Mavhandu-Mudzusi 2016:4; NACOSA 2014).

Higher education institutions, such as the one in this study, are reflections of the larger South African society and they are struggling with the same social issues and prejudices present outside the campus environment. LGBTI students are faced with homophobia (the irrational fear of, hatred against, or disgust towards homosexuals or homosexuality (Muller 2013:2)), biphobia, transphobia, stigma, prejudice and violence on a daily basis at universities (NACOSA 2014). Sexual minority students report experiences of various forms of violence ranging from physical assault, rape and murder to subtle forms such as microaggressions (NACOSA 2014; Brink 2017:196). According to NACOSA (2014) and Brink (2017:196) almost 12% of participants in the MSM sample reported having been forced to have sexual intercourse against their will. These negative behaviours directed at LGBTI students prevent them from accessing healthcare, specifically sexual reproductive health services, and ultimately leaves them with little confidence that the higher education sector can constructively deal with their marginalisation and experiences of violence (NACOSA 2014).

The need to assist LGBTI students to affectively access appropriate, sensitive healthcare is important and has the potential to reduce negative long-term health consequences such as depression, anxiety, eating disorders, alcohol and drug abuse, HIV and other sexually transmitted infections. Having access to these health services not only has the potential to improve health outcomes but it also serves as a vehicle to enhance the overall student experience. This chapter will commence with a background of the study undertaken and is followed by a discussion of the importance and rational for the study. Following this discussion is a clear articulation of the research problem, objectives, and research questions. This chapter will be concluded with a brief outline of the different chapters within the entire dissertation.

## **1.2 Background of the study**

While it has become a widely accepted practice to tie together LGBTI as an acronym, which in many instances suggests sameness, it should be acknowledged that these groups are distinct, and they also comprise subgroups based on race, ethnicity, geographic location, socioeconomic status, age, and other factors (Muller 2014:2; IOM 2011:89). Although it is not the purpose of this study to explore the individual needs of each subgroup, it is important to highlight the fact that they all have unique healthcare needs that require individual attention. It is through their common experiences of stigma and discrimination that they are united as sexual and gender minorities (Muller 2014:2; IOM 2011:89). This study is interested in the collective experience of LGBTI students as they access healthcare within the campus environment.

LGBTI persons in South Africa, including students, continue to experience huge health disparities and access to sexual reproductive health services (Muller 2017:4; Rispel et al 2011). Although little is known about the experiences of LGBTI people in accessing healthcare in South Africa, particularly in the higher education sector, evidence suggests that sexual minority groups continue to face repeated discrimination and a lack of LGBTI-specific health services and information (Muller 2014:12; Mavhandu-Mudzusi & Ganga-Limando 2014:2; Mavhandu-Mudzusi 2016:4; Lane, Mogale, Struthers, McIntyre and Kegeles 2008: 431). Socio-cultural factors, such as experiences and perceptions of discrimination, among vulnerable and key populations have been proposed as salient factors that may be contributing to the health disparities among LGBTI communities (SANAC 2017; Kisler 2013:24). A recent survey conducted by the Other Foundation which looked at attitudes towards homosexuality and gender non-conformity in South Africa found that a large majority (about 7 out of 10 South Africans) feel strongly that homosexual sex and breaking gender dressing norms is simply “wrong” and “disgusting” (Sutherland, Roberts, Gabriel, Struwig, & Gordon 2016:37). While 52% believe that gay people should have the same human rights as all other citizens, a staggering 72% felt that same sex sexual activity is morally wrong. These negative societal perceptions toward LGBTI persons were confirmed in another large-scale survey conducted in the Gauteng city region (Mahomed & Trangoš 2016:1409). Joseph & Culwick (2015:2) reported that only 56% (consistent with the previous study) of respondents agreed that gay and lesbian people deserve equal

rights with all South Africans, which is a drop from 71% in 2013. Even more disturbing is that 14% of residents think it is acceptable to be violent towards gay and lesbian people. It is therefore alarming and worrying that a sizeable and increasing minority of residents in the Gauteng region hold strong exclusionary attitudes towards gay and lesbian people. The university where this study was conducted also falls within this region.

This pattern of discrimination filters through to all spheres of society including the higher education and health systems. Data from a country wide study suggest that LGBTI people face repeated discrimination and a lack of LGBTI-specific health services and information (Muller 2014:12). Similar findings in the higher education healthcare system was also reported which indicates that LGBTI students experience several forms of discrimination in the process of accessing healthcare services on campus and these include: (i) services which mainly target heterosexual students or heterocentric healthcare services, and (ii) heteronormative attitudes of healthcare personnel (Mavhandu-Mudzusi 2016; Mavhandu-Mudzusi & Ganga-Limando 2014:2; NACOSA 2014). Habart (2015:166) argues that heterosexual roles, which in most cases are culturally determined, and assumptions about heterosexuality as natural and normal are imposed on everyone to comply with and this constitutes heteronormativity.

The stress associated with perceptions and experiences of homophobia, known as minority stress, has been found to contribute to poor mental health (Fields, Bogart, Smith, Melebranche, Ellen and Schuster 2015:122) and physical health outcomes (Smith 2015:186), as well as increased HIV risk behaviour (Fields et al 2015; Hatzenbuehler and Pachankis 2016). The university in this study has approximately 50 000 students and it is estimated that about 20-30% of all students access health services annually (Primary Healthcare Service Annual Report 2015). The university has four campuses and healthcare services are equally divided across these campuses.

Regardless of constitutional provision and anti-discriminatory policies, negative attitudes towards LGBTI students persist in South African universities (Mavhandu-Mudzusi & Ganga-Limando 2014:2). The high levels of stigma and discrimination experienced by

these marginalized students pose significant challenges to current HIV prevention initiatives (Arndt & de Bruin 2011:497; NACOSA 2014) and compromise efforts to reduce the spread of HIV and other sexually transmitted infections (Mavhandu-Mudzusi & Ganga-Limando 2014:2). The South African National Strategic Plan for HIV, sexually transmitted infections (STIs) and TB 2017-2022 highlights the fact that nobody should be left behind in the HIV response and three of the eight goals aims to reach all key and vulnerable populations with customised and targeted interventions (goal 3), address the social and structural drivers of HIV, TB and STIs (goal 4), and ground the response to HIV, TB and STIs in human rights principles and approaches. The South African National AIDS Council scaled up the HIV response with regards to LGBTI people and at the 8<sup>th</sup> South African AIDS conference, held in June 2017, the South African National LGBTI HIV Plan 2017-2022 was launched. It is regarded as a milestone in the country's response to HIV, AIDS, STI's and TB for Lesbian, Gay, Bisexual, Transgender and Intersex people and the first of its kind globally (SANAC 2017:ii). However, there has been critique regarding the slow response of the higher education sector in South Africa (Matthyse 2017:115; Nduna Mthombeni, Mavhandu-Mudzusi, & Mogotsi 2017:8). It is therefore critical that more information is gathered regarding the experience of LGBTI students in order to contribute to a growing movement within the higher education and healthcare sectors in South Africa which calls for social justice and the preservation of the human rights of LGBTI students (Mavhandu-Mudzusi 2016; Nduna et al 2017; Muller 2017).

### **1.3 The research problem**

Evidence in the literature alludes to the fact that LGBTI communities including students face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights (Muller 2017:4; Mavhandu-Mudzusi 2016:4). There is a paucity of empirical literature on the experience of LGBTI students in accessing healthcare in the higher education sector in South Africa. Studies conducted in this sector highlight the fact that there is a lack of adequate and dedicated education and health services for LGBTI students (NACOSA 2014:49), and available services tend to be heterocentric and favour heterosexual students (Muller 2017:4). In addition, health care personnel hold strong heteronormative attitudes such as the ignorance of anal intercourse between men

(Mavhandu-Mudzusi 2016:4; Lane et al 2008:431) and religiously motivated stigma and discrimination prevents students from accessing healthcare services (Mavhandu-Mudzusi & Sandy 2015:5). Sexual minority groups, including LGBTI students, experience chronically high levels of stress due to social stigma and discrimination (Russel & Fish 2016:471; Meyer 1995; 2003) and these negative experiences increases the likelihood of mental disorders (suicide, depression and substance use) which ultimately manifest in the form of physical health problems (Lick, Durso and Johnson 2013:521). The researcher, at the time the study was conducted, worked as an HIV/AIDS coordinator and gender specialist at the university under study and has made a number of observations regarding the accessibility of culturally sensitive and appropriate healthcare services for LGBTI students on campus. Therefore, this study aimed to gain a better appreciation of and describe how LGBTI students experience the social stigma and discrimination and how it shapes their experience of accessing healthcare.

#### **1.4 Purpose for the study**

The purpose of this study was to explore and describe the experiences of LGBTI students in accessing healthcare in a contact higher education institution in South Africa. Furthermore, the research findings will be used to formulate recommendations aimed at enhancing the access to campus-based healthcare services by these students.

#### **1.5 The objectives of the study**

- To explore the experience of participants in the process of accessing LGBTI related healthcare service on campus
- To explore the awareness of participants regarding the healthcare needs of LGBTI students and the availability of related services on campus
- To explore where participants prefer to go if they need to access LGBTI related healthcare services on campus
- To explore the suggestions from participants on what will make healthcare services more accessible for LGBTI students on campus



## **1.6 Research questions**

- What are the experience of participants in the process of accessing healthcare services on campus?
- Are participants aware of the healthcare needs of LGBTI students and the availability of related services offered on campus?
- Where do participants prefer to go if and when they need to access LGBTI healthcare services on campus?
- How do participants suggest healthcare services for LGBTI students can be made more accessible on campus?

## **1.7 Brief description of the research process**

This section is a brief description of the research process. A more detailed description can be found in Chapter 3. A qualitative research approach was used for this study in order to explore and describe the experience of LGBTI students in accessing healthcare services. Compared to the more positivistic and scientific nature of quantitative data gathering and analysis a qualitative research approach was better suited to explore the research questions. A total of five key informants were selected to participate in the study and the interviews were conducted in English. Seven LGBTI students were recruited to participate in a focus group discussion. A campus based student society (group), was identified, as an important gatekeeper to gain entry into the study population as well as to assist with the recruitment of participants. Purposive sampling was used to recruit participants for both the key informant interviews and the focus group discussion.

Data from the interviews and focus group discussions were audio recorded. Confidentiality was assured through not collecting participant identifiers (names, date of birth) and not using real names during interviews. Data from the digitally recorded interviews were transcribed verbatim into a word document and the recordings will be kept for five years. Data were reduced into meaning units and was coded and classified accordingly to predefined subcategories, categories and overall themes. Data were analysed for manifest and latent content. Findings were contrasted in relation to data obtained from the group and

findings of other relevant research and the range of perspectives presented. Thick descriptions and direct quotes were generated to contextualize the findings and to present data.

The researcher applied for ethical clearance (Appendix G) and all relevant permission was sort before the research study proceeded. Written informed consent was obtained from all participants in this study before any study procedures commenced (Appendix B). A pilot study was conducted in order to validate the research questions and to assist with the development of the research plan (Prescott & Soeken 1989:61).

### **1.8 Operational definitions of key concepts**

**Access to healthcare** - The ability of an individual or a defined population to obtain or receive appropriate healthcare. This involves the availability of programmes, services, facilities and records. Access can be influenced by such factors as finances (insufficient monetary resources); geography (distance to providers); education (lack of knowledge of services available); appropriateness and acceptability of service to individuals and the population; and sociological factors (discrimination, language or cultural barriers) (WHO 2004:5; Simpson, Bloom, Cohen, & Parsons 1997:1).

**Healthcare:** Healthcare includes preventive, curative, and palliative services and interventions delivered to individuals or populations. In most countries these services account for the majority of employment, expenditure, and activities that would be included in the broader health sector or health system (UNAIDS 2011:14).

**Healthcare experience:** The individual experience of accessing, participating, and receiving healthcare from a healthcare provider (Stover 2011:44).

**LGBTI students:** This acronym refer to Lesbian, Gay, Bisexual, Transgender, and Intersexed students. Although all of the different identities within “LGBTI” are often

lumped together (and share sexism as a common root of oppression), there are specific needs and concerns related to each individual identity (Muller 2014: 2).

**Residential higher education institution:** “higher education institution” means any institution that provides higher education on a full-time, part-time or distance basis (Higher Education Act 101 of 1997).

## **1.9 Conclusion**

This chapter was an introduction to the research topic and presented a detailed background of the study. The research problem highlighted the lack of research on the experience of LGBTI students in accessing healthcare in the higher education sector, particularly here in South Africa. A brief outline of the research process was discussed and this was in line with the research questions and main objectives of the study.

Chapter 2, which will be discussed next, will provide a detailed description of the literature which guided the researcher in conceptualising the need to conduct the study. The literature review will highlight social and structural barriers faced by LGBTI students in the process of accessing healthcare in the higher education sector.

## **1.10 Outline of the chapters**

**Chapter 1** provides a framework for the study as well as a bird’s eye view of what will be covered. It identifies the background to the research problem, focuses on the motivation for the study and includes the problem statement and research questions as well as the objectives of the research. The research design and data generating methods are also briefly addressed.

**Chapter 2** offers a detailed literature review of the research problem as well as a conceptual framework in which the study fits.

**Chapter 3** discusses the research methodology employed in the study and offers a framework of the instruments used as well as the research design.

**Chapter 4** contains the data collected, as well as the analysis and interpretation thereof.

**Chapter 5** discusses the findings, trends and main problems identified in the study. A conclusion is drawn and recommendations are made about the specific health needs experienced by LGBTI students. The chapter also outlines how general health practices including sexual reproductive health and HIV related programmes specifically for LGBTI students can be improved to address the needs of these vulnerable groups.

## CHAPTER TWO

### LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

#### 2.1 Introduction

Since the beginning of its democracy in 1994, South Africa has witness many changes in the legal system, extending the rights of, and providing new protections for LGBTI people. Yet, research suggests that attitudes to minority groups do not always evolve in line with legislative frameworks (Valentine & Wood: 4). This chapter will carefully explore the literature to establish a theoretical basis for addressing the objectives of the study. This literature review allowed the researcher an opportunity to engage with the existing body of knowledge and theories in order to gain a conceptual understanding regarding the experience of LGBTI students in accessing healthcare. How is access facilitated or hindered for these students and how this ultimately impacts on their experience of the healthcare system. It is through a thorough exploration of the literature that the researcher selected the health belief model and the minority stress model as the theoretical basis for this study. This chapter will commence with an exploration of concepts such as health and healthcare and it will be linked to the overall healthcare experience of LGBTI students.

#### 2.2 Health, healthcare and healthcare experience as defined in this study

It is important that this section commence with a definition of health in order to illustrate its appropriateness with the scope of the study established through the objectives in Chapter 1. Health is defined by the Constitution of World Health Organisation (WHO) as “the state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity” (WHO 1946:1315). While this definition highlights the critical interplay between the social, physical and mental health of an individual some argue that its demand for complete wellbeing is no longer fit for purpose and perhaps an overly ambitious target to achieve (Huber, Knottnerus, Green, van der Horst, Jadad, Kromhout, Leonard, Lorig, Loureiro, Van der Meer, Schnabel, Smith, van Weel, Smid 2011:2). The quality of life of an individual is suggested as a better alternative to assess an individual’s health status (McGrail, Lavergne and Lewis 2016:4). This study was particularly interested in exploring how the physical, social and mental health dimensions come together and how these either

facilitate access or create barriers to access these needed services. The adoption of the Rio Political Declaration at the World Conference on Social Determinants of Health in October 2011 signaled a move into the right direction and highlighted the social and economic factors and how they are distributed among the population. Healthcare on the other hand is defined as “the prevention, treatment and management of illness and the preservation of mental and physical well-being through the services offered by the medical, nursing and allied health professions” (Holmes 2010:3) and includes preventive, curative, and palliative services and interventions delivered to individuals or populations (UNAIDS 2011:14). Hence, healthcare is more than just the management and treatment of physical disease but goes much further to include the social determinants of health which impacts significantly on the health outcomes of LGBTI communities and this will be discussed in more detail in the sections to follow.

Since this study is interested in the experiences of LGBTI students, it is important that we also define experience in the context of healthcare. While Stover (2011:44) argues that healthcare experience encompasses the individual experience of accessing, participating, and receiving healthcare from a healthcare provider, a standard consistent definition for healthcare experience seems to be absent in the literature. Wolf, Niederhauser, Marshburn, and LaVela (2014) attempted to come up with such a definition in their 14-year (2000-2014) synthesis of existing literature and other sources. Their findings suggest that when one refers to patient experience one has to consider several concepts and recommendations. For example, they argue that one has to be cognizant of the fact that the patient experience reflects occurrences and events that happen independently and collectively across the continuum of care. This means that social events outside of the clinical experience should also be considered as part of the patient experience such as stigma and discrimination because they will ultimately influence how the person experiences the healthcare system. These authors argue that when one attempts to understand patient experience one moves beyond results from surveys which capture concepts such as ‘patient satisfaction,’ because patient experience is more than satisfaction alone (Wolf et al 2014:7). Furthermore, on the side of the patient, there is a need for individualized care and tailoring of services to meet patient needs and to engage them as partners in their care. Patients’ expectations have also

been found to be very closely linked to patient experience and whether they were positively realized (beyond clinical outcomes or health status) (Wolf et al 2014:7). In the following paragraph we explore the concept of access to healthcare and describe some of the barriers faced by LGBTI persons.

### **2.3 Access to healthcare**

While we have define healthcare experience and determine the scope of it for the purposes of this study, we need to also define access to healthcare and how this shapes the experience of LGBTI students. It is well documented that greater access to healthcare services enables any individual to fully benefit from the healthcare system (IOM 2011:74). Conversely, those with less access face barriers that make it difficult to obtain basic healthcare services and sexual minority groups are among those who are disproportionately represented in this group. Poor access to healthcare comes at both a personal and societal cost. For example, we have seen with the HIV epidemic, if people do not receive HIV counselling and testing services, they are less likely to know their HIV status and more like to transmit the virus to other sexual partners should they be infected with HIV. This is worrisome because it has the potential, such as in the case of South Africa, to increase the burden of disease among the general population in addition to the burden borne individually. Having access to healthcare, according to IOM (1993:4), means having "the timely use of personal health services to achieve the best health outcomes".

There seems to be agreement among researchers and healthcare experts on what is needed to achieve access to healthcare (U.S. Department of Health and Human Services 2010:229; Evans, Hsua & Boerma 2013:546). Both the research reports referenced in the previous sentence seem to suggest that three dimensions or components are necessary in order to attain good access to care. Gaining entry into the healthcare system or physical accessibility as stated by Evans et al (2013:546) "is understood as the availability of good health services within reasonable reach of those who need them and of opening hours, appointment systems and other aspects of service organization and delivery that allow people to obtain the services when they need them". Getting access to sites of care where patients can receive needed services is another dimension and addresses the issues of financial

affordability or being able to measure the ability of people to pay for the healthcare services without financial hardship. The third dimension is about finding providers who meet the needs of individual patients and with whom patients can develop a relationship based on mutual communication and trust which Evans et al (2013:546) refer to as acceptability. Evans et al (2013: 546) argue that acceptability can be measured when we understand the willingness of people to seek services and various social and cultural factors such as language or the age, sex, ethnicity or religion of the health provider need to be considered. Acceptability, they continue, is low when the individual perceives the services to be ineffective or one of the social and cultural factors mentioned above discourages them from seeking services. In summary, it is suggested that one should measure healthcare access structurally by measuring the presence or absence of specific resources that facilitate healthcare, such as having health insurance. Another very important measuring stick are the assessments by patients of how easily they can gain access to healthcare. As a third and final step one can look at utilization measures of the ultimate outcome of good access to care (Evans et al 2013:546; U.S. Department of Health and Human Services 2010:229). Here we are interested in how sexual minority students experienced the service, and whether they received appropriate services successfully.

#### **2.4 Stigma, discrimination and the health of LGBTI students**

LGBTI people including students historically faced stigma, discrimination and violence and, despite constitutional protection, continue to experience these social barriers which prevent them from accessing equitable healthcare (Muller 2016:196). These social barriers have been proven to significantly affect the overall well-being of LGBTI people (Muller 2016:196). For example, studies conducted in Europe and the United States found that people who identify as LGBTI have significantly higher rates of depression, suicide, and anxiety disorders than their heterosexual matched peers because of the social exclusion, discrimination and prejudice they experience (Meyer 2003:676; Mayer, Bradford, Makadon, Stall, Goldhammer, and Landers 2008:990). This higher prevalence of mental disorders among LGBTI people, according to researchers, are caused by a stressful social environment which has been created by stigma, prejudice, and discrimination and what Meyer (2003:376) coined “minority stress”. Meyer’s minority stress theory will be



discussed in more detail later in the chapter. Important to note here is the fact that LGBTI people face similar social and structural barriers as the general society but due to their minority status they experience additional stress and hence elevated risk for mental, behavioural and physical health issues which are further compounded by a stressful social environment. Stigma and minority stress exist at the individual, interpersonal, and structural levels and in the next section we review evidence highlighting the health consequences of stigma across these levels for LGBTI students.

