EXPERIENCES OF HOMOSEXUALS' ACCESS TO PRIMARY HEALTH CARE SERVICES IN UMLAZI, KWAZULU-NATAL

Nokulunga Harmony Cele

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Supervisor : Prof MN Sibiya

Co-supervisor : Ms DG Sokhela

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Declaration

This is to certify that the work is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

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Signature of student Date

Approved for final submission

_____ _____

Prof MN Sibiya Date

RN, RM, D Tech: Nursing

_____ _____

Ms DG Sokhela Date

RN, RM, M Tech: Nursing

Abstract

Introduction

Access to effective health care is at the heart of the discourse on how to achieve the health related Millennium Development Goals. Lesbian and gay persons are affected by a range of social and structural factors in their environment, and as a result have unique health needs that might not be met by existing health care services. Sexual stigma remains a barrier to seeking appropriate health care. Lesbians and gays might delay seeking health care when needed or avoid it all together, because of past discrimination or perceived homophobia within the health care system.

Aim of the study

The aim of the study was explore and describe the accessibility of primary health care services to lesbians and gays in Umlazi in the province of KwaZulu-Natal.

Methodology

A qualitative, exploratory, descriptive study was conducted which was contextual in nature. Aday and Andersons' theoretical framework of access was chosen to guide this study. Semi-structured interviews were conducted with 12 lesbian and gay participants. The findings of this study were analysed using content analysis.

Results

Four major themes that emerged from the data analysis were discrimination of homosexual men and women by health care providers and community members in PHC facilities; attitudes of homosexual men and women towards health care providers; homophobic behaviour and equality of PHC services. Few

participants were satisfied with the primary health care services they received. Intervention by the Department of Health, Department of Education, curriculum planners and Health Professionals Councils is recommended wherein homosexuality education should be addressed during pre-service and in-service education sessions so as to familiarise health care providers with such clients' health care needs and to decreased homophobic attitudes.

Dedication

I dedicate this dissertation to:

- My late father Yekezakhe Norman Cele and my late brother Gamalethu Cele, whom both believed in my academic capabilities.
- Lesbians and gays in KZN, South Africa, and beyond the African continent that have experienced any form of homophobic behaviour while seeking and utilising health care.

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Glossary of terms

Access: Gaining entry into the health care system and obtaining the necessary assistance (Aday and Anderson 1974: 209).

Bias/ prejudice: a disposition or hatred that results from some action or judgment.

Biphobia: hatred towards bisexual people, which can be experienced by people of any sexual orientation (Daley and MacDonnell 2011: 2)

Bisexual: a person who is sexually attracted to both sexes; male and female (Healthy People 2010: 443).

Gay: commonly refers to a homosexual, primarily a man who is sexually attracted to and has sex with men, self-identified as gay and may occasionally engage in sex with females (Healthy People 2010: 445).

Health care providers: are all categories of the multidisciplinary team working in the PHC clinic.

Heteronormativity: is the assumption relying on biological gender identity that a man will grow up and have a relationship a woman. It is related to the cultural norm that promotes heterosexuality as normal and homosexual as abnormal and unacceptable (Brown, Duby and Van Dyk 2013: 14).

Heterosexual: refers to a person primarily attracted to and engages in sexual activities with people of the opposite sex; commonly known as “straight” (Healthy People 2010: 446).

Homosexual: refers to a person primarily attracted to and engages in sex with people of the same sex (Muller 2013: 2). The term homosexual is used interchangeably with the terms lesbians and gays.

Lesbian: commonly refers to a homosexual person, primarily a woman who is sexual attracted to other women and has sex with women, self-identified as lesbian and may occasionally engage in sex with males.

Patient: any individual who enters the health care facility seeking any health assistance. The term 'patient' is used interchangeable with the concept 'client'.

Primary health care facilities/clinics: are first levels health care institutions that render basic medical care.

Sodomy: is oral or anal sex between two members of the same sex or opposite sex, a mouth to anus contact or sexual organ to anus of another person (Healthy People 2010: 448).

Transgender: relating to a person whose gender identity or gender expression does not correspond with or confirm his or her biological gender (Healthy People 2010: 448).

Transphobia: it is a negative/hostile attitude towards transgender people seen as transgressing traditional gender norms such as lesbians and gays who are seen as transgressing gender norms. Transphobia is often associated with homophobia but any sexual orientation can experience it (Brown, Duby and Van Dyk 2013: 14).