#### 2.4.1 Individual level

At this level, Hatzenbuehler & Pachankis (2016:987) suggest that attention should be focused on how the individual responds to cognitive, affective and behavioural level responses to stigma. They identified three individual-level stigma processes, namely: internalised homophobia/biphobia and transphobia, rejection sensitivity, and concealment. Described as “the internalisation of negative societal attitudes about one’s sexual orientation or gender identity” (Hatzenbuehler & Pachankis 2016:987), internalised homophobia/biphobia/transphobia has been associated with poor health outcomes among LGBTI individuals. For example, Vu, Tun, Sheehy and Nel (2012:721), reported high levels of internalised homophobia in their sample of men who have sex with men (MSM) in Pretoria and noted an association between internalised homophobia and HIV related misinformation, which in turn affects individuals’ likelihood of engaging in risky behaviours. Another very important concept to consider when we deconstruct LGBTI health is rejection sensitivity. Wang & Pachankis (2016:764) and Hatzenbuehler & Pachankis (2016:987) describe it as the psychological process through which some individuals learn to anxiously anticipate rejection because of previous experiences with prejudice and discrimination toward their group membership. In their article: *You become afraid to tell them that you are gay: Health service utilization by men who have sex with men in South African cities* Rispel et al (2011) describes how MSM participants conceal their identities in the process of seeking healthcare because they anticipated rejection from healthcare providers. According to Hatzenbuehler & Pachankis (2016:987), there is little conclusive evidence to suggest that the psychological process of rejection sensitivity unfolds in the same way among LGBTI youth as with adult LGBTI people since most of

the research has been conducted with adult LGBTI people. Some recent studies among LGBTI youth showed that high levels of rejection sensitivity are correlated with less condom use and this is mediated by a diminished condom use self-efficacy (Wang & Pachankis 2016:764). Finally, LGBTI students who experience stigma based on their sexual orientation and gender identity may engage in concealment behaviours as mentioned above. This is a form of coping strategy where LGBTI students hide their identity in order to avoid future victimisation. Schrimshaw, Siegel, Downing, and Parsons (2013:11) found in their study that there is an indirect association between concealment of sexual orientation and lower levels of mental health (by way of greater internalized homophobia). Hatzenbuehler and Pachankis (2016:989) highlight the fact that concealment can serve as a positive short term coping strategy to avoid victimisation but in the long term it is associated with a host of psychological consequences, including depressive symptoms, negative affect and anxiety, poor self-esteem and elevated psychiatric symptoms, and psychological strain. In the next section we illustrate how stigma and discrimination function at the interpersonal level.

#### 2.4.2 Interpersonal level

On the interpersonal level, most research focused onto interactional processes that occur between the stigmatised and the non-stigmatised, and includes intentional, overt actions, such as bias-based hate crimes, but also unintentional, covert actions, like micro-aggressions (Hatzenbuehler and Pachankis 2016:988). Research among students in South Africa highlights peer victimisation and bullying (Brink 2017; Mavhandu-Mudzusi & Ganga-Limando 2014). Upon a deeper search of the literature, family acceptance and rejection also surfaced as important concepts at the interpersonal level and have been found to contribute to the sexual identity development of LGBTI youth. The recognition of one's sexual attractions and the process of incorporating this awareness into one's self-identity is conceptualised as one's sexual identity development (Bregman, Malik, Page, Makynen, and Lindahl 2013:417). Parental acceptance has been found to be positively correlated with the development of a positive sexual identity and parental rejection can lead to a stagnant sexual identity marked by significantly increased levels of internalised homophobia or homonegativity (Ryan, Huebner, Diaz, & Sanchez, 2009). For example, a study which

examined the relationship between family rejection in adolescence and the health of LGB young adults found a clear associations between parental rejecting behaviours during adolescence and the use of illegal drugs, depression, attempted suicide, and sexual health risk by LGB young adults (Ryan, Russel, Huebner, Diaz, & Sanchez 2010:206). Family acceptance has been found to predict greater self-esteem, social support, and general health status; it also protects against depression, substance abuse, and suicidal ideation and behaviours (Ryan, Russel, Huebner, Diaz, & Sanchez 2010:208). When young LGBTI students leave the confines of the family, they enter another space, including the higher education system. In the next section we see how the campus environment and the role it plays shapes the experience of LGBTI students in the process of accessing healthcare.

### 2.4.3 Structural level

Stigma processes also operate on the societal level, above the individual and interpersonal levels, and are imbedded in social structures such as cultural norms, and institutional policies that constrain the opportunities, resources, and wellbeing of LGBTI persons including students. While South Africa has made huge strides in its protection of the rights of LGBTI persons, sexual minority persons continue to battle against a dominant heterosexist system (Brouard & Pieterse 2012:63) which impacts the human rights of these people. This was illustrated in a recent population based survey which reflected the contradictions between the country's progressive laws and conservative views, and offers new insights. The findings suggest that while 51% of all South Africans believe that gay people should have the same human rights as all other citizens, a staggering 72% feel that same sex sexual activity is morally wrong (Sutherland, Roberts, Gabriel, Struwig, & Gordon 2016:37). At the structural level we will take a look at the structural environment within higher education institutions as well as the clinical environment and the healthcare provider attitude which plays an important role in the healthcare experience of LGBTI students.

#### **(a) Campus climate and attitudes towards LGBTI students**

Global literature indicates that the healthcare system generally discriminates against LGBTI persons and favours heterosexual people. Before we focus on the general

atmosphere within university campuses, we first take a look at the public healthcare system and how it responds to the needs of LGBTI persons.

While this study is particularly interested in the healthcare experience of LGBTI students, it should be recognized that the healthcare system within higher education institutions forms a small part of a larger campus environment. Important for this study is to understand the atmosphere or ambience of the campus and how this is perceived by LGBTI students. This understanding, according to Hochella (2012:4), is defined as campus climate and is usually reflected in the university's structures, policies and practices; the demographics of its membership; the attitudes and values of its members and leaders; and the quality of personal interactions. Climate is the collective atmosphere that either helps us succeed or holds us back. It's everything from policy to personal attitudes in the classroom, the campus clinic, the residence hall, the dean's office, the laboratory and the paint shop. The climate is often shaped through personal experiences, perceptions and institutional efforts. The campus environment forms a central part of the experience of LGBTI students and has the potential to either facilitate a positive healthcare experience or perpetuate a negative heterocentric agenda which then posts significant challenges to LGBTI students' overall academic performance. Chetty (2000:15) argues that the role of higher education in South Africa is to create an environment conducive to teaching and learning and which promotes the human rights of all students. She further contends that higher education is uniquely positioned to shape debate, action, and policy with regards to gender identity, sexual orientation and HIV/AIDS through its core operations of teaching, learning, research and community engagement (Chetty 2000:15). Students in a recent survey conducted in the higher education sector in South Africa suggested that university management and student leadership have an important role to play in addressing LGBTI issues but did not express a lot of confidence in HEI staff to investigate cases of discrimination based on gender, sexuality and race (NACOSA 2014:3). Research suggests that the structural environment plays a vital role in facilitating access to healthcare services as well as the availability of such services for LGBTI individuals including students and this is discussed next.

#### **(b) The clinic environment**

Rispel et al (2011:144) found that health systems which are unresponsive to the needs of LGBTI persons usually lack targeted health services. Instead, services are heteronormative in nature and healthcare providers are unsympathetic and insufficiently trained. These, they argue, are some of the issues which deter LGBTI persons from accessing healthcare services. Other studies found that clinics which attempted to make small but significant changes in creating an environment that is LGBTI-friendly by including structural elements such as a rainbow sticker on a window where patients are likely to see it, LGBTI-affirming posters, LGBTI magazines and patient education materials, safer sex information and condoms in waiting rooms, and designating single-use restrooms as gender neutral, often increase the utilization of services by these communities (Bolderston & Ralph (2016:209; Wilkerson, Rybicki, Cheryl, Barber & Smolenski 2011:381). Whilst a clinic environment which is LGBTI friendly and welcoming is critical in creating access to healthcare for these individuals, they often times have to deal with the attitude of the healthcare providers in order to complete this leg of the health experience. This topic will be explored in more detail in the following section.

### **(c) Healthcare provider attitude towards LGBTI students**

The attitude, demeanor and how healthcare providers conduct themselves when providing healthcare services, especially to LGBTI communities, have been found to be an important factor that determines whether or not an individual will return to make use of the services again. Heteronormativity, which is the belief that people fall into distinct and complementary genders (man and woman) with natural roles in life, assumes that heterosexuality is the only sexual orientation or only norm, and states that sexual and marital relations are most (or only) fitting between people of opposite sexes (Ratele 2013:135). The views held by some health care providers present various challenges for LGBTI students. They either render LGBTI individuals invisible and therefore services targeting these populations are non-existent, or they assume everyone is heterosexual and therefore an important screening such as an anal swab for early detection of anal cancer for a gay person can go unnoticed, or a memogram for lesbian woman. Mavhandu-Mudzusi (2016:5) also found that often times this heterocentric view is based on Christianity and health care providers use this to discriminate against LGBTI students through the use of

biblical versus that condemn homosexuality. These are direct violations of the human rights of LGBTI students and in the next section we discuss this topic in more detail.

## **2.4 A rights based approach to healthcare**

A human rights-based approach to healthcare according to Muller (2014:2) aims to support better and more sustainable healthcare programmes and policy outcomes by analysing and addressing the inequalities, discriminatory practices and unjust power relations which are very pervasive in the South African healthcare system. According to the human rights based approach, four constructs are important to consider when one assesses healthcare programmes and policies. Below is a summary of the four constructs:

- “Availability: Lack of public health facilities and services, both for general and LGBT-specific concerns
- Accessibility: Refusal to provide care to LGBT people
- Acceptability: Articulation of moral judgment and disapproval of LGBT people’s identity, and forced subjection of persons to religious practices
- Quality: Lack of knowledge about LGBT identities and health needs, leading to poor-quality care” (Muller 2014:2).

### **2.4.1 Inclusive healthcare**

The democratic, non-racial and non-sexist Constitution of South Africa (Republic of South Africa 1996) was the first constitution in the world to contain provisions on non-discrimination against people based on sexual-orientation and gender identity (Mavhandu-Mudzusi 2016:1) and is perhaps the most progressive constitution in the world. However, people with different cultural and religious beliefs and practices continue to violate the right to human dignity of LGBTI students within the higher education sector in South Africa (Mavhandu-Mudzusi and Netshandama 2013; Mavhandu-Mudzusi and Sandy 2015). All institutions and the broader society in South Africa are responsible, according to the human rights framework, to question the existence of homophobic attitudes and the enforcement of heterosexual practices that perpetuate discrimination and stigmatisation against same sex practicing individuals (lesbian, gay and bisexual) as well as people who have a non-normative gender presentation (transgender and intersex individuals) (Brouard

and Pieterse 2012:55). While the health care system in South Africa is not exempt from this provision, Rispel, Metcalf, Cloete, Moorman and Reddy (2011:143) found that the key informants that they interviewed in their study differed with regard to whether health services for MSM should be mainstreamed within the public health sector, or whether separate services were needed. When health care services are not mainstreamed, it tends to discriminate against LGBTI communities and one such example is the HIV/AIDS awareness campaigns which are very heterocentric and designed in such a way that they mainly target the heterosexual population (Mavhandu-Mudzusi 2016:4) thereby excluding LGBTI students from accessing this much needed services. These students are therefore at increased risk of HIV and other diseases because the prevention messages are not reaching them. As a result of their sexual orientation and gender identity, LGBTI people, including students, risk poor health outcomes and, therefore, in the next section, the researcher wants to align himself with a growing call from public health and other professionals to the WHO to officially recognise sexual orientation and gender identity as social determinants of health. These advocates argue that, if sexual orientation and gender identity are acknowledged as social determinants of health, this will force health specialist to prioritise appropriate policy and programme initiatives and thus provide better access to LGBTI persons.

## **2.5 Sexual orientation and gender identity as determinants of health**

There is growing consensus among researchers and health experts that sexual orientation and gender identity are increasingly becoming very important determinants of health for LGBTI people, including students (Muller 2016:197. These constructs are very important to consider since they have been found to have shaped the living conditions and health outcomes of these sexual minority individuals through sociopolitical and sociocultural factors (Logie 2012: 1244; Hosseinpoor, Williams, Amin, de Carvalho, Beard, Boerma, Kowal, Naidoo, Chatterji 2012). Sexual minority individuals are present in all social-economic groups, cultures, abilities, ages and ethnicities. All or any of these factors can have an additional effect on how they are viewed by society, how they view themselves and also on their health status. This intersectionality can work to create new inequities or increase existing ones. Conservative global population based estimates suggest that 1.2%

of the global population belong to sexual minority groups which at the time roughly equates to about 84 million people (Logie 2012:1245). This constitute a large portion of the global community and therefore LGBTI health should be put on top of the agenda and included in health equity dialogues. Men, Frieson, Socheat, Nirmita, and Mony (2011:22) highlights the fact that “sexual orientation, or gender identity in, and of, themselves, are not causally related to poor health outcomes, but are rather the basis for differential treatment, and in many cases, discrimination, rendering them social determinants of health”. For example, being a lesbian woman does not cause breast cancer, but being a lesbian woman significantly increases one’s chances for breast cancer. Due to the social stigma lesbian woman experience from healthcare providers, they are less likely to seek healthcare services as opposed to their heterosexual counterparts and therefore would not have access to diagnostic services for breast cancer. Thus, access to quality sexual reproductive healthcare and other health related services is important in order to eliminate health disparities. Gender roles, norms and behaviour are socially constructed and have a significant influence on how LGBTI persons access health services and how health systems respond to their different needs (Men, Frieson, Socheat, Nirmita, and Mony 2011:22). In light of the impact that social and economic exclusion, violence, and minority stress due to discrimination and stigmatization have on the health of sexual and gender minorities, it has been suggested that sexual orientation and gender identity should be recognized as a social determinant of health, much like gender, socio-economic status, and others (Muller 2016).

Health disparities affecting LGBTI communities are well-documented, and span each subgroup of this population. In the same manner in which other social determinants of health lead to health disparities, so too does gender identity and sexual orientation play a role in creating these inequalities. LGBTI individuals, compared to their heterosexual and non-transgender socioeconomically matched peers, face higher prevalence levels of a number of risk factors for poor health (Whitehead, Shaver & Stephenson 2016:2) and are more likely to face barriers accessing appropriate healthcare (Cele, Sibiyi & Sokhela 2015:6). For example, HIV prevalence estimates revealed that MSM were at least four times more at risk of HIV infection than their heterosexual counterparts (Evans, Cloete, Zungu, Simbayi 2016:52). Unprotected anal intercourse (UAI), having multiple sexual



partners, intravenous drug use (IDU) and other drug use are some of the individual level factors reported to be responsible for the elevated HIV risk among sexual minorities. Another study conducted in South Africa found that “Being Black, living in a township and lacking HIV knowledge reduced MSM’s likelihood of ever having tested for HIV” (Knox, Sandfort, Yi, Reddy & Maimane 2011:5). Scheibe (2014:140) found that black MSM in Cape Town had a lower median income compared to other participants and reported to have had experienced high levels of racism and discrimination. Concerning employment status, in the Marang Men’s Project the majority of MSM respondents in Cape Town and Johannesburg were unemployed (68.4% and 61.8%, respectively), with 48.9% of MSM in Durban reporting to be students (Cloete, Simbayi, Rehle, Jooste, Mabaso, Townsend, Ntsepe, Louw, Naidoo, Duda, & Naidoo 2014:51). In the Soweto Men’s Study, adjusted analysis showed that 62.3% of the study sample reported to be unemployed (Lane, Fisher, Dladla, Rasethe, Struthers McFarland, & McIntyre 2011:628). In combined analysis, in the JEMS, 65.8% of survey respondents reported being unemployed (Rispel, Metcalf, Cloete, Reddy & Lombard 2011:72). In all three studies it was found that being unemployed considerably increased MSM chances of contracting HIV.

## **2.6 Gender-responsive health policies and programmes in the campus healthcare system**

In order for health programmes to be gender responsive they need to attend to the needs of LGBTI students and address LGBTI students’ development and help them establish and sustain consistent, supportive relationships (WHO 2011:22). Gender-responsive programming provides LGBTI students with safe opportunities to heal from trauma without fear that disclosure and discussion will carry negative consequences. The Gender-Responsive Program Assessment is a tool by which programme administrators, programme evaluators, and agency monitors can evaluate the gender responsiveness of programmes for LGBTI people and obtain feedback that can be used to improve the quality of a programme’s services. WHO (2011) designed the Gender Responsive Assessment Scale (GRAS) to guide programme administrators to assess the quality of their health programmes and table 1 below captures a summary of the main tenets of the scale.

**Table 2.1:** Summary of the Gender Responsive Assessment Scale (GRAS)

<b>Gender Responsive Assessment Scale (GRAS)</b>	
Level 1: Gender- unequal	Health programmes and policies which tend to be gender unequal perpetuates gender inequality by reinforcing unbalanced norms, roles and relations. They tend to privilege men over women (or vice versa), heterosexual over homosexual, cisgender over transgender. This often leads to one gender / sex enjoying more rights or opportunities than the other.
Level 2: Gender- blind	Health policies and programmes which are found to be gender-blind ignore gender norms, roles and relations. These policies and programmes very often reinforce gender-based discrimination, ignore differences in opportunities and resource allocation for heterosexual and homosexual persons and are often constructed based on the principle of being ‘fair’ by treating everyone the same.
Level 3: Gender- sensitive	Health policies and programmes which are gender-sensitive consider gender norms, roles and relations but fail to address inequality generated by unequal norms, roles or relations. While such programmes and policies indicate some level of gender awareness, they often fail to develop remedial action.
Level 4: Gender- specific	Health programmes and policies that are found to be gender specific take gender norms, roles and relations for women and men, transgender and cisgender, heterosexual and homosexual into consideration and how they affect access to and control over resources. These programmes and policies consider women’s and men’s specific needs and intentionally targets and benefits a specific group of women or men to achieve certain policy or programme goals or meet certain needs.
Level 5: Gender- transfor- mative	The fifth level in the GRAS considers gender norms, roles and relations for women and men and these affect access to and control over resources. They consider women’s and men’s specific needs, addresses the causes of gender-based health inequities, and includes ways to transform harmful gender norms, roles and relations, with the objective to promote gender equality.

**Source:** WHO 2011

Gender responsiveness in health programme management is extremely important because it addresses the very issues of access, availability and quality of targeted services designed for sexual minority groups. The GRAS is an important tool for this research because it guides the researcher in determining the level of responsiveness or availability health services offered on campus based on the responses from participants.

## **2.7 Healthcare preferences by LGBTI communities**

It is important that when we assess the experience of LGBTI students in accessing healthcare that we also focus on what these individuals prefer when they seek healthcare. Studies which specifically looked into this domain seem to agree on certain matters such as a desire to seek non-judgmental providers, a desire for rapid HIV testing, perceiving sexual health services as more convenient than primary care services (Koester, Collins, Fuller, Galindo, Gibson and Steward 2013:6; Hoffman, Freeman and Swann 2009:225). Both of these studies looked at the healthcare preferences of LGBTI persons but one specifically looked at gay and bisexual men and the other one focused on youth. One noticeable observation in the findings between these two groups was the fact that both groups ranked high the desire to have providers with expertise in sexual health and understanding sexual minority issues. In the following section we will discuss the theoretical basis for this study by looking at two theories, namely the Health Belief Model and the Minority Stress Theory.

## **2.8 Theoretical and conceptual framework**

A theory is an explanation of a phenomenon (happening) or an abstract generalization that systematically explains a relationship among given phenomena for purposes of explaining, predicting and controlling such phenomena. Most theories that are accepted by scientists have been repeatedly tested by experiments and can be used to make predictions about natural phenomena. This study employed two theories, namely the Health Belief Model (HBM) and the Minority Stress Model. These models will be discussed in more detail in the following section.

### **2.8.1 The Health Belief Model**

The HBM was selected as the lens to guide the main objective of the study which is to describe the health related behaviours of LGBTI students by exploring their experiences in the process of accessing healthcare. The HBM is an individual-level theory which posits that individuals are the key decision makers responsible for their own health or health behaviour change, assumes that individuals both value good health and will make behavioural changes to improve health outcomes, and that health behaviour changes are both volitional and the result of rational decision making processes (Youatt 2016:15). As illustrated in the literature review, LGBTI people experience enduring stigma and discrimination from a young age which has the potential to lead to internalised homophobia characterized by expectations of stigma and discrimination, especially from healthcare providers. As a result, many chose not to disclose their sexual orientation and gender identity to the healthcare provider or they simply avoid using the services altogether, thereby missing opportunities for appropriate and targeted healthcare services and at the same time this increases their vulnerability to ill health. The requisite health-related behaviour change, which is absolutely critical, is perhaps best described by applying the HBM (Youatt 2016:15). If sexual orientation disclosure is conceptualized as a health behaviour, using the HMB as theoretical lens to investigate it might offer a better understanding of this behaviour and provide insight into interventions which might increase access to these health related services. The HBM is a psychological model that was conceptualised by social psychologists Hochbaum, Rosenstock and Kegels during the 1950s in response to the failure of a free tuberculosis (TB) health screening programme (Glanz, Rimer and Viswanath 2008:45). Since then, the HBM has been adapted to explore a variety of long- and short-term health behaviours, including sexual risk behaviours and the transmission of HIV.

The model, according to Glanz et al (2008:46), is an expectancy-value approach of decisions that are specifically related to one's health, and assumes that the willingness to engage in preventive health behaviour depends on a two-step appraisal process: (a) the perceived threat of the disease under consideration, and (b) the result of a "cost-benefit analysis" of the preventive behaviour. Six constructs exist within the model, perceived

susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy. The model hypothesizes that three classes of factors exist in health-related action, and the three factors are (1) the existence of sufficient motivation or perceived severity of the health threat, (2) the belief of vulnerability to the disease, and (3) cues to action that make the health-risk salient (e.g., information about the disease communicated by the media). When a perceived threat and susceptibility have been established, a measurement of benefits against barriers dictates the change. If individuals regard themselves as susceptible to a condition, believe that condition would have potentially serious consequences, believe that a course of action available to them would be beneficial in reducing either their susceptibility to or severity of the condition, and believe the anticipated benefits of taking action outweigh the barriers to (or costs of) action, they are likely to take action that they believe will reduce their risks. In other words, for LGBTI students to have access to HIV prevention services, targeted interventions need to address their risk, susceptibility and vulnerability to the disease which will ultimately lead to positive behaviour change. In South Africa, many studies which focused on HIV prevention programmes pointed out the fact that these programmes and services mainly target heterosexual populations and therefore exclude LGBTI communities from these services. In the next section we define the major constructs of the model and explain how the exclusion of LGBTI people affect the way they access these health related services.

### **2.8.1.1 Major constructs of the HBM defined**

**Perceived susceptibility** or vulnerability refers to beliefs about the likelihood of getting a disease or condition (Glanz et al 2008:47). For instance, a person must believe there is a possibility of contracting HIV before he/she will be interested in using a condom. Interestingly, Gerrard, Gibbons, Warner and Smith (1993) cited in Bakker, Buunk, Siero and van den Eijnden 1997:483) found that when they reviewed the evidence in their study for the correlation between perceived vulnerability to HIV infection and HIV preventive behaviour the conclusions were mixed. They reviewed cross sectional as well as prospective studies and the results indicated sometimes negative, sometimes zero and sometimes positive correlations between perceived risk of contracting HIV and HIV preventive behaviour (Bakker, Buunk, Siero and van den Eijnden 1997:483). However, as

indicated earlier, many of these HIV prevention programmes exclude LGBTI individuals from these services and therefore they don't have access to this valuable information regarding their vulnerability to HIV and other sexually transmitted infections in order to make the required behavioural changes.

**Perceived severity** which relates to feelings about the seriousness of contracting an illness or of leaving it untreated includes evaluations of both medical and clinical consequences (for example, death, disability, and pain) and possible social consequences (such as effects of the conditions on work, family life, and social relations). The combination of susceptibility and severity has been labelled as a perceived threat (Glanz et al 2008:47). If sexual minority groups don't have access to information, they are less likely to establish a perceived threat and susceptibility to HIV and therefore lack the motivation to alter any risk behaviour.

**Perceived benefits** relate to beliefs that available actions will lead to a reduction in the threat to acquire the disease and this belief will influence whether the person will alter behaviour regardless of the fact that he/she perceives personal susceptibility to a serious health condition (Glanz et al 2008:47). Again, this highlights the fact that we need targeted interventions that will reach sexual minority groups with information regarding the benefits of protection during anal sex for men who have sex with men for example.

**Perceived barriers.** The potential negative aspects of a particular health action may act as impediments to undertaking recommended behaviours. Again, if we take the example of identity disclosure to healthcare provider as a health behaviour, LGBTI individuals will be less like to disclose due to high levels of expectations of discrimination from healthcare providers. A kind of no conscious, cost-benefit analysis occurs wherein individuals weigh the expected benefits of actions with perceived barriers - "It could help me, but it may be unpleasant, inconvenient, or time-consuming". Thus, "combined levels of susceptibility and severity provide the energy or force to act and the perception of benefits (minus barriers) provide a preferred path of action" (Glanz et al 2008:47).

**Cues to action.** Hochbaum (1958) cited in (Glanz et al 2008:47) was of the perception that readiness to take action (perceived susceptibility and perceived benefits) could be potentiated only by other factors, particularly by cues to instigate action, such as bodily events, or by environmental events, such as media publicity. In other words, media, friends, family, or well-known citizens can provide an impetus for prevention. The absence of cues to action will reduce the likelihood of prevention (Bakker, Buunk, Siero and van den Eijnden 1997:484).

**Self-efficacy** is achieved when one is persuaded that one can successfully execute the behaviour required to produce the outcomes (Glanz et al 2008:49). Alfred Bandura in his work in psychology distinguished self-efficacy expectations from outcome expectations and this is defined as a person's estimate that a given behaviour will lead to certain outcomes. Outcome expectations are similar to but distinct from the HBM concept of perceived benefits (Glanz et al 2008:49).

The HBM will guide the research questions and will be used to broaden our understanding regarding the type of health related decisions LGBTI students engage in and how those decisions are influenced by external forces. In the following paragraph we will explore another theoretical framework, namely the minority stress model.

### **2.8.2 Minority Stress Theory**

The minority stress theory has been described and, in recent times, accepted as one of the most prominent conceptual models which explains the health and health disparities among LGBTI communities (Lick et al 2013:521). Coined by Meyer (2003), the theory looks at factors which are associated with various stressors and coping mechanisms and their resulting negative or positive outcomes. According to Meyer (2003:679), the model describes stress processes, including experiences of prejudice, expectations of rejection, hiding, concealing, internalised homophobia and ameliorative coping processes. The theory postulates that minority individuals, including LGBTI students, have to constantly adapt to stressors such as homophobia or sexual stigma that comes from the environment in which they find themselves and this causes significant stress, which ultimately affects

physical and mental health outcomes. It is important to consider the stressors experienced by minority groups because they are likely to be subject to these conflicts because of dominant culture, social structures, and norms that do not fit those of minority groups (Rodriguez 2016:14; Meyer, 2003:675). Society, in itself, becomes a stressor because dominant negative perceptions towards LGBTI persons often conflict, negate and invalidate minority cultures. Such impositions may occur at an institutional level (macro-level) or individual level (micro-level). All these factors inherent in this model in one way or the other affect how sexual minority groups access healthcare services. This study was particularly interested in exploring how these environmental stressors operate in the campus environment and describing how they create barriers for LGBTI students in the process of accessing healthcare.

The foundation of minority stress rests upon three main assumptions. In the first instance, the theory makes the assumption that stressors are unique to minority groups and not experienced by non-stigmatised populations. In other words, minority stress is additive to general stressors that are experienced by all people. Secondly, these stressors are chronic and related to social and cultural structures. Relatively stable social structures such as laws and social policies are often the source of stress for minority persons in addition to personal events and, according to Meyer (2003:676), may lead to mental and physical health problems. Third, minority stress is “socially based”, that is, it stems from social/structural forces such as social processes, institutions, and structures rather than personal events or conditions which ultimately create these barriers to healthcare for LGBTI individuals (Meyer 2003:676). Meyer argues that the concept of social stress discussed here is actually an extension of stress theory because it considers factors within the environment and beyond personal life events. Social stress might therefore be expected to have a strong impact in the lives of LGBTI students and according to minority stress theory these are exacerbated by additional social categories such as socioeconomic status, race/ethnicity, and even HIV status.

The pervasive levels of homophobia, biphobia and transphobia wielded towards LGBTI communities by society have serious, injurious psychological effects on these



communities. According to Dentato (2012: no pagination), these psychological effects come into force when LGBTI persons apply the negative attitudes towards themselves especially so with feelings associated with internalised homophobia. This, in turn, increases the vulnerability of LGBTI persons to heightened levels of HIV and other sexually transmitted infections (STIs) as well as other physiological health problems. Those LGBTI persons who are living with HIV have to live with the stigma associated with this diagnosis and the ones who are negative constantly worry about becoming infected with HIV. This, according to Dentato (2012: no pagination), “has the potential to cause varied levels of psychological distress that may result in mental health challenges, engaging in risky behaviour including unprotected anal intercourse, substance use or sex with multiple partners”. He further argues that these negative attitudes towards self and the risk behaviours increase exponentially when members of the LGBTI communities are also members of a minority racial or ethnic group. Some LGBTI members have to battle a triple burden of stigma including being a member of an LGBTI subgroup, being HIV positive and being black. These multiple minority statuses also increase the likelihood of experiencing homophobia, biphobia, transphobia, stigma, isolation, rejection, and a heightened risk of sexual risk behaviour and substance use. In the next paragraph we take a look at how the minority stress model has been utilised in other studies.

LGBTI matters have received increased attention in recent times. Here in South Africa a robust debate ensued on social media in January 2017 regarding the legitimacy of homosexuality and the role of Christianity (Pather 2017). What emerged from these discussion is that homophobia, prejudice and discrimination are rife among the general population and they are fuelled by religious assumptions. Various studies conducted with LGBTI communities have found high levels of anti-gay victimisation. In fact, Katz-Wise and Hyde (2012:156) conducted a meta-analysis and estimated that as many as 80% of LGBTI individuals experience some form of harassment throughout their lives. While some studies reported religious environments as a source of support and resilience, especially for people of colour (Miller 2005:41), others found that LGBTI persons of colour are less likely to be open about their sexuality compared to their white LGBTI counterparts (Moradi, Wiseman, De Blaere, Goodman, Sarkees, Brewster & Huang

2010:412). Quinn, Dickson-Gomez, DiFranceisco, Kelly, Lawrence, Amirghanian & Broaddus (2015:217) argue that LGBTI persons who experience this perceived need to conceal their sexuality within an environment that simultaneously provides support and a sense of community are more likely to experience significant internal turmoil and distress and, subsequently, internalised homonegativity.

Meyer extended Lazarus and Folkman's (1984) work on stress by describing minority stress processes "along a continuum from distal stressors, which are typically defined as objective events and conditions, to proximal personal processes, which are by definition subjective because they rely on individual perceptions and appraisals" (Meyer, 2003:5). The minority stress theory goes one step further to explain the higher prevalence of adversarial health conditions among LGBTI persons by distinguishing between several specific, but interconnected processes – distal and proximal stressors – that confront non-heterosexuals as a stigmatized group. This distal-proximal or objective-subjective continuum of minority stressors has been helpful in differentiating between the impact of various types of stressors related to non-heterosexual stigma (Meyer, Bradford, Makadon, Stall, Goldhammer, & Landers 2008:990).

## **2.9 Conclusion**

The purpose of this literature study was to determine current knowledge on the healthcare experiences of LGBTI students in order to establish a solid conceptual framework for the study and to explore related concepts and constructs such as healthcare utilization and healthcare access which encompasses the overall healthcare experience. Through the literature study it has become evident that the healthcare experience of LGBTI persons in general tends to have a negative association and there are various reasons for this. The healthcare experience of LGBTI communities includes the barriers to access and factors that influence healthcare utilization. These can be further reduced to include structural issues such as policies, laws and programmes and individual characteristics which prevent LGBTI communities from entering healthcare and ultimately increase their vulnerability to acquire disease and experience stigma and discrimination.

## CHAPTER 3

### METHODOLOGY

#### 3.1 Introduction

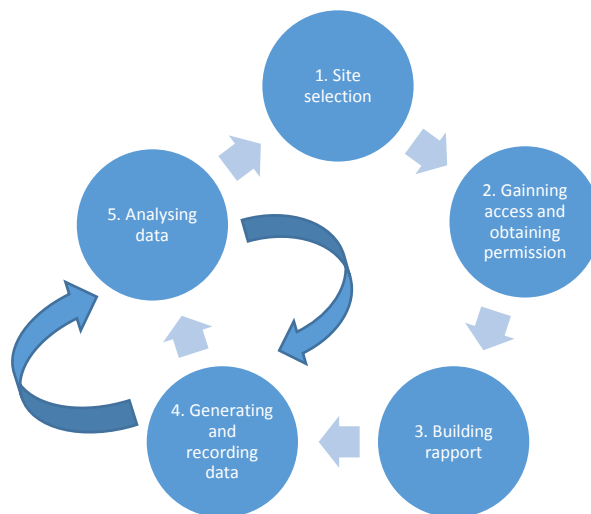
Qualitative research has grown substantially over the last thirty years (Santiago-Delefosse, Gavin, Bruchez, Roux, & Stephen 2016:142) especially so in the health sciences and among health service research (Rosenthal 2016:509). While qualitative research methods cannot be used to study the characteristics of an entire populations, it is argued that this form of enquiry can bring unique opportunities in our efforts to understand LGBTI health and it does allow for a more detailed account of individuals' experiences as members of LGBTI populations (IOM 2011:120). This qualitative enquiry allowed for the research process to occur in its natural setting and for the researcher to gather information up-close by actually talking directly to participants and observing their actions and behaviour within their context (Creswell 2014:234). This approach was a better fit for the purpose of this study, because the researcher gained an in-depth understanding of the underlying reasons, attitudes, and motivations behind various behaviours described by participants (Rosenthal 2016:510). Through this systematic and rigorous form of enquiry, a number of data collection methods such as key informant interviews, focus group discussions, and observations were used. This chapter will describe these methods in more detail including a description of the sampling procedures, data management, data analysis, trustworthiness, and ethical considerations.

#### 3.2 Research process

The data collection process started when the researcher began to negotiate access to the study site with all relevant gate keepers and to build rapport with the study community. The data collection procedure for this study was inspired by Creswell's model of data collection which has been adapted by Cronje (2011:103) and is presented in Figure 3.1 below. Site selection for the study was informed by the fact that the researcher, at the time of the study, was employed by the university where the study was conducted. Based on his

work in HIV prevention on campus, the researcher became interested in the study topic and therefore initiated this study. As a result of previous engagements with the LGBTI group around campus, gaining access and permission was facilitated faster since the researcher had already started building rapport with the group. All other permissions from university authorities were also sought prior to conducting this study. The model is presented in a cyclical diagram making the assumptions that the research is a rather linear process. Qualitative research in general and specifically qualitative data analysis is certainly not linear but rather iterative and goes back and forth (Ritchie, Spencer and O'Connor 2003:219) until the researcher has reached data saturation. This was well illustrated in this study because once the data analysis was completed, the researcher went back to the participants and conducted - as Creswell (2014:3) has coined it - “member checking” to verify the data. The model in Figure 3.1 was adapted by the researcher in order to illustrate the iterative process between data collection and data analysis. This study was interested in describing and exploring the multiple realities and experiences of LGBTI students from the perspective of the study participants themselves or what anthropologists coined the “emic perspective” (Babbie 2015:294) and therefore it was more fitting to apply the social research process of qualitative inquiry. In order to achieve this, the study used three methods to engage the participants which yielded rich data for analysis. These methods are discussed below.

**Figure 3.1: Data collection cycle**



**Source: Adapted from Creswell, 2007:118 cited in Cronje (2011)**

### **3.3 Key informant interviews**

It has been suggested in the literature that one of the ways in which a researcher can quickly gain some insight into a particular topic and in a relatively inexpensive way is through key informant interviews (De Chesnay 2015:153). Key informant interviews are regarded as an expert source of information (Marshall 1996, cited in Stover 2011:54) because key informant interviewees, such as the ones selected for this study, are people who are knowledgeable about the research topic, they provide opportunities to explore the research questions and they also assist in facilitating additional access to the targeted research population. Key informant interviewees were selected based on their leadership roles in the campus healthcare system and involvement with LGBTI students. All head of departments within the campus healthcare system were sent an information sheet about the study and were invited to participate in the study. They all had an equal opportunity to participate. Fortunately, all agreed to participate. The key informant interviews were conducted prior to the focus group discussion and assisted greatly in validating the focus group discussion guide.

A total of five key informant interviewees were selected to participate in the study. Three of the interviewees were selected from the campus healthcare system in order to gain a better understanding regarding the experience of LGBTI students accessing healthcare, specific healthcare programmes for these students and much more. The campus healthcare system comprises, among others, the campus clinic, the HIV office and the psychological services. Two additional interviewees were selected in order to provide both a professional gender perspective as well as the voice of the sexual minority student leadership regarding associated matters on campus. The key informant interviews were conducted in English and were digitally recorded and transcribed along with the other data. Due to the highly stigmatized and discriminatory environment in which sexual minority students find themselves, it was anticipated that research participants might be difficult to recruit and therefore the key informants were instrumental in assisting the researcher in identifying potential participants and facilitating the entry process.

### **3.4 Focus group discussion**

Focus group discussions as opposed to individual interviews can be much more useful for helping LGBTI students to express and clarify their views in relation to their experience in accessing health services on campus. According to Krueger and Casey (2000:11), a focus group provides “a more natural environment than that of individual interviews because participants are influencing and influenced by others- just as they are in real life”. The focus group discussion was dynamic in that it allowed for the participants to engage with other LGBTI persons on pertinent matters which were guided by the focus group discussion guide and the research objectives. The researcher was able to examine how opinions are formed within the group, how ideas are challenged, and how authority was claimed (De Chesnay 2015:159). This strategy allowed the researcher to immerse himself in the life world of the participants through the stories that they were telling (Smith, Flowers & Larkin 2009:56).

The study population comprised of all members belonging to the LGBTI student group. The university where the study took place had a total student population of approximately 50000 students at the time and the membership base for the student LGBTI group was between 300-400 members. According to the chairperson at the time, “The LGBTI student group promotes equality and a non-discriminatory campus environment and also serves as a space for likeminded students to socialise and engage in meaningful group activities on campus”. The group was identified as an important gatekeeper to gain entry into the study population. Many sexual minority students are not out to others, others do not want to be associated with dominant sexual identity categories (LGBTI), and some only feel comfortable coming out to particular people or support groups or counsellors and therefore it can be difficult to reach these students if they do not belong to any support networks or communities. The researcher approached the LGBTI group’s executive committee by way of a letter in which permission to conduct the research was requested and the study procedure explained. The purpose of the engagement was also to build rapport with the group and to earn their trust. Purposive sampling, a form of non-probability sampling, was used and participants were selected based on their capacity and willingness to participate in the research (McComack 2014:475). Inclusion criteria for participation was being a

registered student, membership in the LGBTI student organization, identification as LGBTI and willingness to participate in the study. Students who did not present as LGBTI were excluded from participation. A total of eight participants were recruited to participate in the focus group discussion and the researcher selected a neutral venue in order to accommodate the needs of all participants. This allowed the participants to be comfortable and relaxed and to feel in control of the environment. The discussions were conducted in English and lasted approximately 90 minutes. Due to the fact that this is a dissertation of limited scope the researcher only conducted one focus group discussion.

### **3.5 Field notes**

Detailed field notes were kept throughout the data collection process. Researchers use field notes as a kind of evidence on which they base claims about meaning and understanding (Schwandt 2015:116). The researcher ensured that immediately after each interview detailed notes were jotted down in a notebook while the information was still fresh in order to reflect on some of the verbal and non-verbal cues which were observed during the interviews. These field notes were also used during the data analysis procedure to enhance the descriptions and explanations of some of the findings, as captured in Chapter 5.

### **3.6 Data analysis**

One of the challenging tasks for qualitative researchers is analysing text data and this is further exacerbated by decisions on how to represent the data in tables, matrices and in narrative forms (Creswell 2007:147). Earlier it was mentioned that the qualitative research process is not linear such as quantitative research in which the investigator collects the data, then analyses the information, and finally writes the report (Creswell 2014:194). As indicated in Figure 3.1, the process is iterative and will commence together with the data collection and interpretation processes. Data from the interviews and focus group discussions were digitally recorded and transcribed verbatim into a Word document.

Thematic analysis, one of the most common forms of analysis in qualitative research, was used to analyse the data. This form of analysis was chosen because it emphasises, pinpoints, examine, and records patterns (or themes) within data. Data were reduced into meaning units and was coded and classified accordingly to predefined subcategories, categories and overall themes and the researcher adhered to the suggested number of between 5-7 themes as proposed by Creswell (2014:194). The categories were grouped into themes which were directed by the research objectives. Axial coding was then applied to make connections between categories and codes. The other data collected was also brought into the analysis for interpretation such as the interviews conducted with the key informants. Data was analysed for manifest and latent content. Findings were contrasted in relation to data obtained from the group and data in the literature. Thick descriptions and direct quotes were generated to contextualize the findings and to present data.

### **3.7 Validity of the study**

One of the strengths of qualitative research is validity, and it is based on the principle of determining whether the findings are accurate from both the researcher and the participants' standpoint (Creswell 2014:201) through the application of various strategies. The validation strategies which was used during this study are discussed below:

- *Credibility*

Credibility is defined as the confidence that can be placed in the truth of the research findings (Anney 2014: 276) and the researcher attempted to achieve this through *prolonged engagement in the field and through member checking*. In an attempt to increase the integrity of the research, the researcher spent considerable time with the study community in order to get a closer understanding of the group culture and to build rapport. For example, the researcher attended two social events organised by the leadership where about ten members were present. After the focus group discussion was transcribed, the researcher took the transcribed notes back to some of the participants to verify whether the data was captured correctly and it reflected truthfully their experiences. This strategy, according to Anney (2014:277), is called *member checking* and allowed the participants to evaluate the



interpretations made by the researcher and also allowed them the opportunity to make changes should they have been misrepresented in the interpretations of the researcher.

- *Transferability*

The researcher ensured the degree to which the results of the study can be transferred to other contexts by providing a rich, thick, robust and detailed account of his experiences during the data collection process. A detailed description of the purposive sampling technique employed to recruit the study participants is provided, while the study participants as well as the setting were well described in the report in order to allow the reader to have a full picture of the study and in case someone want to reproduce the study.

- Clarifying researcher bias

The qualitative researcher, as mentioned earlier, cannot divorce himself from the research process and plays an active role in generating the data. In order to clarify his own biases, the researcher kept a reflexive journal in which he reflected on personal assumptions and biases throughout the research process. As mentioned earlier, the researcher assumed an emic perspective and wanted to describe the experiences of participants from their own perspectives. As a member of the LGBTI community, the researcher had to continually reflect his own biases and had to observe from the outside in order to maintain an objective view of what was said.

### **3.8 Ethical considerations**

The concept of vulnerability of the participants was taken with considerable interest in this study because the researcher was cognizant of the ethical considerations required working with sexual minority groups. In the subsequent sections we discuss these ethical considerations in more detail.

- Prior to conducting the field work, the researcher obtained ethical approval form the UNISA Department of Sociology Ethics Committee.
- The researcher ensured that the highest level of *confidentiality* was maintained by not collecting participant identifiers (names, date of birth) and by refraining from using real names during the interviews. This standard was further upheld by the

researcher when he made sure that the completed field notes and digital recordings remained in his possession and locked in a cupboard until data transcription and analysis were completed. Data from the digitally recorded interviews was transcribed verbatim into a Word document and the recordings will be kept for five years.