List of acronyms

Acronym	Full term
AIDS	Acquired immune deficiency syndrome
HIV	Human immunodeficiency virus
HPV	Human papilloma virus
KZN	KwaZulu-Natal
LGBT	Lesbian, gay, bisexual and transgender
MDGs	Millennium Development Goals
MSM	Men who engage in sex with other men
NDOH	National Department of Health (of South Africa)
NGO	Non-Governmental Organisation
NPO	Non-Profit Organisation
PHC	Primary Health Care
SSA	Sub-Saharan Africa
STI	Sexually transmitted infection
UK	United Kingdom
WHO	World Health Organization
WSW	Women who engage in sex with other women

CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

The World Health Organization's (WHO) ultimate goal of *Health for All* for primary health care (PHC) became the core concept in the 1970's (WHO1978: 1), in the declaration of the international conference on PHC held in Alma Ata in 1978. The WHO stipulates five main elements to accomplish this goal namely:

(a) decreasing exclusion and social discrepancies in health services (global coverage reforms);

(b) arranging health services around people's requirements and expectations (delivery of services improved);

(c) integrating all health sectors (developed and rectified public health policies);

(d) combining models of policy dialogue (administration reforms); and

(e) expanding non-governmental organizations' (NGOs) participation (WHO1978: 1-2).

Among these components, there are the main principles identified in the Alma Ata Declaration that were integrated into national policies in order to maintain PHC as part of a comprehensive health care system to increase access to PHC services. The principles of PHC are as follows:

- Equitable supply of health care: this principle emphasises the importance of uniting and working together of PHC with other services, in order to fulfil the health needs of the community. The equal

accessibility of health to all individuals irrespective of their gender, age, caste, colour, urban/rural location and social class.

- Community involvement and participation in order to utilise obtainable resources locally, nationally and internationally. This implies a possibility of being part of the decision making regarding their state of well-being and promotion of their health.

- Health workforce development: comprehensive health care depends on the availability of a trained multidisciplinary health professionals who are supported at the local and referral levels.

- Use of appropriate technology: this principle emphasises the accessibility, affordability and feasibility of medical technology and cultural acceptance to the community.

- Multi-sectional approach: formal health sectors include other sectors to improve health. Social services for an example nutrition (food), rural development, housing, public works ensuring good sanitation, providing purified water, education, and including Non-Governmental Organizations (NGO's), community organization (including local governments and voluntary organizations. These basic principles are the cornerstone of PHC (WHO1978: 3).

The National Department of Health (NDOH) in South Africa has developed National Core Standards assisted by the national, provincial and private sector partners. The main purpose is to establish a common definition of 'quality of care' which should be practised in all health care sectors and serve as a guide to the public and to managers and staff members (National Department of Health 2011: 3). Moreover, South Africa is still guided by the Bill of Rights as enshrined in the Constitution of the Republic of South Africa, (1996) Section 27(1) (a) which emphasises that all citizens are granted the right to access health care services. The rights are directed at individuals, government and the private sectors (Kirby 2010: 488). However, Tucker (2010: 434) argues that in spite of the existence of the legal rights in the

South African Constitution, these rights still continue to fail on the grounds that they are not practised and the lesbian, gay, bisexual and transgender (LGBT) community does not benefit maximally from these services. The author describes homophobia as being still powerful and present in South Africa. Similarly Tucker (2010: 434) and Ochse (2011: 4) agree that homophobia still remains a barrier to LGBT peoples' daily lives in South Africa.

With respect to LGBTs, the majority of the previous South African laws were against them and made things difficult for the group to access many government or private health services. The South African statutory law during the apartheid government in 1970-1980 contained many Acts that were hostile to the human rights of LGBT's. Homosexual men and women were prosecuted under Section 20A of Sexual Offences Act no 23 of 1957; furthermore sodomy and unnatural sexual offences were listed as schedule 1 offences in the criminal procedure Act, placed in the same category as murder, rape and fraud (Sexual Offences Act, 1957). At the same time, the age of consent to sex was set at 19 years for all same-sex sexual conduct whereas for heterosexuals the age of consent to sex was set at 16 years (Sexual Offences Act no 23 of 1957). In 1993, Chapter 2 of the Bill of Rights under equality prohibited discrimination on the basis of sexual orientation (Republic of South Africa 1996: 6-8).

1.2 PROBLEM STATEMENT

Despite the post-apartheid government and the new constitutional and legal system in South Africa which ensures equality and prohibits discrimination based on sexual orientation, social acceptance is still generally lacking. LGBTs are still oppressed and continue to face challenges especially in their daily lives with social stigma, homophobic attacks (particularly corrective rape) and high rates of HIV/AIDS (Ochse 2011: 3). Access to health care is central in the performance of health care systems around the world. Access to effective care is at the heart of the discourse on how to achieve the health

related Millennium Development Goals [MDGs] (United Nations General Assembly 2000). When LGBTs need to access health care services they still have fear, hesitation and a very pure possibility of discrimination by health care providers and they have reported refusal and denial of treatment by health care providers. LGBTs also experience indirect and direct verbal abuse and insults as well as many other forms of discrimination and the inability to be provided with satisfactory care which results in LGBT patients avoidance of seeking health care services (Rounds, McGrath and Walsh 2013: 99). Similarly Mitra and Globerman (2013: 99) add that lesbians and gays are also affected by a range of social and structural factors around their environment, as a result have unique health needs that might not be met by existing health care services. Sexual stigma remains a barrier to seeking appropriate health care. According to Muller (2013: 2), lesbians and gays might delay seeking health care when needed or avoid it all together, because of past discrimination or perceived homophobia within the health care system. According to Tjepkema (2008: 82), a collection of different studies has been conducted in relation to the decision making to approach health care use, and noticed that relatively less research has been conducted regarding health care use and access by homosexual men and women. This research also reveals that much information about homosexual men and women access to health care is from American studies. Furthermore, this author also suggests that all overseas countries, where research was conducted on homosexual men and women access to health care services, revealed that they experienced individual and unique obstacles (Tjepkema 2008: 82). There is a paucity of literature on homosexual men and women accessibility of health care services universally which confirms that the phenomenon has not been explored by many researchers and authors globally, nationally and locally. The researcher noticed that lesbians and gays visited the clinic at a very later stages of their illnesses, and very few come for medical check-ups like heterosexual men and women.

1.3 PROFILE OF THE RESEARCHER

The researcher was employed as a Clinical Nurse Specialist in one of the PHC clinics at Umlazi Township in the province of KwaZulu-Natal (KZN) at the time of conducting this study. She noticed that very few LGBTs visited the clinic and the majority of LGBTs reported at the clinics during later stages of their illnesses particularly when they were very sick or had complications.

1.4 AIM OF THE STUDY

The aim of the study was to explore and describe the experiences of homosexual men and women regarding the accessibility of PHC services in Umlazi in the province of KZN.

1.5 OBJECTIVES OF THE STUDY

The objectives of the study were to:

- Determine the accessibility of health care services to lesbians and gays.
- Assess the experiences of lesbians and gays concerning their access to health care services.

1.6 SIGNIFICANCE OF THE STUDY

It is important for health care providers in Umlazi to be aware of and to be enlightened about the different sexual orientations of people in the community they serve, particularly lesbians and gays who need to access health care services like anybody else. The study might assist health care providers to acknowledge, understand and be more aware of different sexual orientations; thus enabling them to provide this community with truly comprehensive health care services. The study might also help the lesbian and gay community to access health care services without fearing discrimination, homophobia and heteronormativity.

1.7 THEORETICAL FRAMEWORK

Aday and Andersons' framework of access was used to guide this study as this framework measure access to health services. The main elements of the framework are:

- Health policy objectives.
- Characteristics of the health care delivery system.
- Characteristics of population at risk.
- Utilisation of health services, and consumer satisfaction (Aday and Andersen 1974: 208).

Further discussions about and indications as to how the theoretical framework guided the study will be presented in chapter 3.

1.8 OUTLINE OF THE DISSERTATION

Chapter 1: Introduction and background.

Chapter 2: Literature review.

Chapter 3: Research methodology.

Chapter 4: Presentation of the results.

Chapter 5: Discussion of results, conclusion, limitations of the study and recommendations.

1.9 SUMMARY

This chapter provided an overview of the study's aim, objectives, significance and an outline of the chapters. The following chapter will discuss the literature reviewed about LGBTs in order to gain a broader perspective on the topic under study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

A literature review is an arranged written presentation of what the researcher finds when retrieving research reports about previously conducted studies. It is accredited scholarly and research work published on related topics (Grove, Burns and Gray 2013: 97). This chapter will provide an overview of literature to provide an orientation to the study. PubMed and Cumulative Index to Nursing and Allied Health Literature (CINAHL) databases were searched for papers using the following terms: access, accessibility, utilisation of health services, PHC, lesbian, gay, bisexual and transgender. These key words were combined to restrict the number of articles retrieved. Textbooks in the field of public health and PHC were searched for chapters on access of health care services. Google scholar was also one of the search engines which was used to retrieve documents, listing publications related to the conceptualisation of access.