- *An informed consent form* was provided to each participant prior to conducting the field work. Permission to audio-record the interviews was also obtained during the informed consent process. The researcher presented an information sheet to each participant and explained the research prior to conducting the informed consent process. This process assisted participants to make an informed decision about participating in the study.
- All participants in the study were assured that their participation in the study was *voluntary* and that they could withdraw at any time without any negative consequences. Due to the nature of the study and the high levels of stigma and discrimination present in the environment, the researcher made absolutely sure that the participants understood the voluntary nature of their participation.
- The researcher ensure that the principles of *no harm* and *protection* were adhered to by selecting a neutral venue to conduct all the interviews where participants felt protected and in a safe environment. The researcher again emphasized the importance of confidentiality when he discussed no harm with focused group participants. The researcher highlighted the risk which accompanies participation in a focus group discussion as the researcher cannot assure that everyone in the group will keep the information private when they leave the group.
- Debriefing: A debriefing sessions was held with the focus group participants after the discussion where they were provided with an opportunity to share their views about the discussion and to make possible suggestions.

### **3.9 Conclusion**

This chapter provided a detailed description of how the research process unfolded in order to answer the research questions. A justification of the research approach (qualitative

research) was presented together with arguments on the use of the stated data generating tools (key informant interviews, focus group discussions and observations). The following two chapters will capture a detailed account of the data that were generated and present the researcher's interpretation thereof.

## **CHAPTER 4**

### **FINDINGS**

#### **4.1 Introduction**

This chapter presents the findings from the data that was collected from a total of five key informant interviews and one focus group discussion. The focus group discussion consisted of a diverse group of seven LGBTI participants who were selected from the LGBTI student society. A profile of all the participants in the study will commence the chapter and this will be followed by a detailed discussion of the findings, which outlines the major themes, categories, and sub-categories that emerged from the analysis of the data. The presentation of the data will include direct quotes from the transcriptions in order to illustrate the respondents' perceptions and these will be discussed with reference to existing literature.

The purpose of the study was to explore and describe the experience of LGBTI students in accessing healthcare in a contact higher education institution. Furthermore, it describes whether participants were aware of the healthcare needs of sexual minority students, where these students prefer to go if and when they need to access sexual reproductive health and related healthcare services on campus, and how they suggest current services can be improved to make them more accessible to marginalised students.

#### **4.2 Profile of participants**

The profiles of participants presented below in table format were derived from the two types of interviews described above. All names are omitted to protect the identity of the participants and to maintain confidentiality. Five key informants were interviewed and they all shared one common attribute, which is to render a service to the LGBTI student community, and these services include health, education and recreation.

Table 4.1: Profile of key informants (KI)

	Description
KI 1	LGBTI student leader
KI 2	Gender specialist and lecturer
KI 3	Primary Healthcare nursing specialist
KI 4	Primary Healthcare specialist (Sexual Reproductive health and Rights)
KI 5	Psychologist

The focus group consisted of four males and three females and a description of how they prefer to identify themselves is presented below in table 4.2. Two participants identified themselves as gay, two as lesbian and three as bisexual. At the time of recruitment, no transgender students were identified. All participants were young students between the ages of 18-35 years. All participants were Black and were comfortable speaking English.

Table 4.2: Profile of LGBTI focus group participants (FGP)

	How they presented themselves
FGP 1	I identify as a woman that is attracted to other woman (female)
FGP 2	I identify as a man who is attracted to other man and also woman to some extent (male)
FGP 3	I identify myself as a homosexual (male)
FGP 4	I am bisexual as well (male)
FGP 5	I identify myself as gay (male)
FGP 6	I am bisexual (female)
FGP 7	I am very lesbian (female)

### 4.3 Key findings

The data generated from both data collection tools described above will be presented in an integrative manner and not individually because the researcher is not interested in drawing comparisons between the two samples but important associations have rather been

highlighted. It was important for the researcher to capture the voices of all participants in the study in order to describe the experience of LGBTI students when they access healthcare in the higher education sector. The data will be presented in four sections representing the research questions. Each section will highlight the main themes that emerged from the data analysis. Section 1: Factors affecting the experience of LGBTI students in accessing healthcare will address research question 1. Section 2 will cover the healthcare needs of LGBTI students from the perspective of participants and will address research question 2. Section 3 answers research question 3 and will capture the voices of participants in the focus group regarding their preferences of health services on campus. Section 4 is the final section and will present the suggestions from all participants on how services in the campus healthcare system can be improved to provide greater access for LGBTI students. This chapter will be concluded with a discussion on how the theoretical frameworks were integrated in the data analysis process to provide further understanding regarding certain concepts and to support the findings.

#### **4.3.1 SECTION 1: The experience of LGBTI students in the process of accessing healthcare**

The definition of healthcare experience as it is articulated by Wolf, Niederhauser, Marshburn, and LaVela (2014) includes social events that happen outside of the clinical experience and reflects occurrences and events that happen independently and collectively across the continuum of care. This was very helpful in guiding the analysis of the findings which suggest that LGBTI students experience various barriers and multiple forms of stigma within the university that manifest at various levels and have the potential to limit the availability, accessibility and utilisation of health services for these students. The following themes will be discussed:

- Structural barriers impede access to health services for LGBTI students on campus
- Discriminatory structure of the campus health system blocks sexual minority students from accessing healthcare services
- Mental health stigma

#### 4.3.1.1 Structural barriers impede access to health services for LGBTI students on campus

Queer issues, as some scholars prefer to call them, remain invisible within the higher education sector in post-apartheid South Africa (Msibi 2013:67) and, according to most participants, this campus environment reflects a similar scene. Contributions to this theme mainly came from the participants in the key informant interviews and understandably so since most of them form part of the institutional management team and are therefore in a position to comment on such issues. Participants overwhelmingly agreed that the campus environment is not conducive for open and honest discussions about queer issues or issues related to sexual orientation and gender identity. They put various reasons forward as to why they felt that management are failing to address sexual orientation and gender identity issues. For KI2 it simply meant a lack of leadership from university management to appreciate the importance of queer issues:

*“I don’t think there are a lot of leadership when it comes to LGBTI rights and how we can improve the environment... These are our students, our LGBTI community on campus still does not have a voice and I don’t think management have really address that you know.” - KI 2*

KI 3 agreed that there is a lack of leadership and explained it as a governance issues which should be addressed from the top.

*“I will start from top. I think the first thing is issues relating to governance because if a policy wise there is no clear strategy of what is the aim of a making sure that there is diversity and all of us adhere to that strategy for diversity.” - KI 3*

According to KI 3, the university needs to recognize that LGBTI matters deserve serious attention and this usually comes in the form of a policy decision which will ultimately translate into a strategy. She further explained that the reason there are no health related programmes targeting LGBTI students on campus is that there is no clear strategy. KI2 is of the opinion that there is a lack of political will to address matters of sexual orientation and gender identity and usually these matters are shielded under the banner of diversity.

*“So they never talk about like LGBTI issues like that’s not the main aim it’s like part of diversity. I don’t know whether that is because (silence)*

*there is not enough will to only tackle the LGBTI issues or whether it is because uhm yeah or whether it's because there is a (silence) it's like a sensitive, not a sensitive topic but it's a topic that people are a bit scared off.” - KI 2*

According to participants, it is merely a tick box exercise for the university and being disguised under the banner of diversity perpetuates the silence around the topic. Msibi (2013:67) makes the same assertions and argues that information about how LGBTI students experience university is lacking because “queer issues in general remain silenced and very much in the closet”. He further argues that the silence in our institutions of higher learning is not surprising at all because 23 years post-apartheid and we still struggle to address sexual orientation and gender identity issues even though racial and gender discrimination received considerable attention. Participants argue that because of the inability of the university to address gender identity and sexual orientation issues head on, programmes targeting sexual minority students are lacking. In other words the university does not think that these matters deserve serious attention. Msibi (2013:70) agrees that the silence perpetuates a culture of heterosexism and promotes homophobia in the campus environment. Key informant interviewees were adamant that the silence around sexual orientation and gender identity is a clear indication of a lack of political will from the side of the university and this make it difficult to design, implement and coordinate specific health related programmes for LGBTI students. In summary, a lack of political will acts as barriers for LGBTI students to access healthcare services on campus. The statement below from KI3 captures the general feeling among key informant interviewees that calls for decisive action from university management to urgently put matters of sexual orientation and gender identity on its priority list.

*“Doesn't mean if a child is not complaining a child is happy. So I do think this kind of a session raises awareness on my part to say should we think we are doing the right thing, should we think we are on track all because we are not hearing any voices. Are we waiting for the frustrated voices to burst out and then we do crises management...” - KI 3*

Key informant interviewees further explained that due to the silence around queer issues on campus a heteronormative culture dominates which makes it difficult for queer students



to navigate the campus environment and access healthcare services. According to van Vollenhoven and Els (2013:280), “silence, misconceptions, disregard and social prejudice upholds a ‘hidden curriculum’ that violates LGBTI students' rights to dignity and equality, and enhances the homophobic stigma that still exists in the minds of many people”. This silence within the campus environment that perpetuates heteronormativity also instils a sense of fear for sexual minority students, according to most participants.

*“we (LGBTI students) can say that we are free and stuff like that but in actually reality we still live in fear of our lives”. – FGP 7*

According to KI 3:

*“...you don't know whether this is a safe environment for you to be free to everybody and for everyone to know your sexuality...So is this a safe environment? Do we have safe zones for our LGBTI students where if I experience discrimination because of my sexual identity I go through?...So I, it's, I think that is how I would feel if I was a student who's belonging to the LGBTI community.” KI 3*

Yet another participant made the following comment about the campus environment:

*“...I think there are still people who, who are still in the closet, who have been in the closet and still bumped into people they went to school with on campus and they still feel that they cannot express themselves. They would rather die than come out of the closet because there is...I know quite a number of people who would rather stay in the closet forever.” – FGP 4*

The campus environment is said to be even more hostile towards lesbian students because they feel excluded from the campus and have to constantly navigate a patriarchal system which is even present in the LGBTI circles. KI3 explains:

*“As much as lesbian woman go I have heard that they just say that there is no place for them on campus. They don't feel that they are welcome here but that does not only have to do with homophobia it also has to do with patriarchy. They do feel like men whether or not they gay or straight actually don't see them.” - KI 3*

So for lesbian students it appears the campus environment is a very difficult terrain to navigate since it exhibits elements of both homophobia and patriarchy. Again, Msibi (2013:70) reminds us of the slow transformational progress we have made in the higher education sector in South Africa and this campus space is a mere reflection of the sector as a whole. Just recently the HEAIDS (2014:51) study concluded that LGBTI students face homophobia and stigma on a daily basis which inhibit their access to sexual health services. These experiences of homophobia and stigma also leave them with little confidence that the higher education sector can constructively deal with their marginalisation and experiences of violence (HEAIDS 2014:51). Matthyse (2017:123) agrees that prejudice becomes more and more justifiable in an environment of continued silence, which perpetuates misconceptions, a blatant disregard for social prejudice against sexual minority students in the education system and a culture of violation of LGBTI peoples' constitutional rights to dignity and equality. We will quickly explore some examples of this heteronormativity on campus. Student residences or housing is the one space where LGBTI students have the least ability to hide their sexual orientation or gender identity. This is especially true for first year students who have no choice on where they are placed and often times have to share a room with another student. The issue of bullying and violence in the residences came up numerous times during some of the key informant interviews as well as the focus group discussion. Key informant 2 describes how LGBTI students explain to her that they feel scared and unsafe on campus:

*“they have mentioned to me that they do feel that they are like these alpha male macho man that look at them funny, they almost scared...”* – KI 2

Historically male residences on campuses have been characterized by notions of masculinity driven by a heteronormative agenda. KI 2 describes how some of these LGBTI students choose to isolate themselves from the rest of the student community because they fear being victimized and would rather avoid public spaces. FGP 2 explains his residence life as follows:

*“I am very uncomfortable in the male bathroom at the male residence where I live because when guys know you gay they make all sorts of remarks and assume you watching their private parts.”* – FGP 2

This is a classic example of the negative construction of LGBTI students who are often perceived as sexual predators, ready to have sex with everyone they see (Msibi 2013:70). These experiences are very emotional and, as FGP 2 explained, when he was a teen he was sexually molested and now he has to endure this ridiculing as well. An emotional FGP 2 explained to the group how hopeless he feels because he is unable to report these incidences to the authorities simply because he fears being further humiliated by management and other security authorities. Sometimes, as participant 2 explained, these negative experiences can be subtle such as name calling and being ridiculed but nonetheless damaging, and other times it can be as brutal as sexual violence or rape. Noticeably, all participants in the key informant interviews and one participant in the focus group discussion mentioned at least one incidence of sexual violence. FGP 3 mentioned his experience of sexual violence:

*“...my first sexual encounter with a man it was through rape, when a man molested me.” - FGP 3*

Key informant 4 mentioned at least one experience of sexual violence and possibly the involvement of illicit drugs:

*“...some of them do experience sexual violence. A recent example was one student who came in and said no I don't know what happened and he was not obviously gay... he narrated he's story I think I was raped.” - KI 4.*

KI 4 explained that the student consulted her for medical advice and reported that he thinks he was raped. He told her that he was at the club and then someone drugged him. When he came to, he found himself in a fight. Research conducted among the youth indicated that young people who have experienced violence and abuse report poorer physical health (Marshall, Dietz, Mark, Friedman, Stall, Smith, McGinley, Thoma, Murray, D'Augelli & Brent 2011:111). According to these authors, experiences of violence, harassment and bullying impact on mental health of LGBTI persons, and a much higher incidence of attempted suicide and self-harm have been reported among the LGBTI communities when compared with the general community. The study reported that amongst same-sex attracted youth, the experience of verbal abuse doubled the likelihood of self-harm, and the experience of physical abuse tripled the likelihood of self-harm (Marshall et al 2011:111). These experiences of violence and abuse might also prevent LGBTI students from

disclosing information about their sexuality to health care providers and in turn might affect their health and well-being and limit their access to health information. So from the analysis it appears that the experiences of stigma and discrimination are perpetuated by this dominant heteronormative culture present on campus. Matthyse (2017:123) concludes that the lack of political will and the silence act as structural barriers that are making the availability of services for gender non-conforming and same sex practicing students scarce and therefore these students don't have access to targeted interventions and services on campus. A study conducted in Europe that investigated the correlations between internalised homonegativity and sexual health (HIV) concluded that structural and environmental factors are associated with internalised homonegativity among MSM (Berg, Ross, Weatherburn & Schmidt 2013:65). The study reported that high levels of internalised homonegativity are correlated with lower levels of HIV information and less likelihood of accessing HIV prevention information. A low level of information about a particular disease is equal to a lower perceived susceptibility and therefore the individual is less likely to access HIV prevention services, according to the HBM. Another interesting finding is that internalised homonegativity was also positively associated with loneliness. In the next section we discuss the importance of social support and how this invisibility impacts on this very important resource for LGBTI students.

- ***Lack of social support systems as a barrier to access health information***

In order for an individual to improve his or her adaptive competence in dealing with long-term or short-term challenges and stresses he or she requires important attachments and this is referred to as social support (Clarke 2012:14). It was clear from the focus group discussion that participants place great value on attachments such as family, friends and other social networks on campus. Clarke (2012:14) agrees that social support is important for all individuals, especially so for LGBTI students, since it offers a sense of comfort and security and can reinforce one's sense of worthiness and identity. Similar to this finding, Berg, Weatherburn, Ross and Schmidt (2015:29) found that higher levels of internalised homonegativity is positively associated with loneliness. These researchers further suggest that MSM who experience social isolation have less access to safer sex information and resources. The analysis of the data revealed an interesting finding that involves social

networks, which in a way act as vehicles to access important health information. Participants explained how important it was for them to belong to the LGBTI group because it is through this group that they were able to access important health-related information.

*“If you not part of Liberati which is the only gay society, there is no other way, I think to know about MSM, no way... I don't think there is any other way you know, you will have information about such.” – FGP 4*

Another participant explained:

*“I honestly did not know until I met up with all these people here. That's when I started finding out about all these Liberati meetings and everything else but when I came here I did not know anything.” FGP 6*

FGP 5 shares his experience with the LGBTI student society:

*“When I came here I immediately bumped into all these people so I am a second year so I know these people since I got here and it helped me a lot.”  
- FGP 5.*

It is clear, based on the statements above, that the LGBTI student society plays an instrumental role in creating access to health information for many queer students. Not only does social networking create access to health information but Meyer (2003:680) argues that this group solidarity and cohesiveness, as mentioned by focus group participants, is perhaps one of the most important resources for LGBTI persons which act as a shield and protection from the adverse mental health effects of minority stress. By learning from the experiences of other LGBTI students who has been around campus for longer, they are able to ameliorate existing coping skills and mechanisms to deal with every day LGBTI related stress. However, many concerns have been raised by key informant interviewees regarding the student society.

According to KI 1:

*“Things are really slow this year because the people, coz when...took over it was not a matter of being voted for, it was because the people from last year didn't have a, a meeting like. Usually when the year ends there is elections taking place where they elect the new people who were going to take over. They just left without doing those things, so basically this year*

*there was not going to be a Liberati society but than a group of friends were like no, we can't do that. Let's just take over..." - KI 1*

This statement seem to suggest that the group is experiencing operational and governance issues. Another participants said:

*"It (LGBTI student society) kind of seem to change every year depending on the structures. So sometimes it seem like the structure is quite strong and they doing all the things and something and other times it seems like they not doing their things but so it kind of depends on which students are running things." - KI 5.*

It is clear that the group is experiencing huge challenges and according to KI3 the reason the group is struggling is that there is no institutional "university" support for the LGBTI student group and therefore the group is not sustainable:

*"Yes we do have liberati but it also, does it have a clear mandate? Does it, is there sustainability as well when you have that type of a society because every year it's a drawback you start afresh you go back you get the new leadership who takes time to get things going and whilst that is happening people are suffering." - KI 3*

She explained that the group does not have a clear mandate, in other words, it does not have an official order from management to act on behalf of LGBTI students. This statement implies that the university should get more involved since this is a serious matter that needs urgent attention. Another assumption that can be drawn from this statement is that the group needs resources from the university in order to perform its work and this needs some form of formalization at the top level. This is rather concerning given the fact that the university is turning a blind eye towards LGBTI matters. Furthermore, participants made us aware that the student society is perhaps the only opportunity for sexual minority students to access health information since most of them do not access campus health services and other health services outside campus. According to Snapp, Watson, Russel, Diaz and Ryan (2015:426), the presence of a network of friends to whom youth can be out has been linked to measures of health and well-being. It is therefore concerning that the current LGBTI student society is not functioning optimally, meaning that the campus environment is not providing any social support to LGBTI students. If this group is not

functioning well, this means that most LGBTI students don't have any access to health services on campus. If, for example, HIV services targeting LGBTI students are limited, this means that these students don't have access to prevention information and therefore would not understand their susceptibility to the disease. According to the HBM, these students would be less likely to make positive behavioral changes in order to prevent the acquisition of HIV, therefore increasing their risk substantially. In the following section we take a closer look at the experience of LGBTI students with the campus health system.

#### 4.3.1.2 *The discriminatory structure of the campus health system prevents sexual minority students from accessing healthcare services*

The structural barriers discussed in the previous section articulated an environment that is believed to exhibit elements of a heteronormative culture and in essence inculcate a culture of silence around matters related to sexual orientation and gender identity. In this section we discuss the discriminatory practices experienced by participants in the process of accessing healthcare. The following sub-themes will be discussed:

- Heterocentric healthcare services
  - Heteronormative attitudes held by healthcare workers
- 
- ***Heterocentric healthcare services***

While most participants in the focus group discussion mentioned that the healthcare services offered on campus discriminate against LGBTI students because they are focused on heterosexual students only, it was the statement from one of the key informant interviewees that stood out most. When key informant interviewees were asked about specific health related services for LGBTI students, all participants seem to support the fact that these students need targeted services, except one participant. According to KI4, during her training as a nurse, she was taught the anatomy of the human body and this is the same whether you lesbian, gay or straight:

*“So when you talk anatomy, anatomy remains anatomy whether you are gay or you are lesbian. You know when you are male or female uh LGBTI it remains the same. You know a penis is a penis, a vagina is a vagina.” -*

KI 4.

While this statement holds partially true, one cannot help but to notice the undertone in this statement, which seem to ignore the fact that LGBTI persons have unique healthcare needs. The statement also bears elements of a heteronormative approach that fails to acknowledge other sexualities. For example, men can have sex with other men by using the anus for sexual pleasure. If healthcare is assumed from a heteronormative angle then anal sex ceases to exist and therefore the LGBTI student might not get optimal healthcare. This heteronormative culture, similar to the culture of silence mentioned earlier, acts as a barrier for sexual minority students to access these health services. In other words, if they are rendered invisible, then there is no need for targeted services. Healthcare systems that tend to communicate elements of heteronormativity have been reported to lead to a feeling of invisibility, fear of mistreatment post disclosure, lack of trust and confidence in the physician, and lack of disclosing sexual orientation (Utamsingh, Richman, Martin, Lattanner & Chaikind 2015:568). Participants mentioned that the healthcare services offered at the university targets heterosexual students and therefore those who do not conform to the gender binary feels excluded. Almost in total contrast to the comment made by KI4, focus group participants felt that healthcare providers do not know enough about them in order to provide culturally competent services. According to FGP4 this is a heterosexual approach because healthcare providers tend to conform to the gender binary:

*“I feel like our health practitioners, they are not well informed about us as the LGBTI communities. They are a little bit narrow minded in a sense that they already, they always have that thing like it’s a boy and a girl.” - FGP*

4.