2.2 ISOLATION OF LGBTs

LGBTs suffer discrimination and prejudices associated with HIV/AIDS and are blamed for it. The first name that was given to HIV/AIDS was ‘GRID’ or ‘gay-related immune deficiency’. Gays and the people from Haiti were among the first people who were diagnosed with HIV/AIDS (Section 27 of Human Rights 2010: 228). According to Rounds *et al.* (2013: 99), sexual orientation is an individuals’ sexual identity in relation to the gender to which they are attracted, whereas gender identity refers to the person’s understanding or inner sense of being male, female, or other gender. The gender role may or may not be in line with the person’s biological gender. These authors continue to explain that LGBTs are usually grouped together because of the same oppression and difficulties of discrimination and stigma they face throughout the country

even though sexuality and gender are defined differently, this population is suspected to violate cultural gender norms.

Ard and Makadon (2012: 1) concur that LGBTs are always grouped together as an acronym that defines homosexuality or homogeneity but illustrate that this is a very large group of people of different norms, colour, identities, caste, ages, socioeconomic status and cultural backgrounds. This group has been developed and united as a homogenous group by homophobia and they suffer discrimination and stigma. Furthermore, across a number of countries previous public health researchers agree that there is strong evidence of the existence of the LGBT population, as a broad population suggesting sexual and gender identities (Daley and MacDonnell 2011: 10).

According to McIntyre, Szewchuk and Munro (2010: 885), the lesbians' exclusion from papanicolaou (Pap) smears in Canada resulted from cultural beliefs and from excluding lesbians from safe sex health education. There is a belief that penile penetration is the actual sex that can lead to sexually transmitted infections. This detracts from the lesbians' lived experiences and their decisions to seek cervical screening services (McIntyre *et al.* 2010: 886). The results of the study conducted by these authors in Calgary, Canada about experiences and perceptions of Pap smears by lesbians, suggest that lesbians perceived themselves to be at a low risk of contracting sexually transmitted infections (STIs) and human papillomavirus (HPV). This perception was attributed to a lack of knowledge and to their exclusion from sexual health scripts and STI dialogues. There is proof that previous experiences of discrimination, unequal treatment, reduced access and lack of knowledge by health providers resulted in the exclusion of lesbians from the health system. On the other hand, Rounds *et al.* (2013: 99) conducted a study in Ontario, Canada examining LGBT issues regarding access and quality of health care services using gender-based diversity analysis. The results indicated that a long history of discrimination and marginalisation had been experienced by LGBTs, resulting in barriers when accessing health care services.

2.3 PERCEPTIONS OF HEALTH CARE PROVIDERS TOWARDS HOMOSEXUAL MEN AND WOMEN

Previously, being lesbian was looked upon as a disease on the health care providers perspectives that needed or necessitated treatment and could be cured. Basically, behavioural aversion therapy was used to convert lesbians to heterosexual females after lesbianism was conceptualised as inherently unhealthy (Fish and Bewley 2010: 356). These authors also suggest that lesbians experience homophobia when they access health care. Recent studies health care providers refer to lesbians as the healthiest group regarding STIs; they are seen as a group with no major health problems (Fish and Bewley 2010: 356; McIntyre *et al.* 2010: 886; Matebeni *et al*. 2013: 34). These authors also suggest that lesbians and gays have different healthcare risks such as alcohol consumption, smoking, drug use, suicide and cancer similar to every human being. Bjorkman and Malterud (2009: 289), agree that lesbians have distinct health complaints. According to these researchers, although the social situation of LGBTs has improved over the last decade, lesbians still face unique challenges when seeking heath care services. Their study examined the utilisation of general practices of homosexual men and women and heterosexual men and women. The results revealed that homosexual women were not following the sequence of screening programmes, such as pap smears, like heterosexual women. They emphasised that homosexual women might suffer from any health problems to a greater extent than heterosexual women do or than the general female population suffer from due to marginalisation.

Previously, it has been generally alleged that lesbians and gays are prone to diseases. This group is not only affected by HIV/AIDS as is the perception, homosexual men and women may suffer from mental problems (depression and anxiety disorders), breast cancer, anal cancer, STIs and obesity due to high risk factors such as alcohol consumption, smoking, using drugs, failing to maintain healthy bodies and not bearing children (Bjorkman and Malterud 2009: 238). Similarly, Daley and MacDonnell (2011: 2) emphasise that in

spite of the principles of universality and accessibility that guide health care delivery, LGBTs still suffer from suppression to utilise health services in constant terms and conditions unlike their heterosexual counterparts. The history of threats and bad attitudes to LGBTs' health has been associated with transphobia, biphobia and heterosexism, which are the main causes of social exclusion, stigmatisation and discriminatory changes in services delivery. Moreover, the insufficiency of health care providers' insight and a state of being uncomfortable working with this group due to a lack of knowledge or personal beliefs might obstruct equitable access to the health care system. The study also highlights an increased need for health care among health care providers concerning the LGBTs. Public health committees still need to address these concerns and to develop health policies and documents that explore quality health care delivery to LGBTs experiencing health disparities (Daley and MacDonnell 2011: 2). Heteronormativity articulated as the most reason causing obstacles to accessing adequate health care (Fish and Bewley 2010: 357).

American studies by Tjepkema (2008: 61) and Fish and Bewley (2010: 356) have confirmed that most lesbians postpone or prevent acquiring health care services. This was attributed to reasons related to their sexual orientation such as fear of disclosing to their doctor and health care providers due to past negative experiences. Fear was considered to be the most reason for delayed accessing of health care services. They considered attending mental health services, social workers and psychologists to be easier than accessing general medical/health care services. It has been suggested that counselling seems to be important to homosexual men and women as attending these types of services is familiar to them. Counselling services play a major role in homosexual men and women lives as they frequently experience problems form the general community due to their sexual orientation. The reason to attend this type of care could be sought by individuals who live in stigmatised families and communities (Tjepkema 2008: 61). Research has shown that more lesbians seek health care services from health care providers and doctors to whom they have disclosed their sexual orientation. However, gay

persons were more likely to access health services out of concerns regarding their HIV/AIDS status, but were not specifically concerned about disclosure of their sexual orientation (Tjepkema 2008: 60). Furthermore, the results demonstrate that homosexual men and women need not be labelled as a homogenous group when seeking health care, they should be respected and recognised as individuals and in research they should be studied in separate groups (Fish and Bewley 2010: 355).

In the United Kingdom (UK), LGBTs' human rights were recognised globally in the political struggle to be merged for social equality. The Yogyakarta Principle which is their universal guide includes LGBT rights and, emphasises the 'right to health' in principle number 17 which ensures access to healthcare services, and disseminates the importance of improving health status to all the countries regarding LGBTs. The struggle also motivated other countries to create a tool to contend anti-prejudice, anti-discrimination and to prohibit any form of undermining the individuals' health because of their sexual orientation or gender identity (Fish and Bewley 2010: 355).

Globally, the reasons for health disparities in LGBTs are associated with stigma and discrimination when accessing health care services. Health care providers are not clear about the sexual health needs and the wellbeing of all the members of the LGBTs (Daley and MacDonnell 2011: 2). Similarly, Fish and Bewley (2010: 356), reported that health care providers lack knowledge about lesbians' health needs. Heteronormative assumptions of health care providers result in treating ill people as if they were heterosexuals whereas LGBTs might have unique needs (Fish and Bewley 2010: 356).

2.4 ACCESS TO HEALTH CARE

Access to health care is central in the performance of health care systems around the world (Levesque, Harris and Russell 2013: 1). These authors define access to health care as the opportunity to identify health care needs, to seek health care services, to reach, to obtain or use health care services

and to actually have the need for services fulfilled. The Constitution of the Republic of South Africa, (1996) section 27(1) (a) emphasises that all citizens are granted the right to access health care services. Differences in access to health care services and the resulting adverse health outcomes are major public health priorities (Graves 2009: 49). Moreover, the high quality of health care, easy accessibility of health services and reduction of health disparities depend on diversifying the health work force in terms of education as they provide services to different populations (Williams, Hatens, Smithey, Burnley, Koplitz, Koyama, Young, and Bakos 2014: 33). According to Rutherford, Mulholland and Hill (2010: 509), access is described as the interaction between both health services and population factors. The authors continue to emphasise that utilisation of health services is an important part that defines access. These authors revealed that access has several definitions due to different interpretations but all have one meaning. Access to health care begins with entry into the health system and continues throughout the treatment process, this is determined by features of the system and the population at risk (Posse, Meheus, Van Asten, Van der Ven and Baltussen 2008: 905). These authors argue that access has been the subject of much research due to its capability of describing barriers between the health care delivery system and the population at risk and that brings about the changes for improving the health system and satisfying the needs of population.