This is similar to findings made by Mavhandu-Mudzusi (2016:8) in a study conducted at a rural university in South Africa that confirms the discriminatory structure of healthcare services within the higher education sector. Section 3, which covers the perceptions of participants regarding the healthcare services on campus, further explores some of these discriminatory practices. The heteronormative environment within the campus healthcare system instils a sense of distrust and this can be deduced from the statement made by FGP4 above. When the researcher further explored the trust issue participants in the focus group mentioned disclosure of sexual orientation to the healthcare provider as one of the barriers to accessing healthcare in the campus healthcare system. While all participants agreed that



disclosing their sexual orientation and gender identity to the healthcare providers was extremely important, most of them admitted that they do not have trust in the healthcare providers. Most of the participants agreed that disclosing their sexual orientation to the healthcare provider would allow them to be part of the healthcare process. However, almost all of them said that they would rather not and this was because of previous experiences and strong expectations of stigma and discrimination from healthcare providers:

*“I would (disclosing sexual orientation or gender identity) but experience has taught me that even public service people can be very rude can be very (judgmental being shouted by other participants) judgmental and don’t care and ignorant to such things. So rather not.” - FGP 3*

Another participant echoed:

*“I think it’s extremely important so that they (healthcare providers) can know the case that they are dealing with. Because I mean if, as I have already mention if I go there, automatically they assume that I am a heterosexual. They don’t know who I’m sleeping with, but the moment I start opening up then they know the kind of case they are dealing with. But again it’s like opening up is like you open a can of worms. It’s like you make yourself so vulnerable that they going to throw everything at you because most of these health practitioners they have their own Christian beliefs or whatever beliefs they have. The moment you start opening up they start telling you about their belief. At the end of the day I am not there for your belief, I am here in the direction of get healthcare.” - FGP 6.*

According to Bolderston & Ralph (2016:209), participants in their study shared a similar sentiment that it is important for healthcare providers to know about their sexual orientation and gender identity and interestingly many healthcare professionals didn’t think that this information was relevant for health. This has been confirmed in the opening statement in this section by KI 4 who felt that there are no distinctions between male, female and being homosexual from a healthcare provider’s point of view. These statements above capture strong expectations of stigma and discrimination from healthcare providers and again highlight the deep feelings of distrust from participants. While most participants saw the value in having an open relationship with the healthcare provider, it was interesting to note

that expectations of stigma and discrimination deterred participants from disclosing their sexual orientation and therefore they do not have adequate access to these services.

According to the HBM, if disclosure of sexual orientation is the required behaviour, various factors will influence this decision. If the reason for the visit is minor such as a cold then the individual will be less likely to disclose his or her sexual orientation. The severity of the health problem is not strong enough to motivate the individual to make a behavioural change but if the condition is severe, like in cancer treatment, the individual will be more inclined to disclose his or her orientation. According to Youatt (2016:18), the disclosure behaviour of an individual is influenced by his or her beliefs regarding the threat of the illness or health concern (an evaluation of both susceptibility and severity). In line with expectancy-value approaches, this model predicts that, when more than one behaviour is possible, the behaviour chosen will be the one with the largest combination of expected success and value. However, in this study it seems that the expectation of stigma and discrimination from healthcare provider was a stronger motivator not to disclose. Another issue raised in the statement from FGP 6 above is the issue around religion and how it affects the accessibility of LGBTI students in the healthcare system. The statements made by KI4 above captures the attitudes held by healthcare providers that discriminate against LGBTI students and this will be discussed next.

- ***Heteronormative attitudes from healthcare providers***

The assumption that heterosexuality and heterosexual norms are universal is referred to as heteronormativity (Mavhandu-Mudzusi 2016:4). This is a worldview that assumes everyone is heterosexual or that LGBTI is a deviation from the heterosexual norm. The following statement captures the thinking of KI3 who is also a healthcare provider:

*“Accept I cannot ignore that religion playing a part in that you know and its things that you wonder about that. I wonder because with the Christian faith there are varying schools of thought with regards to men having sex with men and the stance that various religious groups take particularly in the Christian community. It’s a wonder to say, I wonder if there is judgment in that case ...” - KI 3.*

The statement above which is based on Christianity reinforces the idea that heterosexuality is the only accepted sexual orientation. Mavhandu-Mudzusi (2016:4) argues that healthcare personnel whose worldview is based on Christianity discriminate against LGBTI individuals, sometimes through the use of biblical verses that condemn homosexuality. Based on the statement above, it is clear that the participant is also grappling with the concept of religion but what is interesting is her uncertainty whether discrimination based on sexual orientation and gender identity in the healthcare setting is in fact wrong. Her assertion of Christian beliefs and providing healthcare leaves open fundamental questions. It begs a deeper understanding regarding the religious beliefs of healthcare providers and how this influences their ability to provide services that are non-judgmental, non-discriminatory and accessible to all members of society. Many authors argue that important social institutions such as the church or religion are used to justify homophobia and discrimination against LGBTI persons.

In earlier research which focused on racism and religion, researchers argued that organised religion forbids certain prejudices such as racism but others such as prejudice toward homosexuals are tolerated or even encouraged (Ford, Brignall, van Valey, & Macaluso 2009:147). Just recently, here is South Africa, for example, a sermon delivered by a homophobic bishop at Grace Bible Church in Soweto caused an outraged which reverberated throughout the country. The Grace Bible Church defended the homophobic pastor's remarks who compared gay people with animals (Pather 2017). Here we can see a strong tension between the religious beliefs held by healthcare providers and conducting themselves professionally in the clinical encounter. While this poses challenges for healthcare providers, it proves even more detrimental to the LGBTI students because it act as a barrier to access healthcare services. Even though none of the participants in the focus group discussion reported any personal experiences of religiously motivated stigma and discrimination, these stigmatising and discriminatory practices create barriers to accessing healthcare for LGBTI students. They could potentially have a negative impact on their physical, social, emotional and spiritual wellbeing (Mavhandu-Mudzusi & Sandy 2015:6). In the next section we take a look at how accessible the mental health services are for LGBTI students.

#### 4.3.1.3 Mental health stigma as barrier to accessing healthcare

All participants in the focus group discussion agreed that psychological services are an important and much needed healthcare service for LGBTI students. Some participants described it as a supporting structure for LGBTI students to cope with the daily stress of having to deal with stigma and discrimination. While most participants who have made use of the psychological services on campus generally spoke highly of the services, one participant recounted a negative experience. FGP 5 explained:

*“I was told by the psychologist that she does not believe in gay people and that it was a choice I made.” - FGP 5*

Healthcare providers, including psychologists, who hold varying beliefs about homosexuality, create barriers for LGBTI students to access healthcare. Contrasting with the fact that they feel that mental health services are important, some of the participants were of the opinion that mental health services are for students who are mentally disturbed. They further seem to suggest that this particular negative view about mental health services is mainly held among a majority of black students on campus. While FGP 2 was busy talking most of the other participants were nodding and commenting in agreement with what was said. This is what FGP 2 said:

*“The general population of the university is black people and they see it as you are mad (giggles and nods from other participants, almost in agreement with what is being said). So when you go there you had that, you are crazy. I am so crazy I need a shrink. (Laughs and giggles from the group).” - FGP 2*

FGP 1 echoed the same sentiment:

*“The problem with PsyCaD is that a lot of people think the moment you go to PsyCaD you are mentally disturbed. That’s why a lot of people don’t go there.” – FGP 1*

It is clear from this statement and the responses from other participants that mental health stigma is a real issue that they all are still dealing with. Again what stood out most from this discussion was the fact that participants seem to understand the value of psychological support but then they are confronted with the expectations of stigma once again and this

creates a barrier to accessing this much needed health service. The stigma associated with being both LGBTI and having a concurrent diagnosis of a mental illness may result in LGBTI students believing that they are perceived as an object of disgust. According to Hansen (2007:845) it is “as if their peers, teachers, and parents perceive their presence as a foul odor being discharged when they walk in the room”. This situation is further amplified by a diagnosis of HIV and this was confirmed by one participant who approached the researcher after the focus group discussion to disclose his HIV status. When asked why he did not feel comfortable to disclose his status to the group, the participant said that he feared being further stigmatised by the group for being HIV positive and that he might miss out on an opportunity for a life partner if he discloses his status. His exact words were “Who wants to date someone that is HIV”. Again, as mentioned earlier, the negative societal attitudes about HIV is being internalised in what is referred to as internalised homophobia and stigma (Meyer 1995:40). It is clear from these experiences mentioned above that participants experience multiple forms of stigma which prevent them from accessing healthcare. We have touched on some of the perceptions held by participants regarding the psychological services on campus. In the following section we will take a closer look how participants perceive the overall healthcare services on campus.

#### **4.3.2 SECTION 2: Healthcare needs of LGBTI students**

This section responds to the research question: What do participants think are the healthcare needs of LGBTI students?

- ***LGBTI students lack awareness of own healthcare needs***

It emerged from most of the focus group discussion that participants were generally unaware of their own healthcare needs. This same sentiment was also shared by some of the key informant interviewees. For example, KI 2 said that in her work with sexual minority students she discovered and was surprised that LGBTI students did not have the language. They did not understand the basic health-related concepts and topics. According to FGP 4:

*“It’s not really about LGBTI students having their own specific health needs but it about the LGBTI students not knowing that they can catch the*

*same health diseases, sexual transmitted infections as other heterosexual couples because now the heterosexual couple uses a condom and what not. Most LGBTI students don't know which protection to use when having sex or what you use to protect yourself.” – FGP 4*

Participants during the discussions argued that the current HIV awareness campaigns around campus mainly target heterosexual students and therefore they are more aware of their risks as opposed to LGBTI students. They felt that these services do not reach the LGBTI student population and therefore this puts them at more risk of contracting sexually transmitted infections and other diseases. In other words, sexual minority students do not have access to these services because the services mainly targets heterosexual students and fails to address their needs. This is congruent with the HBM which posits that an individual might avert a disease provided there is enough motivation and a belief that the disease is a threat. There was definitely enough motivation among participants which expressed a deep need for sexual education, particularly regarding the risks involved in anal sex. It was noticeable that participants generally did not make use of healthcare services and current HIV prevention activities excluded sexual minority students. This means sexual minority students might not be aware of the risks involved in anal sex and therefore the level of perceived susceptibility is low. While participants acknowledged that HIV counselling and testing services for men who have sex with men are periodically made available on campus, female participants, on the other hand, argued that the MSM services tend to discriminate against lesbian students therefore excluding them from accessing these services because they focus only on men's health related issues. FGP 3 shared the view of most female participants:

*“With all the people that come because of IOHA (the office responsible for organizing HIV testing campaigns) to test and Men's health and all those tents that are usually there. Its men's health but for lesbians do you go to men's health? Do you just go test blood and that's it.” - FGP 3.*

KI 2 shared the same sentiment as the lesbian participants:

*“As much as lesbian woman go I have heard that they just say that there is no place for them on campus. They don't feel that they are welcome here...”*

- KI 2

The female focus group participants felt left behind because HIV prevention services are not reaching them. All the statements above clearly highlight huge gaps in the healthcare services offered for LGBTI students on campus and a need to provide inclusive healthcare services for all students especially lesbian and transgender students. There was a strong sense from focus group participants that they want to know more about transgendered persons and their experiences.

*“Yeah, I feel like we need to know more about trans people because we don’t really talk about them and they are there. Although it’s not many of them that we know that this one is trans. We need to have like a bit of information about them and what they go through.” - FGP 7*

This participants highlighted that fact that there is a huge need for more information about transgender people, especially so among LGBTI people. Based on the discussions during the focus group it was clear that one or two participants might have questions about their own gender identity but this was not explored. Consistent with the statement above, literature also indicates a paucity of research among transgender people. Jobson, Theron, Kaggwa & Kim (2012:161) argue that due to a lack of knowledge about transgender people, they remain highly stigmatized and avoid social interactions at all cost, especially so with the health care systems, in order to avoid being ousted. This situation is posing considerable health challenges for these people and their HIV risk is considerably higher within the LGBTI communities. The following section will discuss the healthcare preferences of LGBTI students as described by focus group participants.

#### **4.3.3 SECTION 3: Perceptions held by LGBTI participants regarding healthcare services**

Key informant interviewees as well as focus group participants were asked to comment on the health services offered for LGBTI students on campus. The data analysis revealed various themes. It emerged that available LGBTI services offered on campus tend to be fragmented and uncoordinated and they largely favour heterosexual students. Stigmatising practices on the part of healthcare providers prevents LGBTI students from accessing healthcare services. These are some of the themes which will be discussed in this section.

- ***LGBTI service fragmented and uncoordinated***

All participants in the study were asked to comment on the available LGBTI specific services offered on campus. While there was acknowledgement and agreement among all participants that some services for sexual minority students are available on campus, KI 3 felt that these services are fragmented and uncoordinated due to a lack of strategy and clear direction. KI 3 described:

*“We are not all having a clear one direction and it makes the programme not sustainable. Currently we don’t have a programme. We have events for LGBTI which is a concern because there is no sustainability when you have that type of a strategy.” - KI 3*

The fact that there is no clear strategy to address LGBTI health needs is an indication of a system that is unresponsive to the rights and well-being of LGBTI students and therefore restricts these students from accessing these services. Also referred to as structural factors, these forces usually operate outside and beyond the individual’s control to either foster or impede health or health behaviours (Levy, Wilton, Phillips, Glick, Kuo, Brewer, Elliot, Watson and Magnus 2014:973). KI 3 seems to suggest that the current available services targeting LGBTI students will have little impact if they are not properly coordinated. Other participants expressed concern regarding the availability and sparseness of the LGBTI services on campus. KI 5 explained:

*“Um I am not sure what is going on elsewhere. I know in PsyCaD this year there was no specific initiatives. There has in the past. This year there was no initiative directly targeting LGBTI.” - KI 5*

Another participant, KI 2, said the following:

*“I feel that too little is being done. I can’t think of a single thing. I remember a couple of years ago there was this I think it was called diversity week and I was asked to speak about homophobia.” - KI 2*

It is quite clear from these excerpts above that participants feel that not enough is being done to address the healthcare needs of sexual minority students and services targeting these students are often scanty and uncoordinated. Participants argued that in order to address these structural barriers one needs institutional commitment and without such commitment, sexual minority students will continuously be victimised by a patriarchal



system that applies patriarchal norms and values that reinforce heteronormativity, cisnormativity, homophobia, biphobia and transphobia (Mathysse 2017:124). Participants also felt that the current healthcare services offered on campus discriminate against sexual minority students based on their gender identity and sexual orientation and this will be further discussed in the following section.

- ***Healthcare services are heteronormative, inequitable and discriminate against LGBTI students***

While it was reported that the campus clinic provides basic services such as general treatment of normal aches, pains and minor ailments, it is clear from the statement that these services tend to favour female students more than male students.

*...um we mostly are focusing on the female and a bit on the male but awareness focusses on all students.” - KI 3*

When this was further explored in relation to LGBTI students, KI 3 said that all patients are treated equally:

*“LGBTI remember with healthcare we treat all patients equally, it’s one of the ethical obligations...So when it comes to healthcare, we don’t have a specifically tailor made healthcare for them, they fall in the regular healthcare programme.” - KI 3*

While she acknowledged that special attention is needed to understand the social and psychological challenges faced by LGBTI students within the healthcare setting, KI 3 seems to suggest that either this particular university don’t have a tailor-made programme for LGBTI students or in general there is no need for a tailor-made LGBTI programme because all patients are treated equally. In both instances, it raises questions about whether the healthcare needs of LGBTI students are adequately understood by these healthcare workers and addressed accordingly. This statement blatantly ignores the fact that LGBTI students have unique healthcare needs especially with regards to HIV and sexually transmitted infections. It also does not consider the social determinants of health for sexual minority students and therefore the services are rendered inequitable and inaccessible. It emerged from the discussions that the HIV prevention activities including counselling and testing services also seem to favour heterosexual students.

*“I think even when it comes to sexual health educators. When they teach about sexual health, they neglect the MSM and WSW. They teach about sexual health in general, about uhm female condoms, straight condoms. They forget about anal sex and lubrication. How to use lubrication, how to use lubrication and which kinds of lubrications are proper. Coz there is, I still know a lot of my friends who still use Vaseline and stuff that is inappropriate to use as lubrication and who carry themselves in inappropriate ways. Nje.” - FGP 4*

While it was established that sporadic HIV prevention services targeting LGBTI students specifically are made available, participants complained that these services address men who have sex with men only, therefore excluding lesbians and others within the LGBTI communities.

*“It’s men’s health but for lesbians do you go to men’s health? Do you just go test blood and that’s it?” - FGP 6*

Other participants felt that the HIV prevention methods made available such as condoms also discriminate against LGBTI students:

*“I think it’s a matter of the supply of the sexual equipment that we as the LGBTI community use. As much as they are trying lately that you would find lubrication... You find those lubrication is like, that’s if you can find them...” - FGP 3*

Another participant echoed:

*“Firstly uhm the condoms to protect yourself. If you go to all the bathrooms there you will find choice condoms but you will never find anything for a lesbian couple to protect themselves.” - FGP 5*

FGP 6 shared the same sentiment:

*“Or you will find condoms only and there is no lube in the toilets.” - FGP 6*

Participants in the focus group agreed that access to very important HIV prevention methods such as lubrication for MSM and dental dams for lesbians are limited. Again, this implies that the HIV prevention services tend to favour heterosexual students and fail to reach LGBTI students on campus.

- ***Discomfort with healthcare provider and provider stigma and insensitivity***  
Participants in the focus group discussion said that they don't always feel comfortable using the healthcare services on campus. A lengthy discussion unfolded and one of the main reasons cited by participants was a particular discomfort with the healthcare providers. Culturally, according to FGP 1, it is uncomfortable speaking to an old lady (nurse) about his personal issues related to his sexual orientation. In his culture, he says, an older woman is seen as a mother figure and therefore it is almost impossible for him to open up to her about his personal life. Another participant shouted, "You don't talk to your mother about your sex life!"

*... let's say I go to the campus health. When I get there it, I feel uncomfortable to talk to old woman about my whatever, whatever is happening to me. You know because first of all I see my mother when I, I am black like that, I am still cultural. I still, when I see an older woman I see my mother. I feel like I am speaking to my mother about something's that she has uh not liked at some point in her life you know." - FGP 1*

Again, we see here that participants raise issues of culture as potential barriers to accessing healthcare services on campus. Most participants were in agreement that they would rather avoid discrimination and being judged by the healthcare provider by not making use of the services. Other participants added to this discussion and said that when they indeed utilised these services, they don't feel like the healthcare providers fully understand their particular healthcare needs and therefore they feel uncomfortable to use the services. This is what FGP 4 had to say:

*"... I feel like if I go there and I am talking to woman about something that are happening to me. Part of me in the back of my mind...She actually don't even get what I am talking about. She is just going to help me because she has to help me..." - FGP 4*

Focus group participants felt that the healthcare providers do not understand or have an appreciation for the fact that they belong to the LGBTI communities and therefore do not have an understanding of their particular healthcare needs. In fact, they fear that the healthcare provider will judge them and therefore they would rather avoid utilizing the

services. When participants in the focus group discussion were asked to comment about the LGBTI specific services they have utilized on campus, they responded as follows: “I have never used any of the services” and “only HIV testing services”. While no participant mentioned any experience of homophobia in the clinical setting, most participants feared that if they disclosed their sexual orientation to the healthcare providers they would face homophobic and insensitive questions or remarks. There is high expectation of stigma and discrimination among participants which increases their likelihood of not using the services. This was most often discussed in reference to accessing sexual health services such as HIV testing or STI (sexually transmitted infection). FGP 4 explained:

*As a lesbian, I would say the system has . . . it's not working properly for LGBTI students... We can go to the clinic, maybe I have STI because I could have STI although I sleep with another women. I'm going to the clinic, I say to the nurse that I have an STI, the nurse could ask me, 'Why? Why do you have an STI although you sleep with another woman?' You see, so something like that. If you're [HIV] positive, the nurses will ask you some questions about your sexuality but not about the thing that you came for.”*

- FGP 4

The same concern shared by participant 4 about the inappropriate questions nurses in the clinic ask when LGBTI students access sexual health services, resonated with other participants:

*“It is a lot of admin going to the healthcare centre or whatever but it's even more admin now to explain how did you get this and why are you doing it this way coz obviously they going to ask why did this come in this side, you not using it the normal way you know (referring to anal sex). It's strenuous really.”* - FGP 6

Another participant echoed the same sentiment:

*“You know what this is what happen, maybe let's just say for instance I have a sores in my anus and she like what were you doing. Is it not that the anus is used for this...you understand?”* - FGP 3.

These statements reflect participants' perceptions that healthcare providers are uneducated and uninformed about the specific healthcare needs of LGBTI students. They are unable to

provide testing services in a culturally sensitive manner and are judgmental about LGBTI students' same-sex sexual behaviour. These perceptions held by participants coincide with the findings from a study which was conducted in Cape Town among lesbian women (Smith 2015:184). Another concept closely related to the insensitivity of healthcare providers towards LGBTI students which focus group participants raised is the notion that healthcare providers tend to pathologise LGBTI students when they present for healthcare. Participants explained how they fear to go to the clinic because the nurse will see them as a collection of diseases or symptoms. FGP 1 explained his experience with one of the nurses at the clinic:

*“I had a skin abscess in my behind. So I told this woman that I have a skin abscess and she was like (speaking in vernacular) meaning your population is very sick, you should get tested first. I was like already and you not going to ask me about....already you made that conclusion in your mind that I am positive. Just like the rest of my population.” - FGP 1*

FGP 1 described how this made him feel very uncomfortable with the nurse because she created this barrier between him and herself. There was no way he could open up to her about other health related issues and he certainly won't return to seek healthcare because of this experience. According to the United Nations (2016) Prevention Gap Report, LGBTI persons continue to be subjected to abusive, harmful and unethical practices in the healthcare setting because of their gender identity and sexual orientation. These include being forced to have an HIV test done, and undergo so-called 'conversion' or 'reparative' therapies for transsexual persons. Both the discriminatory practices of healthcare providers as well as internalised homophobia act as barriers for sexual minority students to access healthcare.

#### **4.3.4 SECTION 4: Suggestions from participants on how healthcare services can be improved to make them more accessible to LGBTI students**

The final research question: what do participants suggest should be changed about the current services within the university sparked a robust discussion among all participants. These suggestions made by participants mainly addresses the structural barriers such as a

need for directive action from management and a demand for LGBTI friendly healthcare services.

- ***Support from university management***

There was strong agreement among participants that management has a key role to play in addressing LGBTI matters within the university. Key informant 2 felt that perhaps management needs to come out strongly and make a statement in support of LGBTI rights. She said the following:

*“And I think that you know there is also so much that management can really do. Uhm but at least putting that kind of like on the research agenda and making it that...making their position also bit more clearer what they feel about sexual orientation and gender rights on campus.” - KI 2*

KI 2 felt that management could devise a supportive statement by introducing a human rights framework in order to protect the rights of LGBTI students in the university. Management holds the power to make strategic interventions, she argued, and if they show strong political will to put these matters on top of the agenda, the rest of the university will be obliged to follow suit. One participant choose to single out one department that she felt should be responsible to drive this process. Student affairs is a department responsible for all student related matters and also for managing the student societies. KI 4 felt that this department should take the lead in terms of policy direction and collaborate with the other departments which offer health services in order to build a programme that will be sustainable and address the health and other related issues that LGBTI students experience on campus. This is her comment:

*“Student Affairs has an office which takes care of these societies and I think IOHA as an office that says we are here for sexual and reproductive health rights for all groups of people. We should be a coordinating and collaborating with student affairs to come together and have a clear strategy so that every year when there is new leadership. They come in and there is a document that clearly shows them and it’s not something that we will do on our own but working with the students that will tell us yes you are on the right direction or not but we need a people that are there uh*

*permanently. That will make sure that things are, there is a sustainable programme which currently we don't have.” - KI 4*

This according to KI 4 will speed up service delivery because everyone will have a clear mandate. Should everyone have a clear mandate, they argued, than LGBTI friendly services will be made possible.

▪ ***LGBTI friendly healthcare services and LGBTI specific healthcare providers***

Participants were asked to describe to the group what they think would be the ideal healthcare experience for an LGBTI student. Participants almost unanimously agreed that they would prefer a healthcare provider who understand their challenges, someone who has walked the walk with them. They mentioned that the university must employ LGBTI healthcare providers because this would spare them the emotional trauma that they go through when they have to explain to the nurse their sexual orientation or gender identity and why they perform certain things in certain ways. A healthcare provider who identifies as an LGBTI person would understand and this will make them more comfortable and it would be easier to talk to this person. FGP 2 explained:

*“I also think it's much more easier when you are talking to somebody who have been walking on the same path that we are walking because I feel like if I go there and I am talking to woman about something that are happening to me. Part of me in the back of my mind about that things. She actually don't even get what I am talking about.” - FGP 2*

FGP 1 also shared the same sentiment:

*“I think we do need a designated uhm department for us to access the proper healthcare we deserve, we need. I mean, it's, let's say I go to the campus health. When I get there it, I feel uncomfortable to talk to old woman...I think it's better if more gay people would be employed to deal with us specifically in the health department. It will be much more comfortable that way.” - FGP 1.*

Participants argued that if a concerted effort is made by the clinic and other departments to include LGBTI healthcare providers, then they would feel more comfortable and open about their sexual orientation and gender identity. FGP 1 explained that he had an anal

abscess which the nurse at the campus clinic had difficulty to treat. He eventually went to one of the men's clinics where he received appropriate and effective treatment and the abscess was gone immediately. FGP 1 explained his story:

*"...For instance, ok when I went to campus health, that woman gave me something to put on and gave me uh pills for that duration. Than when I eventually went to men's health coz that skin abscess didn't go away, they gave me proper stuff, they injected me and they, you know coz they know when skin abscess is in the behind, near the anal area, it heals slower because of the friction when you walking and when it gets hotter the more puss comes out, you know. They understood that and the more sex I have, the more friction I still have because it's behind there you know. That woman wouldn't understand because I can't tell her, you know, mamma (audio not clear) referring to the nurse as mother figure) (giggles from group)." - FGP 1*

FGP 1 argued that if the nurse understood exactly what he was going through his complication would have been dealt with much quicker, but because she did not understand and he was not comfortable to give her more information, it took much longer to get the abscess treated and healed. Eventually he consulted a men's clinic and, according to him, they knew exactly how to treat it. Participants suggested that healthcare providers need to be trained on the social experiences that LGBTI students go through in order to provide appropriate care during consultations. If they understood, then they would ask the correct questions and therefore LGBTI students would feel comfortable using the services and be more open. FGP 5 explained:

*"I feel like our health practitioners, they are not well informed about us as the LGBTI communities. They are a little bit narrow minded in a sense ...I feel like if they could be trained in way that hey we understand that you probably, you leave beliefs aside, this is what is happening in the real world. There are people who are doing this. It has absolutely nothing to do with you, you at the end of the day, your job is to get them the best healthcare."*  
- FGP 5.



Other participants added to the conversation and suggested that healthcare providers need to be reminded that they are professionals and that they are there to do their job and not to judge LGBTI students based on their sexual preferences and gender identity.

#### **4.4 Application of the two theoretical frameworks**

Both of the selected theories for this study provided valuable insight into the value perceptions held by LGBTI students, the interaction between these perceptions and the environmental influences and how these impact or shape the experience of sexual minority students when they access healthcare in the campus environment. The HBM which operates on the intrapersonal level highlighted the individual perceptions held by sexual minority students and how these perceptions influence health behaviour and, on the other hand, the minority stress theory illustrated how these individual perceptions are influenced by external or environmental factors which ultimately shape the experience of LGBTI students when they access healthcare.

The findings of this study, through the framework of the HBM, highlight the influential perceptions, modifying factors, and cues to actions related to key health behaviours among LGBTI students and healthcare providers. The HBM, which is an expectancy-value theory, suggests that behaviour is a function of the expectancies one has and the value of the goal toward which one is working (Gipson & King 2012:211). The concept of expectancy represents the idea that most individuals will not choose to do a task or continue to engage in a task when they expect to fail. The findings illustrate how continuous negative experiences of stigma, discrimination, name calling, bullying and many more such experiences since childhood have influenced and formed the views and perceptions of participants towards healthcare services, and many described how they anticipate similar experiences from healthcare providers and simply chose to avoid these services altogether. Interestingly, participants overwhelmingly felt that it was important for them to disclose their sexual orientation to the healthcare provider because this would have positive benefits such as appropriate and efficient services in return. According to HBM, this would motivate them to actually make use of the services but it appears that the anticipation of stigma and discrimination acts as a stronger barrier to access these services. This is in line

with expectancy-value approaches which predict that, when more than one behaviour is possible, the behaviour chosen will be the one with the largest combination of expected success and value.

The findings also suggest that healthcare services such as HIV counselling and testing discriminate against LGBTI students because they mainly target heterosexual students. This means that these students do not have access to HIV prevention information and thereby might not be aware of their susceptibility to HIV and unable to see the perceived threat in the situation. Participants mentioned that a few men-specific HIV prevention services take place on campus but these services fail to address the needs of lesbian, bisexual and transgender students. A lack of LGBTI specific services means that LGBTI students don't get the necessary information regarding their own risks and health needs and therefore perceived susceptibility would be low. While focus group participants indicated that they were aware of the benefits of accessing healthcare, they were not motivated enough to actually make use of these services. Clearly, the cues to action need to be improved in order to provide an environment where LGBTI students feel comfortable to express themselves. The absence of information about transmission related to anal sex practices in the context of abundant information related to heterosexual transmission (specifically, vaginal-penile transmission) has, in part, resulted in a population being ill equipped to protect themselves when having sex with other men. This was confirmed in the findings which suggest that the majority of the participants were unaware of their own healthcare needs and those of other LGBTI students on campus. Through the application of the HBM one is able to highlight the gaps in the campus healthcare system and how these can be eliminated in order to improve access to healthcare services for LGBTI students. Although HBM is useful to explain central concepts with regard to what motivates LGBTI students to access healthcare, there are structural factors which has been identified that influence the process of accessing healthcare. The minority stress theory was better to explain this interaction and how it affects the healthcare experience of these students and this will be discussed next.

The findings, through the lens of the minority stress theory, illustrated the importance of understanding gender identity and sexual orientation as social determinants of health. Minority stress theory postulates that stressors are unique to minority groups and not experienced by non-stigmatised populations. They are related to the social processes and entrenched in the cultural and institutional structures (Meyer 2003:676). The research findings indicate that participants shared experiences of stigma and discrimination because of their sexual orientation, which, for most, have occurred since they first discovered that they had same sex attractions. Participants recalled persistent experiences of name calling, ridicule, sexual violence, bullying, exclusion and family rejection because of their minority status. Literature indicates that LGBTI communities experience high levels of antigay victimisation. In fact, Katz-Wise and Hyde (2012:156) conducted a meta-analysis and estimated that as many as 80% of LGBTI individuals experience some form of harassment throughout their lives. These persistent negative experiences, according to minority stress theory, leads to the internalisation of the negative perceptions held by society which is called internalised homophobia, biphobia or transphobia. The pervasive levels of homophobia, biphobia and transphobia wielded towards LGBTI communities by society have serious, injurious psychological effects on these communities. These psychological effects come into force when LGBTI persons apply the negative attitudes towards themselves especially so with feelings associated with internalised homophobia (Dentato 2012: no pagination). This, in turn, increases the vulnerability of LGBTI persons to heightened levels of HIV and other sexually transmitted infections (STIs) as well as other physiological health problems. Those LGBTI persons who are living with HIV have to live with the stigma associated with this diagnosis and the ones who are negative constantly worry about becoming infected with HIV. This, according to Dentato (2012: no pagination), “has the potential to cause varied levels of psychological distress that may result in mental health challenges, engaging in risky behaviour including unprotected anal intercourse, substance use or sex with multiple partners”. He further argues that these negative attitudes towards self and the risk behaviours increase exponentially when members of the LGBTI communities are also members of a minority racial or ethnic group. Some LGBTI members have to battle a triple burden of stigma including being a member of an LGBTI subgroup, being HIV positive and being black.

Based on these two theories, one can draw some theoretical assumptions on which the research objectives and questions were based. They guided our understanding regarding the pervasive negative experiences of stigma and discrimination, how these increase the risk of psychological and physical health problems and how environmental or structural barriers influence accessibility and availability of services.

#### **4.5 Conclusion**

The key research findings that were guided by the research objectives and the purpose of the study were presented in this chapter. The findings were corroborated with empirical evidence and the two selected theories (Health Belief Model and the Minority Stress Theory) were used to further explain certain phenomena. In the next chapter we will summarise the main findings, draw conclusions and make suggestions.

## CHAPTER 5

### CONCLUSIONS AND RECOMMENDATIONS

#### 5.1 Introduction

This chapter presents a summary of the key research findings from this study and the conclusions drawn from the analysis. The main purpose of this study was to explore and describe LGBTI students' experiences of accessing healthcare in a contact higher education institution. Furthermore, this study aimed to understand whether participants were aware of any specific healthcare services and needs for sexual minority students on campus, where these students prefer to go if and when they need to access healthcare services, and what they (participants) suggest could be improved about the current healthcare services offer to sexual minority students on campus.

Guided by the purpose of the study and the literature, a qualitative approach was selected as most appropriate for the study. In order to achieve the objectives, three forms of data collection methods were applied consisting of five key informant interviews, one focus group discussion with eight participants and field notes during the data collection process. Thematic analysis was used to analyse the data since the researcher was interested in patterns within the data and these patterns were recorded as themes which described a phenomena closely associated to a particular research question.

A summarised version of the research findings will be presented next, as it relates to each of the research questions, with the purpose of making recommendations for further research.

#### 5.2 Summary of key findings

The summary of the key findings will be presented in four broad themes that are based on the aims and objectives of the study and will capture the comments of all the participants in the study.

### **5.2.1 The experience of LGBTI students in accessing healthcare**

The newly democratic South Africa heralded a global paradigm shift in 1994 when it became the first nation to decriminalise homosexuality. However, literature alludes to the fact that transformation in terms of perceptions and attitudes towards LGBTI persons has been tardy and this is quite evident in the higher education sector. Many gender authors and researchers in this space highlight the fact that the transformational processes within the South African higher education sector have unfolded at a snail's pace, despite the fact that this sector is expected to lead society into dialogue and to cultivate debate around these very issues of sexual orientation and gender identity through its core mandate of teaching, learning, research and community engagement. Msibi (2013), for example, argues that little is known about sexual orientation and gender identity in the higher education sector because queer issues remain stigmatised and very much in the closet. We begin our discussion in the following paragraphs by highlighting some of the structural barriers identified by participants.

#### *5.2.1.1 Structural barriers impede access to health services for LGBTI students*

The findings revealed that the campus where this study was conducted represents a mere reflection of the higher education sector as it is described above and is represented in the literature. Queer issues, many scholars argue, remain silenced and very much 'in the closet'. This was also one of the main findings in this study which suggest that health related programmes targeting queer students are scanty and sometimes non-existent because queer issues are silenced within university spaces. The silence, according to participants, manifest in various forms. They argued that a prevailing heteronormative attitude on campus is fuelled by a lack of political will from university management. Literature confirms that a lack of political will perpetuates a culture of heteronormativity and at times justify homophobia within these spaces. Furthermore, participants describe the lack of political will as the inability of management to act decisively with regards to the needs and the protection of the rights of LGBTI students. This ultimately means that the university lacks a clear strategy to address the healthcare needs of queer students, which leads to a lack of targeted healthcare services for these students. Other participants argued that university management should take the lead in affirming their unconditional support

for the protection of the rights of LGBTI students. These structural barriers inculcate a heteronormative campus environment which excludes non-heterosexual students from important health related services and therefore increases their risk of contracting HIV and other sexually transmitted infections. Literature also highlights the fact that structural and environmental factors are strongly associated with internalised homophobia among LGBTI communities. Focus group participants reported that they don't feel safe on campus and therefore are unable to be themselves and, according to evidence in the literature, this also increases the likelihood of developing internalised homophobia among sexual minority students. Evidence suggests that LGBTI individuals with high levels of internalised homophobia are less likely to access healthcare services, including sexual reproductive health and HIV services, which was also confirmed in this study.

Almost all the participants in the focus group discussion indicated that social support is very important to them, especially in an environment that exhibits elements of homophobia and, in order for them to improve their adaptive competences in dealing with the resulting stresses, they require important attachments within the campus environment. While it was reported that an LGBTI student group was present on campus, participants felt that, due to a lack of support from the university, the group failed to function optimally. As mentioned above, LGBTI students are likely to develop internalised homophobia as a result of the homophobic campus environment and, according to some studies, higher levels of internalised homophobia is positively associated with loneliness and this highlights the importance of social support. There is evidence which suggest that LGBTI individuals who experience social isolation have less access to safer sex information and resources. Interestingly, while many participants indicated that they have not utilised healthcare services on campus, they regarded the student LGBTI group as one of the only sources where they can access health related information. Researchers argue that this group solidarity and cohesiveness provided by the LGBTI student group can act as a shield and protection from the adverse effects of internalised homophobia and what Meyer (2003) calls 'minority stress'. The need for social support on campus cannot be over-emphasised and therefore university management and responsible departments need to support the current student organisation in order to ameliorate the effects of minority stress on sexual

minority students. While the campus was found to exhibit elements of a heteronormative culture, this seem to have filtered through to other spaces within the university, including the campus healthcare system.

#### *5.2.1.2 A heteronormative campus healthcare system blocks LGBTI students from accessing healthcare services*

The findings suggest that the campus healthcare system reflects a true image of the negative campus environment towards LGBTI students. In line with the findings above, the campus healthcare system was found to exhibit elements of a heteronormative culture, which blatantly exclude non-heterosexual students from accessing services. For example, one participant argued that there is no distinction between a heterosexual male student and a gay student for the simple reason that anatomy remains anatomy. This statement clearly ignores the unique experiences and needs of gay and other LGBTI students and therefore might potentially exclude them from receiving culturally appropriate healthcare and the risk of a misdiagnosis. This heterocentric approach to healthcare is also a direct violation of the human and constitutional rights of LGBTI students.

Popular perceptions held by most participants regarding healthcare workers in the campus healthcare system was that they merely provide services to them as a matter of obligation because they need to earn a salary as opposed to genuinely caring for their health. The adverse result has been that these LGBTI participants refrained from using the available services and the ones who did reported that they rather not disclose their sexual orientation to the healthcare provider due to expectations of stigma and discrimination. Both situations described above have the potential to increase the risk of LGBTI participants and render them vulnerable to HIV and other health related conditions.

#### *5.2.1.3 Religion and perceptions of homosexuality*

Religious perceptions about homosexuality held by healthcare workers create additional barriers for LGBTI students to access healthcare. This is consistent with current literature and was also confirmed by one participant in the key informant interviews, who was of the opinion that Christianity holds a certain view regarding homosexuality. She questioned



whether this view about homosexuality can be seen as judgmental in the healthcare setting. Her uncertainty on whether religiously related stigma and discrimination in the healthcare setting is indeed wrong raises pertinent questions regarding a clear understanding and the protection of the human rights of sexual minority students.

#### *5.2.1.4 Mental health stigma and discrimination in the campus healthcare system*

Mental health forms an integral part of the healthcare experience of LGBTI students and this was confirmed in this study. While most participants described it as a much needed resource that helps them to cope with the daily stresses of stigma and discrimination, some reported experiences of stigma and discrimination while accessing this service. One focus group participant reported that the psychologist told her that homosexuality does not exist and that it was a choice she made. Over and above the discrimination present in the mental health system, it was found that there are high levels of mental health stigma present among LGBTI participants which deter them from accessing these services. All participants in the focus group discussion collectively suggested that the stigma attached to mental health had some sort of cultural origin. Historically Black South Africans, they say, viewed mental health as only relevant to ‘mad people’. This they argued prevents a lot of students from accessing mental health services because other students would think they are mentally disturbed. Interestingly, this view about mental health was juxtaposed with an understanding regarding the benefits of mental health to which they all unanimously agreed. While they acknowledged the benefits of mental health, the stigma related to it is so strong that it creates a barrier for them to access this much needed service. Some researchers argue that the stigma related to being a member of the LGBTI communities and having a concurrent diagnosis of mental illness has the ability to make these sexual minority students perceive themselves as objects of disgust. In fact, for Hansen (2007) it is, “as if their peers, teachers, and parents perceive their presence as a foul odour being discharged when they walk in the room.” This situation is even further complicated when LGBTI students have a dual diagnosis of mental health and HIV.

## **5.2.2 Healthcare needs of LGBTI students**

### *5.2.2.1 LGBTI students lack awareness of own healthcare needs*

This study pointed out that LGBTI students generally lack awareness about their own healthcare needs and about general information regarding LGBTI matters. One example was made by one of the key informant participants who is of the opinion that LGBTI students don't have the language, in other words, the basic concepts about sexuality and gender. The fact that they lack this information is an indication that they do not access gender information or that awareness campaigns are not reaching them. This was confirmed when participants mentioned that healthcare services target mainly heterosexual students and one example they highlighted was the HIV awareness campaigns. This lack of awareness means that LGBTI students do not know how to prevent or reduce unhealthy sexual behaviours or to reduce the risk of HIV infection.

### **5.2.3 Perceptions and preferences of healthcare service offered on campus**

#### *5.2.3.1 LGBTI services are fragmented and uncoordinated*

There was a general consensus among participants in the focus group discussion that the university is lacking healthcare services targeting sexual minority students. While it was also acknowledged that some services do exist, participants felt that they were fragmented because they lack a clear strategy and a coordinated programme. Most key informant participants were unsure whether any services for LGBTI students were present on campus. Even more surprising is the fact that they reported knowledge of some LGBTI related projects within their own departments. This is concerning because it is not possible to measure whether these projects are having an impact on the health of LGBTI students and therefore there is a need for a coordinated programme to be put in place with a clear monitoring and evaluation framework.

#### *5.2.3.2 Healthcare services are heteronormative, inequitable and discriminate against LGBTI students*

Gender inequalities are pervasive in the campus healthcare system where services mainly target female students. Over and above the fact that there exist inequities with regards to male and female services, the campus healthcare system seems biased and discriminates against LGBTI students. One participant in the key informant interviews argued that in healthcare “we treat all patients equally”. According to her this is an ethical obligation and

therefore they don't have a "tailor made" as she quoted, service for LGBTI students. This clearly renders LGBTI students invisible in the healthcare system. Literature supports these findings and suggests that this heterocentric approach to healthcare is a clear violation of the right of LGBTI individuals to dignity and access to healthcare services. Participants in the focus group also mentioned how HIV awareness campaigns target only heterosexual students. Although this was true, they also mentioned that sporadic HIV awareness campaigns targeting men who have sex with men does happen around campus. Again, these services excluded other sexual minority groups such as lesbians, transgender and intersexed students. It is evident in the literature review and confirmed in the findings that the heterosexual bias present in the campus healthcare system is a form of social exclusion of LGBTI individuals and also denies them recognition of their sexual health needs. The findings concur with prominent researchers in this area who argue that social structures legitimise heterosexuality over queer desires.

#### *5.2.3.3 Discomfort with healthcare provider and provider stigma and insensitivity as barriers to accessing healthcare*

As mentioned earlier, focus group participants reported incidences of stigma and discrimination from healthcare providers and, in other instances, insensitivity in the healthcare setting. One lesbian participant explained how she presented to the clinic with an STI and the nurse asked her how is it possible that you have an STI if you sleep with other woman. The worldview of healthcare professionals acts as a barrier for LGBTI students to access healthcare. Another participant explained that he was apprehensive to use the healthcare services when he presented with an anal sore because he feared that the nurse would ask him why he used the anus for sex because it is used for other purposes.

Other participants in the focus group discussion mentioned how they feel uncomfortable to speak to the older nurse about their sexuality and the health issues they present at the clinic. They unanimously agreed that culturally they see the older woman as a mother figure and therefore it is difficult to talk to her. There is a strong expectation that the nurse will judge them (like their mother did) and therefore will not provide the appropriate treatment they need. Closely related to expectations of being judged by healthcare

professionals, participants also mentioned how nurses tend to pathologise LGBTI persons. One participant explained that when he approached the nurse with a skin abscess the nurse told him “your population is very sick, you should get tested first”. This worldview about LGBTI persons held by nurses creates barriers for these students to access healthcare and similar findings have been reported in other studies.