2.5 DENIAL OF HOMOSEXUALITY IN THE AFRICAN CONTINENT

In the African continent, transmission of HIV has been associated with heterosexuality and transmitted through the sharing of drug needles and blood products excluding homosexuality (Sallar and Somda 2011: 280). The denial of homosexuality suggests that many in the African continent are secretly practising same sex sexual acts. Furthermore, homosexuality is not reported due to stigmatisation in most countries on the African continent (Sallar and Somda 2011: 280). These authors argue that prevention of HIV/AIDS has been primarily directed to heterosexuals and prostitutes due to underreporting of homosexual HIV infections, considered to be perpetuated

by homophobia, stigma and discrimination and this might hinder homosexual men and women reaching health services in order to prevent HIV/AIDS and to access early treatment.

Whilst Swaziland is reported to be among the countries with a high HIV prevalence in generative age in the world at (26.1%), it is still focusing on the general population when addressing the HIV epidemic excluding gays and lesbians (Kennedy, Baral, Fielding-Miller, Adams, Dludlu, Sithole, Fonner, Mnisi and Kerrigan 2013: 2). The author suggests that only one article was reviewed in Sub-Saharan Africa (SSA) when they were preparing for their survey of the experiences of MSM living with HIV in Swaziland, which suggests less focus on homosexual men and women, particularly on MSM (Kennedy et al. 2013: 3). Similarly, a Kenyan study found that the Nairobian MSMs were not attending or visiting health care providers for utilisation of HIV/AIDS programmes' services due to fear of stigma and discrimination as same sex relationships remain unacceptable in many Kenyan communities (Rispel, Metcalf, Cloete, Moorman and Reddy 2011: 148).

2.6 HOMOSEXUALITY IN SOUTH AFRICA

According to the Constitution of the Republic of South Africa, the previous South African apartheid statute became number one in the world and the first jurisdiction to provide constitutional protection to LGBTs, in section 9(3) under equality, which stipulated that:

> "The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, disability, religion, conscience, belief, culture, language and birth" (Republic of South Africa (1996 : 6-8).

It is worth noting that in 1997, the National Coalition for Gay and Lesbian Equality and the South African Human Rights Commission challenged the discriminatory laws as unconstitutional (Section 27 of Human Rights 2010:

228). HIV/AIDS and STI Strategic Plan for South Africa 2000-2005 called for these laws to be withdrawn and the South African Law Commission recommended in its review of the Sexual offences Act that the age of consent for homosexual men and women should be the same as that of heterosexuals (Section 27 of Human Rights 2010: 229). A 2009 survey conducted on South African students in the Western Cape, regarding their attitudes and beliefs towards homosexuality, found that 44% of students disapproved of the idea of homosexuality to be accepted in South Africa whereas 41% believed that granting equal rights to homosexual men and women by the constitution was right and they fully accepted it (Mwaba 2009: 803).

2.7 FEAR OF DISCLOSING ONE'S SEXUAL ORIENTATION

Homosexual men and women have been experiencing problems especially when it comes to looking after their health and getting access to health care services and this has become a serious concern. Lesbians have had barriers that made it difficult to access health care services. These barriers included being discriminated against due to heteronormativity, homophobia and not being treated equally when it comes to being given attention and sufficient treatment within the health care services (Bjorkman and Malterud 2009: 242). These authors also highlight the difficulties encountered with the identification 'homosexual', because some of them had not 'come out' about their sexual orientation due to cultural reasons and others were not even accepted by their families and communities as a result they feared rejection. Others decided to live without disclosing their sexual orientation or sexual behaviours in order to prevent stigma and discrimination. Furthermore, homosexual men and women were still experiencing discrimination in their daily lives at home, in the community and in the workplace.

South African lesbians are living in the fear of being 'found out' due to discrimination as well as the risk of physical harm (Ochse 2011: 3). At the same time, Desmond Tutu, the former Anglican Archbishop of Cape Town, has raised his voice in the fight against homophobia saying, 'Homophobia is a

crime against humanity'. He stood his ground and made it clear that he cannot keep quiet because people are treated as if they are not human due to something that they could not change, he then specified that all citizens are human beings in this country and deserve equal treatment regarding services that are provided worldwide especially health services for maintaining life (Matthes 2013: 28).