#### **5.2.4 Suggestions on how healthcare services can be improved to make them more LGBTI friendly**

##### *5.2.4.1 Decisive action and support from university management*

Participants argued that the availability of healthcare services for LGBTI students within the campus healthcare system is strongly dependent on management’s position regarding queer issues. In order to break the silence, management needs to come out strongly in support of the protection of the human rights of LGBTI students. Only once this has been achieved, will culturally competent and targeted healthcare services be made available to these students.

Six out of the eight focus group participants (75%) reported not utilising the campus health services mainly out of fear of being discriminated against and to avoid an unpleasant experience. In order to facilitate access to these services and to make them more attractive for queer students, management needs to take decisive action. Participants in the key informant interviews suggest that certain departments such as student affairs need to get involved to lead such action. This action they say should be in the form of a clear strategy that will clarify the roles and mandate of all other important role players in the campus environment.

##### *5.2.4.2 LGBTI friendly healthcare services and LGBTI specific healthcare providers*

Almost ninety percent (7 out of 8) of the participants in both the focus group and the key informant interviews felt that in order to make healthcare services more accessible the university needs to employ LGBTI health providers. An LGBTI nurse, for example, has walked the walk, they argued, and would understand what they have experienced, and therefore would be able to provide more culturally appropriate healthcare. Some argued

that it would be much easier for them to open up to an LGBTI nurse as opposed to someone who does not understand their healthcare needs.

Other participants said having a gay nurse, for example would spare them the emotional trauma to have to explain their sexual orientation and sexual preferences. The clinic environment also needs to transform and become more LGBTI friendly. In line with the literature, they recommend LGBTI health related posters and signs which indicate a safe space for LGBTI students, and a LGBTI specific programme. Participants also recommend that all healthcare providers be sensitise and trained on LGBTI matters so that they can become more sensitive to the healthcare needs of queer students.

### **5.3 Limitations of the study**

This study was conducted at an institution where the researcher worked and might have influenced various factors about the study. In the first instance, while the study made use of convenient sampling, the researcher might have been biased in selecting participants with similar experiences. Due to the confines of a dissertation of limited scope the researcher only conducted one focus group discussion. Therefore, when these findings are read and interpreted, it should be done with these limitations in mind.

### **5.4 Recommendations for institutions of higher learning**

(a) Issues of gender identity and sexual orientation form an integral part of diversity but they risk being clouded by other important factors within this space and hence do not receive the immediate attention they need. This portraits a campus culture fraught by heterosexism and, as many researchers assert, an organisational culture is not something that is overtly noticeable by its people, and can guide the behaviour and beliefs of people which in turn influences the way the institution functions if people are not aware of this. Therefore the university needs to establish an enquiry in order to devise a clear strategy to address issues of sexual orientation and gender identity.

(b) The campus healthcare system needs to adopt a human rights framework that values the healthcare needs of all its students and staff regardless of gender identity and sexual orientation.

(c) Concerted effort should be made to sensitise all staff especially healthcare professionals on issues of gender and sexuality with a clear focus on sexual orientation and gender identity. This will facilitate access to healthcare for queer students.

(d) The training curriculum of all healthcare professionals including lecturers should include aspects of diversity, sexual orientation and gender identity to ensure that they have the knowledge and skills to provide culturally competent health services.

(e) The higher education sector and the Department of Higher Education should strongly rally behind initiatives that assist in bringing about a paradigm shift in how we view gender and sexuality in a post democratic South Africa. This will ensure the establishment of clear healthcare programmes that will deliver individualised care to all LGBTI students.

(f) The findings suggest that social support is pertinent to the health and well-being of LGBTI students and therefore the university has to make sure that they create safe spaces and support the current LGBTI student society on campus. As mentioned in the findings section, this will ameliorate the effects of minority stress on sexual minority students.

### **5.5 Recommendations for further research**

(a) Due to the fact that this is a qualitative study the findings cannot be generalised and therefore a larger quantitative study might be necessary to look at the experience of LGBTI students within the higher education sector.

### **5.6 Conclusion**

The following quotation captures the concluding thoughts of this research. According to Hatzenbuehler & Pachankis (2016), “Stigmatization is entirely contingent on access to social, economic and political power that allows the identification of differentness, the

construction of stereotypes, the separation of labelled persons into distinct categories and the full execution of disapproval, rejection, exclusion and discrimination”. As mentioned earlier, these might manifest within the university culture, which is not always visible to everyone, and inculcate a heteronormative culture that excludes certain people. Therefore university management should strongly guard against this practice.

## LIST OF REFERENCES

1. Anney, VN. 2014. Ensuring the quality of the findings of qualitative research: Looking at trustworthiness criteria. *Journal of Emerging Trends in Educational Research and Policy Studies*, 5(2):272-281.
2. Arndt, M & de Bruin, K. 2011. Measurement of attitudes toward bisexual men and women among South African university students: The validation of an instrument. *Journal of Homosexuality*, 58(4): 497-520.
3. Babbie, E. 2015. *The practice of social research*. Boston: Cengage Learning.
4. Bakker, AB, Buunk, B, Siero, FW & van den Eijnden, RJJM. 1997. Application of a modified health belief model to HIV preventive behavioral intentions among gay and bisexual men. *Psychology & Health*, 12(4): 481-492.
5. Berg, RC, Ross, MW, Weatherburn, P, & Schmidt, AJ. 2013. Structural and environmental factors are associated with internalised homonegativity in men who have sex with men: Findings from the European MSM Internet Survey (EMIS) in 38 countries. *Journal of Social Science & Medicine*, 78: 61-69.
6. Berg, RC, Weatherburn, P, Ross, MW & Schmidt, AJ. 2015. The relationship of Internalized Homonegativity to sexual health and Well-Being among Men in 38 European Countries Who Have Sex with Men. *Journal of Gay & Lesbian Mental Health*, 19:285–302.
7. Bolderston, A, and Ralph, S. 2016. Improving the health care experience of lesbian, gay, bisexual and transgender patients. *Radiography*, 22(3): 207-211.
8. Bregman, HR, Malik, NM, Page, MJL, Makynen, E, & Lindahl, KM. 2013. Identity Profiles in Lesbian, Gay, and Bisexual Youth: The Role of Family Influences. *Journal of Youth Adolescence*, 42: 417–430.
9. Brink, JG. 2017. Considerations for South African Higher Education: A ‘National Student Men Who Have Sex With Men’ Sexual Behaviour Survey. *South African Journal of Higher Education*, 31(4): 184–207.



10. Brouard, P, & Pieterse, J. 2012. 'Two steps forward, one step back: Equality and sexual orientation in South Africa 2009-2011', in South African Human Rights Commission Report. Commentaries on Equality: Race, Gender, Disability and LGBTI Issues. Braamfontein: South African Human Rights Commission.
11. Cele, NH, Sibiyi, MN, Sokhele, DG. 2015. Experiences of homosexual patients' access to primary health care services in Umlazi, Kwazulu-Natal. *Curationis*, 38(2): 1-9.
12. Chetty, D. 2000. *Institutionalising the Response to HIV/AIDS in the South African University Sector: A SAUVCA Analysis*. Arcadia, Sunnyprint.
13. Clarke, TJ. 2012. The Influence of Social Connections and Social Support on Academic Achievement among LGBT and Straight Students. PhD – Dissertation, University of Arizona.
14. Cloete, A, Simbayi, LC, Rehle, T, Jooste, S, Mabaso, M, Townsend, L, Ntsepe, Y, Louw, J, Naidoo, D, Duda, T, Naidoo, P & the Marang Men's Project Team. 2014. The South African Marang Men's Project: HIV bio-behavioural surveys using respondent-driven sampling conducted among men who have sex with men in Cape Town, Durban and Johannesburg. Cape Town: HSRC Press.
15. Creswell, JW. 2007. *Qualitative enquiry and Research Design: Choosing among five approaches*. Thousand Oaks, CA: SAGE Publications.
16. Creswell, JW. 2014. *Research Design: Qualitative, quantitative and mixed method approaches*. Thousand Oaks, CA: SAGE Publications.
17. Cronje, A. 2011. The professional development of science teachers for the implementation of a new curriculum. MA – Dissertation, University of Johannesburg.
18. De Chesnay, M (ed). 2015. *Nursing Research Using Data Analysis: Qualitative Designs and Methods in Nursing*. New York: Springer.
19. Dentato, MP. 2012. The minority stress perspective. *Psychology & AIDS Exchange*, 37: 12-15.
20. Evans, DB, Hsua, J & Boerma, T. 2013. Universal health coverage and universal access. *Bull World Health Organ*, 3(91): 546–546A.

21. Evans, MGB, Cloete, AC, Zungu, N, Simbayi, LC. 2016. HIV Risk Among Men Who Have Sex With Men, Women Who Have Sex With Women, Lesbian, Gay, Bisexual and Transgender Populations in South Africa: A Mini-Review. *The Open AIDS Journal*, 10: 49-64.
22. Fields, EL, Bogart, LM, Smith, KC, Malebranche, DJ, Ellen, J, Schuster, MA. 2015. "I Always Felt I Had To Prove My Manhood": Homosexuality, Masculinity, Gender role strain, and HIV risk among young black men who have sex with men. *American Journal of Public Health*, 105(1): 122-131.
23. Ford, TE, Brignall, T, van Valey, TL, Macaluso, MJ. 2009. The Unmaking of Prejudice: How Christian Beliefs Relate to Attitudes Toward Homosexuals. *Journal for the Scientific Study of Religion*. 48(1): 146-160.
24. Gipson, P, & King, C. 2012. Health Behavior Theories and Research: Implications for Suicidal Individuals' Treatment Linkage and Adherence. *Cognitive and Behavioral Practice*, 19(2): 209-217.
25. Glanz, K, Rimer, BK & Viswanath, K. 2008. *Health behaviour and health education: Theory, Research, and Practice*. 4<sup>TH</sup> edition. San Francisco: Jossey-Bass.
26. Habarth, JM. 2015. Development of the heteronormative attitudes and beliefs scale. *Journal of Psychology and Sexuality*, 6(2): 166-188.
27. Hansen, AL. 2007. School-based interventions for GLBT youth: A review of three levels of research. *Psychology in the School*, 44(8): 839-848.
28. Hatzenbuehler, ML, & Pachankis, JE. 2016. Stigma and Minority Stress as social determinants of health among Lesbian, Gay, Bisexual, and Transgender youth: Research evidence and clinical implications. *Pediatric Clinics of North America*, 63(6): 985-997.
29. Higher Education and Training HIV/AIDS Programme. 2014. National Student Sexual Health HIV Knowledge, Attitude and Behaviour Survey: Focusing on Student Men who have Sex with Men at 14 Higher Education Institutions in South Africa. Pretoria: HEAIDS.

30. Hochella, R. 2012. *An Examination of Campus Climate for Lesbian, Gay, Bisexual, and Transgender (LGBT) Students*. Master's thesis, Syracuse University.
31. Hoffman, ND, Freeman, K, & Swann, S. 2009. Healthcare Preferences of Lesbian, Gay, Bisexual, Transgender and Questioning Youth. *Journal of Adolescent Health*, 45: 222–229.
32. Hosseinpoor, AR, Williams, JS, Amin, A, de Carvalho, IA, Beard, J, Boerma, T, Kowal, P, Naidoo, N, Chatterji, S. 2012. Social Determinants of Self-Reported Health in Women and Men: Understanding the Role of Gender in Population Health. *PLoS ONE* 7(4): e34799. doi:10.1371/journal.pone.0034799.
33. Huber, M, Knottnerus, JA, Green, L, van der Horst, H, Jadad, AR, Kromhout, D, Leonard, B, Lorig, K, Loureiro, MI, Van der Meer, JWM, Schnabel, P, Smith, R, van Weel, C Smid, H. 2011. How should we define health? *BMJ* 343:d4163.
34. IOM (Institute of Medicine). 1993. *Access to Health Care in America*. National Academy, Washington.
35. IOM (Institute of Medicine). 2011. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Washington, DC: The National Academies Press.
36. Jobson, GA, Theron, LB, Kaggwa, JK, & Kim, HJ. 2012. Transgender in Africa: Invisible, inaccessible, or ignored? *Journal of Social Aspects of HIV/AIDS*, 9 (3): 160-163.
37. Joseph, K & Culwick, C. 2015. *Quality of Life Survey 2015*. Gauteng City-Region Observatory Quality of Life Survey 2015: Press release. Available at [http://www.gcro.ac.za/media/redactor\\_files/GCRO\\_QoL\\_2015\\_Press\\_pack\\_low\\_res.pdf](http://www.gcro.ac.za/media/redactor_files/GCRO_QoL_2015_Press_pack_low_res.pdf) [Accessed on 02/08/2016].
38. Katz-Wise, SL, & Hyde, JS. 2012. Victimization Experiences of Lesbian, Gay, and Bisexual Individuals: A Meta-Analysis. *Journal of Sex Research*, 49(2–3): 142–167.
39. Kisler, KA. 2013. Minority Stress and HIV Risk Behavior among HIV-Positive Bisexual Black Men with Histories of Childhood Sexual Abuse. PhD thesis, University of California, Los Angeles.

40. Knox, J, Sandfort, T, Yi, H, Reddy, V & Maimane, S. 2011. Social vulnerability and HIV testing among South African men who have sex with men (MSM). *International Journal of STD AIDS*, 22(12): 709–713.
41. Koester, KA, Collins, SP, Fuller, SM, Galindo, GR, Gibson, S, & Stewart, WT. 2013. Sexual Healthcare Preferences among Gay and Bisexual Men: A Qualitative Study in San Francisco, California. *PLoS ONE* 8(8): e71546. doi:10.1371/journal.pone.0071546.
42. Krueger, RA and Casey, MA. 2000. *Focus Groups: A Practical Guide for Applied Research*. Thousand Oaks (Calif.): Sage Publications.
43. Lane, T, Fisher, R, Dladla, S, Rasethe, J, Struthers, H, McFarland, W & McIntyre, J. 2011. High HIV prevalence among men who have sex with men in Soweto, South Africa: Results from the Soweto Men’s Study. *AIDS & Behavior*, 15(3): 626–634.
44. Lane, T, Mogale, T, Struthers, H, McIntyre, J, Kegeles, SM. 2008. They see you as a different thing: The experiences of men who have sex with men with healthcare workers in South Africa. *Sexually Transmitted Infections*, 84(6): 430-433.
45. Levy, ME, Wilton, L, Phillips, G, Glick, SN, Kuo, I, Brewer, RA, Elliot, A, Watson, C, and Magnus, M. 2014. Understanding Structural Barriers to Accessing HIV Testing and Prevention Services among Black Men Who Have Sex with Men (BMSM) in the United States. *AIDS Behaviour*, 18(5): 972–996.
46. Lick, DJ, Durso, LE, & Johnson, KL. 2013. Minority Stress and Physical Health among sexual minorities. *Perspectives on Psychological Science*, 8(5): 521-548.
47. Logie, C. 2012. The Case for the World Health Organization’s Commission on the Social Determinants of Health to Address Sexual Orientation. *American Journal of Public Health*, 102(7): 1243-1246.
48. Mahomed, F, & Trangos, G. 2016. An Exploration of Public Attitudes toward LGBTI Rights in the Gauteng City-Region of South Africa. *Journal of Homosexuality*, 63(10): 1400-1421.
49. Marshal, MP, Dietz, LJ, Mark, S, Friedman, MS, Stall, R, Smith, H, McGinley, J, Thoma, BC, Murray, MJ, D'Augelli, A & Brent, DA. 2011. Suicidality and

- depression disparities between sexual minority and heterosexual youth: A meta-analytic Review. *Journal of Adolescent Health*, 49(2):115–123.
50. Matthyse, G. 2017. Heteronormative Higher Education: Challenging this status quo through LGBTIQ awareness-raising. *South African Journal of Higher Education*, 31(4): 112–126.
  51. Mavhandu-Mudzusi, AH. 2016. Citizenship rights, discrimination and stigmatisation of LGBTI students by health care services at a South African rural-based university, *Agenda* 1-9.
  52. Mavhandu-Mudzusi, AH, & Ganga-Limando, RM. 2014. ‘Being lesbian, gay, bisexual, transgender and intersex (LGBTI) students in a South African university: Implications for HIV prevention’. *African Journal of Nursing and Midwifery*, 16(2): 125–138.
  53. Mavhandu-Mudzusi, AH, & Netshandama, VO. 2013. ‘Attitudes of students towards the lesbian, gay, bisexual, transgender and intersex community: A case of a South African, rural-based university’. *African Journal for Physical, Health Education, Recreation and Dance, Supplement*, 1, 1: 56–66.
  54. Mavhandu-Mudzusi, AH & Sandy, PT. 2015. ‘Religion related stigma and discrimination experienced by lesbian, gay, bisexual and transgender students at a South African rural-based university’. *Culture, Health & Sexuality: An International Journal for Research, Intervention and Care*, DOI: 10.1080/13691058.2015.1015614.
  55. McCormack, M. 2014. Innovative sampling and participant recruitment in sexuality research. *Journal of Social and Personal Relationships*. 31(4): 475–481.
  56. McGrail, K, Lavergne, R, and Lewis, S. 2016. The chronic disease explosion: Artificial bang or empirical whimper? *BMJ*, 352: i1312.
  57. Men, CR, Frieson, K, Socheat, C, Nirmita, H and Mony, C. 2011. Gender as a social determinant of health: Gender analysis of the health sector in Cambodia. Paper presented at the World Conference on Social Determinants of Health, 19-21 October 2011, in Rio de Janeiro, Brazil. Available at

[http://www.who.int/sdhconference/resources/draft\\_background\\_paper15\\_cambodia.pdf](http://www.who.int/sdhconference/resources/draft_background_paper15_cambodia.pdf) (Accessed on 26/05/2017).

58. Meyer, IH. 1995. Minority Stress and Mental Health in Gay Men. *Journal of Health and Social Behavior*, 36(1): 38-56.
59. Meyer, IH. 2003. Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence. *Psychol Bull.* 129(5): 674–697.
60. Meyer, IH, Bradford, JB, Makadon, HJ, Stall, R, Goldhammer, H, & Landers S. 2008. Sexual and Gender Minority Health: What we know and what needs to be done. *Am J Public Health*, 98: 989–995.
61. Miller Jr., RL. 2005. An appointment with god: AIDS, place, and spirituality. *The Journal of Sex Research*, 42(1): 35-45.
62. Moradi, B, Wiseman, MC, De Blaere, C, Goodman, MB, Sarkees, A, Brewster, ME, Huang, Y. 2010. LGB of Color and White Individuals' Perceptions of Heterosexist Stigma, Internalized Homophobia, and Outness: Comparisons of Levels and Links. *The Counseling Psychologist*, 38(3): 397-424.
63. Msibi, T. 2013. Queering transformation in higher education. *Perspectives in Education*, 31(2): 65-73.
64. Muller, A. 2013. Teaching lesbian, gay, bisexual and transgender health in a South African health sciences faculty: addressing the gap. *BMC Medical Education* 13:174.
65. Muller, A. 2014. Public Health Care for South African Lesbian, Gay, Bisexual and Transgender People: Health Rights Violations and Accountability Mechanisms. Paper presented at the International Conference: Putting Public in Public Services: Research, Action and Equity in the Global South – Cape Town, April.
66. Muller, A. 2016. Health for All? Sexual Orientation, Gender Identity, and the Implementation of the Right to Access to Health Care in South Africa. *Health and Human Rights Journal*, 18(2): 195-208.
67. Muller, A. 2017. Scrambling for access: Availability, accessibility, acceptability and quality of healthcare for lesbian, gay, bisexual and

- transgender people in South Africa. *BMC International Health and Human Rights*, 17(16): 1-10.
68. NACOSA. 2014. National Student Sexual Health HIV Knowledge, Attitude and Behaviour Survey: Focusing on Student Men who have Sex with Men at 14 Higher Education Institutions in South Africa. Pretoria: HEAIDS.
  69. Nduna, M, Mthombeni, A, Mavhandu-Mudzusi, AH, & Mogotsi, I. 2017. Studying Sexuality: LGBTI experiences in Institutions of Higher Education in Southern Africa. *South African Journal of Higher Education*, 31(4): 1–13.
  70. Pather, R. 2017. Grace Bible Church: We don't discriminate against anyone. *Mail & Guardian*, 23 January 2017.
  71. Prescott, PA. & Soeken, KL. 1989. The potential uses of pilot work. *Nursing Research*, 38(1): 60-62.
  72. Quinn, K, Dickson-Gomez, J, DiFranceisco, W, Kelly, JA, Lawrence, JS, Amirkhanian, YA, & Broaddus, M, 2015. Correlates of Internalised homonegativity among black men who have sex with men. *AIDS Education and Prevention*, 27(3): 212-226.
  73. Ratele, K. 2013. Masculinities without Tradition. *Politikon: South African Journal of Political Studies*, 40(1): 133-156.
  74. Rispel, LC, Metcalf, CA, Cloete, A, Reddy, V & Lombard, C. 2011. HIV prevalence and risk practices among men who have sex with men in two South African cities. *Journal of Acquired Immune Deficiency Syndromes*, 57(1): 69–76.
  75. Rispel, LC, Metcalf, CA, Cloete, A, Moorman, J, & Reddy, V. 2011. You become afraid to tell them that you are gay: Health service utilisation by men who have sex with men in South African cities. *Journal of Public Health Policy*, 32(1): 137-151.
  76. Ritchie, J, Spencer, L, & O'Connor, W. 2003. Carrying out qualitative analysis. In J. Ritchie & J. Lewis (Eds.). *Qualitative research practice: A guide for social science students and researchers* (pp. 219-262). London: Sage.

77. Rodriguez, IV. 2016. Internalized Heteronegativity & Resilience in Relation to the Health of Sexual Minorities of Color. Master's thesis, University of Rhode Island.
78. Rosenthal, M. 2016. Qualitative research methods: Why, when, and how to conduct interviews and focus groups in pharmacy research. *Currents in Pharmacy Teaching and Learning*, 8(4): 509–516.
79. Russel, ST, & Fish, JN. 2016. Mental Health in Lesbian, Gay, Bisexual, and Transgender (LGBT) Youth. *Annu. Rev. Clin. Psychol.*, 12: 465–87.
80. Ryan, C, Huebner, D, Diaz, R, & Sanchez, J. 2009. Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay and bisexual young adults. *Pediatrics*, 123(1): 346–352.
81. Ryan, C, Russell, ST, Huebner, D, Diaz, R, & Sanchez, J. 2010. Family Acceptance in Adolescence and the Health of LGBT Young Adults. *Journal of Child and Adolescent Psychiatric Nursing*, 23 (4): 205–213.
82. Santiago-Delefosse, M, Gavin, A, Bruchez, C, Roux, P, & Stephen, SL. 2016. Quality of qualitative research in the health sciences: Analysis of the common criteria present in 58 assessment guidelines by expert users. *Social Science & Medicine*, 148: 142–151.
83. Schrimshaw, EW, Siegel, K, Downing, MJ, & Parsons, JT. 2013. Disclosure and Concealment of Sexual Orientation and the Mental Health of Non-Gay-Identified, Behaviorally-Bisexual Men. *J Consult Clin Psychol.*, 81(1): 141–153.
84. Scheibe, A. 2014. The social determinants of HIV among men who have sex with men in Cape Town, South Africa. Master in Public Health (Health Economics), University of Cape Town.
85. Schwandt, TA. 2015. *The SAGE Dictionary of Qualitative Inquiry*. 4th edition. Thousand Oaks, CA: Sage
86. Selye, H. 1982. *History and present status of the stress concept. Handbook of stress*. [sl].
87. Smith, JA, Flowers, P & Larkin, M. 2009. *Interpretative phenomenological analysis: Theory, method, and research*. Los Angeles: Sage.



88. Smith, R. 2015. Healthcare experiences of lesbian and bisexual women in Cape Town, South Africa. *Culture, Health & Sexuality*, 17(2): 180–193.
89. Snapp, SD, Watson, RJ, Russel, ST, Diaz, RM & Ryan, C. 2015. Social Support Networks for LGBT Young Adults: Low Cost Strategies for Positive Adjustment. *Family Relations*, 64: 420–430.
90. South African National AIDS Council. 2017. *The National Strategic plan for HIV, TB & STI's 2017-2022*. Pretoria: Government Printer.
91. Stover, CM. 2011. *Exploring Healthcare Experiences of Lesbian, Gay, and Bisexual College Students Using Community-Based Participatory Research: A Dissertation*. PhD-thesis, University of Massachusetts.
92. Sutherland, C, Roberts, B, Gabriel, N, Struwig, J, & Gordon, S. 2016. *Progressive Prudes: A Survey of South African Attitudes to Homosexuality and Gender Non-Conformity in South Africa. (Commissioned by the Other Foundation)*. Johannesburg.
93. The United Nations. 2016. "Pathologization – Being lesbian, gay, bisexual and/or trans is not an illness" For International Day against Homophobia, Transphobia and Biphobia - Tuesday 17 May 2016. Available at: <http://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=19956&LangID=E#sthash.C8qzqzI0.dpuf> [Accessed on the 24/01/2017].
94. UNAIDS. 2011. *Political Declaration on HIV and AIDS: Intensifying our efforts to eliminate HIV and AIDS*. Geneva.
95. US Department of Health and Human Services. 2010. National Healthcare Disparities Report, 2010. AHRQ Publication, Rockville.
96. Utamsingh, PD, Richman, LS, Martin, JL, Lattanner, MR and Chaikind, JR. 2015. Heteronormativity and practitioner–patient interaction. *Health Communication*, 31(5): 566-574.
97. Valentine, G, and Wood, N. 2009. The experience of lesbian, gay, bisexual and trans staff and students in higher education. Research report 2009. Equality Challenge Unit, England.

98. van Vollenhoven, WJ, & Els, CJ. 2013. The human rights paradox of lesbian, gay, bisexual and transgender students in South African education. *De Jure*, 263-284.
99. Vu, L, Tun, W, Sheehy, M, Nel, D. 2012. Levels and Correlates of Internalized Homophobia among Men Who Have Sex with Men in Pretoria, South Africa. *AIDS and Behaviour*, 16(3): 717-23.
100. Wang, K, and Pachankis, JE. 2016. Gay-Related Rejection Sensitivity as a Risk Factor for Condomless Sex. *AIDS Behaviour*, 20(4): 763–767.
101. Wilkerson, MJ, Rybicki, S, Barber, CA & Smolenski, DJ. 2011. Creating a Culturally Competent Clinical Environment for LGBT Patients, *Journal of Gay & Lesbian Social Services*, 23(3): 376-394.
102. Whitehead, J, Shaver, J, Stephenson, R. 2016. Outness, Stigma, and Primary Health Care Utilization among Rural LGBT Populations. *PLoS One*, 11(1): 1-17.
103. Wolf, JA, Niederhauser, V, Marshburn, D, LaVela, SL. 2014. Defining Patient Experience. *Patient Experience Journal*, 1(1): 7-19.
104. World Health Organisation. 1946. Constitution of the World Health Organization. *American Journal of Public Health*, 36: 1315-1323.
105. World Health Organization. 2004. WHO Centre for Health Development Ageing and Health Technical Report Volume 5. Geneva: WHO Press.
106. Youatt, EJ. 2016. *Exploring Sexual Orientation Disclosure to Health Care Providers among Sexual Minority Women*. PhD-dissertation, University of Michigan.

## **LIST OF APPENDICES**

### **Appendix A**

#### **PARTICIPANT INFORMATION SHEET**

17 September 2015

A qualitative inquiry into the experience of LGBTI students in accessing healthcare in a contact higher education institution

#### **Dear Prospective Participant**

My name is Atholl Kleinhans and I am doing research with Leon Roets, a lecturer/senior lecturer in the Department of Sociology towards a MA, at the University of South Africa. We are inviting you to participate in a study entitled “A qualitative inquiry into the experience of LGBTI students in accessing healthcare in a contact higher education institution”.

#### **WHAT IS THE PURPOSE OF THE STUDY?**

I am conducting this research to explore and describe the experiences of LGBTI students in accessing healthcare in a contact university in South Africa with the view of formulating recommendations towards HIV prevention for LGBTI students.

#### **WHY AM I BEING INVITED TO PARTICIPATE?**

You have been selected to participate in the study based on your membership of the LGBTI student group. Permission has been sought from the executive committee of the student group and key informants have been identified to assist the researcher to recruit participants. You have been chosen because you fulfil the inclusion criteria of the research which is being a LGBTI students and a members of the LGBTI student group. You will be

asked to participate in a focus group discussion with six to eight other LGBTI students. The information that you share in the focus group discussion will be treated with confidentiality. Your real name will never be used in the analysis of the data and no one will ever be able to connect you to this research.

### **WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?**

If you consent to participate in the study you will be asked to join a group of 6-8 LGBTI students and the focus group discussion will last for about 60 minutes. We will have the focus group discussion wherever you feel most comfortable, and at a time that will suit you best. I will ask you questions about your health and your experiences of visiting the campus clinic or other health related services when you have had a problem with your health. The questions that I will ask will focus on your personal experience, and I might ask you to elaborate on your answers. An example of a question would be: "What have you done about your health problems?" This type of question is called an open-ended question. There are no right or wrong answers to the questions. Should you not understand any of the questions, please do not hesitate to ask me to clarify any uncertainties. If you feel that any of the questions that I am asking are too personal, you may choose not to answer the particular question.

I will ask your permission to audio record the focus group discussion and I will be making notes while you are talking to me. The recording and the notes will help me to remember everything that you have told me. When I have completed the analysis of our interview I will set up a follow up appointment with you to verify the information that you have given me.

### **CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?**

Participating in this study is voluntary and you are under no obligation to consent to participation without being disadvantaged. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form. You are free to withdraw at any time and without giving a reason.

### **WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?**

Your participation in this study will give you an opportunity to share your life experiences with a group of students who share similar experiences as you. The information that you share will also help the researcher to complete this study, and to effect positive change which might benefit other LGBTI students.

### **ARE THERE ANY NEGATIVE CONSEQUENCES FOR ME IF I PARTICIPATE IN THE RESEARCH PROJECT?**

There are no anticipated risks. However, there is a small chance that you may experience distress during the focus group discussions since you will be sharing personal information in a group setting. Should you feel distress at any point during the discussion, you should immediately inform me. Should the distress persist, I will refer you for counselling at the Psychological Services and Career Developments Department where a psychologist will provide counselling. Should you discontinue, there will be no negative consequences. Due to the nature of the group discussion, we cannot guarantee confidentiality of your information outside the group discussions.

**WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER AND MY IDENTITY BE KEPT CONFIDENTIAL?**

You have the right to insist that your name will not be recorded anywhere and that no one, apart from the researcher and the supervisor, will know about your involvement in this research. Your name will not be recorded anywhere and no one will be able to connect you to the answers you give. Your answers will be given a code number or a pseudonym and you will be referred to in this way in the data, any publications, or other research reporting methods such as conference proceedings. Your answers may be reviewed by people responsible for making sure that research is done properly, including the supervisor and members of the Research Ethics Review Committee. Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

While every effort will be made by the researcher to ensure that you will not be connected to the information that you share during the focus group, I cannot guarantee that other participants in the focus group will treat information confidentially. I shall, however, encourage all participants to do so. For this reason I advise you not to disclose personally sensitive information in the focus group.

**HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?**

Hard copies of your answers will be stored by the researcher for a period of five years in a locked cupboard in the researcher's office at the University of Johannesburg for future research or academic purposes; electronic information will be stored on a password protected computer. Future use of the stored data will be subject to further Research Ethics Review and Approval if applicable. After five years, if necessary, hard copies will be shredded and/or electronic copies will be permanently deleted from the hard drive of the computer through the use of a relevant software programme.

**WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?**

There will be no financial reward for participating in the research but the researcher will provide refreshments during the focus group discussion.

**HAS THE STUDY RECEIVED ETHICS APPROVAL?**

This study has received written approval from the Research Ethics Review Committee, Unisa. A copy of the approval letter can be obtained from the researcher if you so wish.

**HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?**

If you would like to be informed of the final research findings, please contact Atholl Kleinans on 0837851750 or [athollkleinans@yahoo.co.uk](mailto:athollkleinans@yahoo.co.uk). The findings are accessible for two years. Should you require any further information or want to contact the researcher about any aspect of this study, please feel free to contact him.

Should you have concerns about the way in which the research has been conducted, you may contact Leon Roets, [Roetshjl@unisa.ac.za](mailto:Roetshjl@unisa.ac.za) or 0124296975.

Thank you for taking time to read this information sheet and for participating in this study.  
Thank you.

Atholl Kleinans

**Appendix B**

**CONSENT TO PARTICIPATE IN THIS STUDY**

I, \_\_\_\_\_ (participant name), confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet.

I have had sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that I am free to withdraw at any time without penalty (if applicable).

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I agree to the recording of the focus group discussion.

I have received a signed copy of the informed consent agreement.

Participant Name & Surname..... (please print)

Participant Signature..... Date.....

Researcher's Name & Surname.....(please print)

Researcher's signature..... Date.....

## Appendix C

### Focus Group Discussion Guide & Key Informant Interview Guide

#### 1. Research question 1

Where do LGBTI students prefer to go if and when they need to access healthcare services? Please elaborate on your answer.

Sub questions:

- What factors contribute to your choice of healthcare services?
- What services do you prefer to access on campus / off campus?
- How accessible are the current healthcare services on campus for LGBTI students?
- What are some of the challenges they may face in accessing these services?
- What services are lesbian, gay, bisexual and transgender students currently using to get health and social support in the university?

#### 2. Research question 2

What are the experiences of LGBTI students in accessing healthcare services on campus?

- What has been your experience in accessing these health services on campus?
- How did you find out about the services offered?
- When do you decide to go for these services?
- Tell me a little bit more about the type of services you require?
- How do you feel about current services offered on campus?
- What are your perceptions regarding the quality of services received in the past?
- What are the challenges that prevent LGBTI students from accessing healthcare

#### 3. Research question 3

What are the specific healthcare needs that LGBTI students have?

- How do you think the university makes sure that these needs are met?
- What measures do you suggest the university put in place to meet these needs?
- What do the healthcare needs for LGBTI students include?

#### 4. Research question 4



What can be improved in the current healthcare facilities and services to make them more accessible for LGBTI students?

Sub questions:

- What should happen to make the healthcare services on campus more lesbian, gay, bisexual and transgender friendly?
- What suggestions do you have to improve current health services

### **Key Informant Interview Guide**

1. What are some of the major challenges experienced by LGBTI students when they access healthcare services on campus?
2. What are current initiatives to improve the health outcomes of LGBTI student on campus?
3. How do you suggest improving the current situation regarding LGBTI students on campus?

**Appendix D**  
**Request for permission to conduct research 1**

The Executive Committee  
Liberati Student Organisation  
University of Johannesburg  
PO Box 524  
Auckland Park  
2006

Date: 20 May 2015

Attention: Mr. Xolani Mabuso (Chairperson)

**RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH**

Dear Mr. Mabuso

My name is Atholl Kleinhans, and I am a Master's student at the University of South Africa. I am conducting research to explore the experience of LGBTI students in accessing healthcare. This type of research has never been done at the university. Your participation may help to assist other LGBTI students to identify their health needs and negotiate appropriate healthcare. This project will be conducted under the supervision of Mr. Leon Roets.

I am hereby seeking your consent to approach members of your organisation to participate in this study. The main objectives of the study are: (1) to gain insight and to understand whether LGBTI students are aware of any specific healthcare services on campus for LGBTI persons, (2) explore their understanding of how and how often they access these services, (3) explore their understanding of their specific healthcare needs for LGBTI students, (4) where do they prefer to go if they need healthcare services, (5) what LGBTI students think will make healthcare services more friendly, and (6) to provide recommendations on how to enhance the current health services on campus to be more sensitive to LGBTI students.

What is expected from participation in the study?

Should any member agree to participate in this study, I will meet with them once for a short screening interview that will last for about 20 minutes. We will have the interview wherever they feel most comfortable, and at a time that will suit them best. Thereafter, they will be asked for consent to join a group of ten LGBTI students to

participate in a focus group discussion. The focus group discussion will last for approximately 60 minutes.

I will ask their permission to audio record discussions with a digital recorder and I will be making notes while they discussing in the group. The recording and the notes will help me to remember everything that was discussed.

When I have completed the analysis of our interview, I will set up a follow up appointment with them to verify the information that they have given me. I will also seek consent from all the participants to exhibit their photos at an event that will be organized by themselves.

What are the potential benefits?

There are no direct benefits to them in participating in this study; however, their participation in this study will give them an opportunity to share their life experiences with other LGBTI students, who endeavour to effect positive change in the lives of persons who are undergoing similar experiences as they do. The information that they share will help me to compile a report that might benefit other LGBTI students.

What are the potential risks?

There are no anticipated risks. However, there is a small chance that they may experience distress during the group discussion. Should they feel distress at any point during the activities, they should immediately inform me. Should the distress persist, I will refer them for counselling. A psychologist at Psychological Services and Career Developments (PsyCaD) will provide counselling. Should they discontinue, there will be no negative consequences.

Confidentiality

The information that they share in the group activities will be treated with confidentiality. Their real names will never be used in the analysis of the data and no one will ever be able to connect them to this research.

Voluntary participation

Participation in this study is voluntary and they may withdraw their participation from the study at any time without being disadvantaged.

Where can they find more information on this study?

If they need any more information about this study, or questions with regarding to their rights and welfare as research participants, they may contact the following person:

1. Mr. Leon Roets

Research supervisor and Programme Convener: Postgraduate Programme of Social and Behavioural Studies (HIV/AIDS), Department of Sociology, UNISA

Tel: 012 429 6975

E-mail: [Roetshjl@unisa.ac.za](mailto:Roetshjl@unisa.ac.za)

What do they do if they wish to participate in the study?

If they agree to participate in this study, they will be requested to sign a consent form as evidence that they understand what the study is about and that they participate voluntarily.

Upon completion of the study, I undertake to provide the Liberati Student Organization with a bound copy of the full research report. If you require any further information, please do not hesitate to contact me on 0837851750 or [athollk@uj.ac.za](mailto:athollk@uj.ac.za). Thank you for your time and consideration in this matter.

Thank You,

Atholl Kleinhans

Researcher

Tel: 011 559 4927

E-mail: [athollk@uj.ac.za](mailto:athollk@uj.ac.za)

## Appendix E

### REQUEST FOR PERMISSION TO CONDUCT RESEARCH 2

A qualitative inquiry into the experience of LGBTI students in accessing healthcare in a contact higher education institution

18 September 2015

Professor K Burger  
Chairperson UJ HIV/AIDS committee  
University of Johannesburg  
PO Box 524  
Auckland Park  
2006  
0115591088

Dear Prof Burger

I, Atholl Kleinhans, am doing research with Mr Loen Roets, a lecturer, in the Department of Sociology, towards a MA, at the University of South Africa. We are inviting members from your LGBTI group to participate in a study entitled “A qualitative inquiry into the experience of LGBTI students in accessing healthcare in a contact higher education institution”.

The aim of the study is to explore and describe the experiences of LGBTI students in accessing healthcare in a contact university in South Africa with the view of improving the accessibility of healthcare services for LGBTI students and by formulating recommendations towards HIV prevention for LGBTI students.

The study procedure will involve the identification of key informants in the first instance. These will comprise of informed members from your executive committee of the LGBTI group and other experts on LGBTI issues within the university. A number of 5 key informants will be selected. Key informants will assist the researcher in recruiting potential participants to participate in the study.

A total of 6-8 participants who consent to participate in the study will be recruited to form part of a focus group discussion. One of the main inclusion criteria is membership in the LGBTI student group. The focus group discussion will last for approximately 60 minutes and participants can withdraw at any time without prejudice. Consent will also be sought to digitally record the focus group discussions. Prior to the start of the focus group discussion, the researcher will attempt to build rapport by means of group activities and also highlight confidentiality during and after the focus group discussion.

Although there are no direct benefits to the participants, their participation in this study will give them an opportunity to share their life experiences with a group of students who shares similar experiences as them. The information that they will share will also help the researcher to complete this study, and to effect positive change which might benefit other LGBTI students.

There are no anticipated risks. However, there is a small chance that they may experience distress during the focus group discussions since they will be sharing personal information in a group setting. While every effort will be made by the researcher to ensure that participants will not be connected to the information that they share during the focus group, the researcher cannot guarantee that other participants in the focus group will treat information confidentially. However, as mentioned above, all efforts will be made to ensure that all participants fully understand the concept of confidentiality and all participants will be encouraged to uphold the principle.

Once the final report has been submitted and feedback has been received from the supervisor, the researcher will provide your organisation with a hard copy of the final report.

Ethical clearance has been sought from UNISA and the approval letter will be sent to the ethics committee at UJ for further verification. I hereby seek your permission to enter the site and to conduct the research provided that all ethical clearances have been received.

Yours sincerely

Atholl Kleinhans  
Student Researcher

## **Appendix F:**

### **Field notes observation guide**

After every interview, the researcher should reflect on the following observations and make field notes:

1. What was the overall experience in conducting this interview? Explain more.
2. How was the group dynamics of the interview per age and gender?
3. What were the key concepts used most often by participants? Why?
4. What was the atmosphere during the interview amongst participants?
5. Where were agreements and disagreements about opinions amongst the participants?
6. What was the feedback from the participants about being part of the research?
7. Any other observations:

# Appendix G

## Ethical Clearance form



**RESEARCH ETHICS COMMITTEE: DEPARTMENT OF HEALTH STUDIES  
REC-012714-039 (NHERC)**

1 June 2016

Dear Mr AV Kleinhans

**Decision: Ethics Approval**

**HSHDC/525/2016**

Mr AV Kleinhans

Student: 3343-600-2

Supervisor: Mr L Roets  
Qualification: MA Sociology  
Joint Supervisor: -

**Name:** Mr AV Kleinhans

**Proposal:** A qualitative inquiry into the experience of LGBTI students in accessing healthcare in a contact higher education institution.

**Qualification:** DLSBH95

Thank you for the application for research ethics approval from the Research Ethics Committee: Department of Health Studies, for the above mentioned research. Final approval is granted for the duration of the research period as indicated in your application.

*The application was reviewed in compliance with the Unisa Policy on Research Ethics by the Research Ethics Committee: Department of Health Studies on [add date of meeting].*

*The proposed research may now commence with the proviso that:*

- 1) The researcher/s will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.*
- 2) Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to the (Name of unit/sub-unit) Ethics Review Committee. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.*



University of South Africa  
Preller Street, Muckleneuk Ridge, City of Tshwane  
PO Box 392 UNISA 0003 South Africa  
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150  
[www.unisa.ac.za](http://www.unisa.ac.za)



3) *The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.*

4) *[Stipulate any reporting requirements if applicable].*

*Note:*

*The reference numbers [top middle and right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants, as well as with the Research Ethics Committee: Department of Health Studies.*

Kind regards,  
For Prof L. Roets

Prof L Roets  
CHAIRPERSON  
[roetsl@unisa.ac.za](mailto:roetsl@unisa.ac.za)



Prof MM Moleki  
ACADEMIC CHAIRPERSON  
[molekmm@unisa.ac.za](mailto:molekmm@unisa.ac.za)



University of South Africa  
Preller Street, Muckleneuk Ridge, City of Tshwane  
PO Box 392 UNISA 0003 South Africa  
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150  
[www.unisa.ac.za](http://www.unisa.ac.za)