A health survey was conducted in two cities namely Johannesburg (which is the biggest city in South Africa) and Durban (which is the biggest city in KZN). The survey was about perceptions, preferences and utilisation of health care services by male and female homosexuals, specifically MSMs (Rispel *et al.* 2011: 138). The MSMs perceive the health care system as being very difficult to access due to bias, biphobia and heteronormativity approaches from health care providers. The negative attitudes from health care providers make MSMs unable to disclose their sexual orientation due to previous unpleasant experiences. They reported fearing disclosure due to being judged by health care providers, resulting in bad treatment. Some LGBTs perceive the private sector to be more understanding than the public health institutions (Rispel *et al.* 2011: 147-149).

2.8 SUMMARY

This chapter presented the thoughts, views, assumptions and studies conducted by different authors and researchers on LGBTs. Different contexts were explored so that the lesbian and gay community will access health care without fear of discrimination, homophobia and heteronormativity. The following chapter focuses on the methodology adopted by the researcher to conduct the current study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter will address the methods used in the research design, research setting, sampling process, data collection, data analysis and ethical considerations adhered to during the study.

3.2 RESEARCH DESIGN

A qualitative research study that was exploratory, descriptive and contextual in nature was conducted. A qualitative design is useful when the researcher wants to examine the experiences of human beings in the real natural environment. A qualitative study is an arranged collective work with a subjective approach used to define life experiences and give them meaning (Grove *et al.* 2013: 23). The study provides an overview of the real life situation of homosexual men and woman, particularly of lesbians and gays', access to health care services at the PHC level in Umlazi.

The exploratory design sheds light on the various ways in which a phenomenon is manifested and on underlying processes (Polit and Beck 2012: 640). The researcher used an exploratory design to better understand the accessibility of PHC services to lesbians and gays.

A descriptive research design provides an accurate account of the characteristics of a particular group in real-life situations for the purposes of describing what exists, determining the frequency with which something occurs, and categorising information (Grove *et al.* 2013: 26). The study was contextual in nature since the validity of the findings is claimed only in a specific context. This design was used to obtain more information about characteristics within the lesbian and gay communities. The purpose of the

descriptive study is to show a real picture of what is happening in real life situations (Grove *et al.* 2013: 215).

3.3 THEORETICAL FOUNDATIONS OF THE STUDY

According to Grove *et al.* (2013:116), a framework is the abstract, logical structure of meaning that guides development of the study and enables the researcher to link the findings to the body of knowledge for nursing. Aday and Andersons' theoretical framework of access was chosen to guide this study (Aday and Andersen 1974). This framework was first developed in the late 1960s and has been continually revised with an aim of increasing access to health services, decrease health disparities, increase utilisation of health care services in order to achieve health equity by satisfying customers (Anderson and Newman 1973: 1 ; Aday and Andersen 1974: 208; Anderson 1995: 1).

This theoretical framework comprises five elements namely:

a) Health policy objectives
b) Characteristics of the health care delivery system
c) Characteristics of population at risk
d) Utilisation of health services
e) Consumer satisfaction (Aday and Andersen 1974: 208)

For the purposes of this study four of the five elements were used to guide the study and have relevance for exploring and describing the experiences of homosexuals' access to PHC services. The health policy objectives element was excluded because it seemed irrelevant to the study.

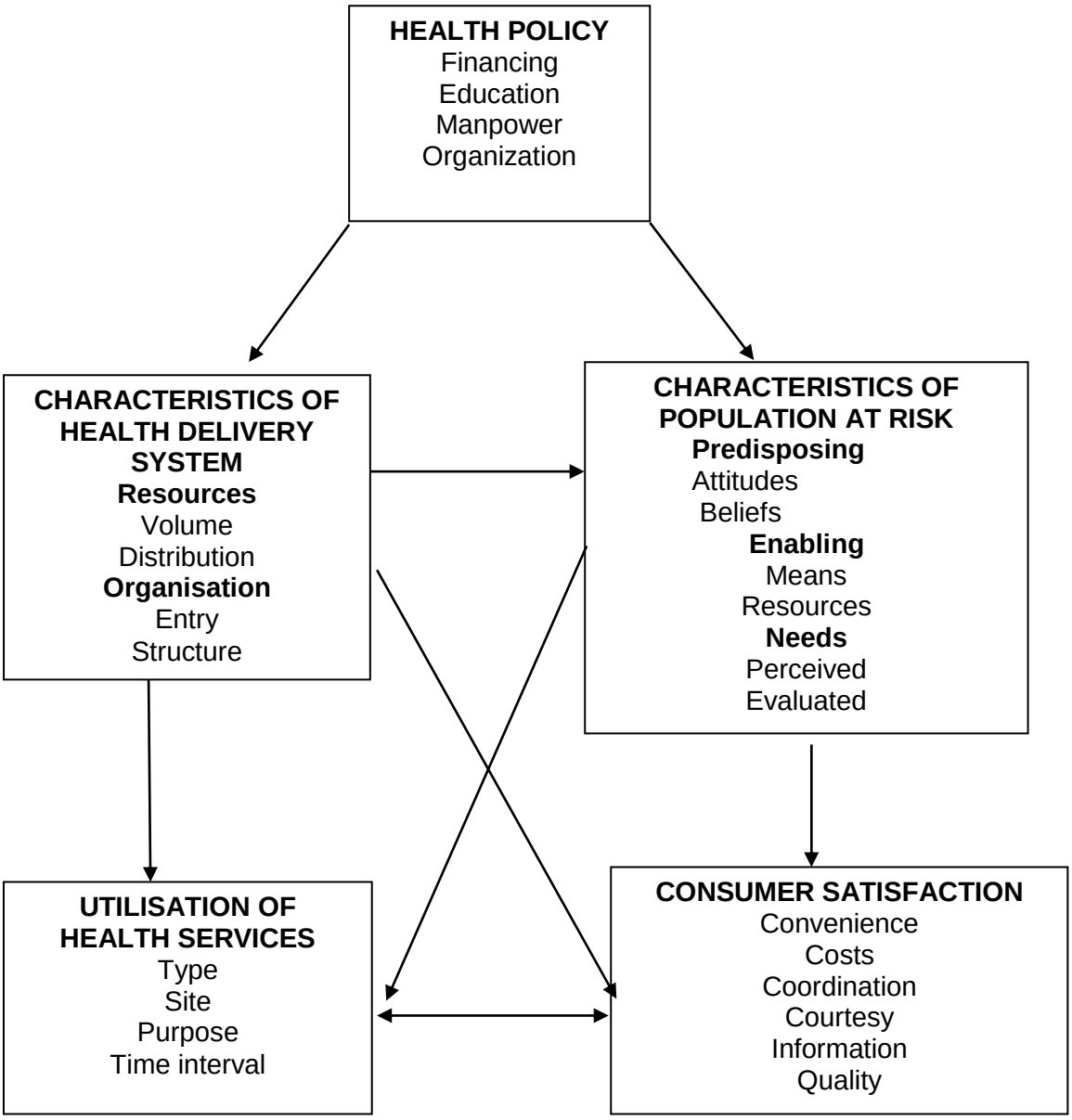


Figure 3.1: Framework of the study of access to PHC services in Umlazi (Aday and Andersen 1974)

3.3.1 Health care policy

Access has been referred to as a governmental framework rather than a functional idea (Aday and Andersen 1974: 212). It has been the ultimate goal of health policies to increase and improve access to health care services. Funding, health educators, health care dialogues, work force and health care reform programmes have been based on this concept. Health planners and policy makers are most concerned about evaluating the effect of health policy in order improve access to health care services. They review the way that

policies are designed in order to implement improvement in the health system (Aday and Andersen 1974: 208).

3.3.2 Characteristics of the health care delivery system

The delivery system is defined as a health care plan of rendering health services to the customers (Aday and Anderson 1974: 212). The delivery system consists of two characteristics namely a) resources (volume and distribution) and b) organisation (entry and structure).

a) Resources (volume and distribution)

Resources are the assets, work and money provided for the department of health in on order to function properly. It is used for acquiring and maintaining departmental equipment, health personnel, health education programmes and all aspects of providing health services. The assets are distributed to the health facility according to its capacity. In South Africa the NDOH has delegated duties to provinces which further decentralised resource distribution to districts. This study was conducted in the Umlazi area which falls within the eThekwini district.

a) Organisation (entry and structure)

Organisation defines what the delivery system does with the resources. It solely concentrates on the way in which the health multidisciplinary team, the facility management system and the manner how health care services are provided (Aday and Anderson 1974: 213). Organisation consists of two elements namely: entry and structure.

- *Entry*

Aday and Anderson (1974: 214) define access as the ability of a client to gain entry to the health care system and continue to use the actual service (treatment point). The term ‘entry’ is used interchangeably with the concept ‘access’.

- *Structure*

Structure determines how the health facility is structured to ensure that the client receives health care. It is what occurs with the treatment of the client once in the health care setting after gaining entry (who helps and how the client is treated).

3.3.3 Characteristics of the population at risk

Aday and Anderson (1974) named three characteristics of the population at risk namely: predisposing, enabling and need factors. These authors define the characteristics of the population as individual considerations for utilising services that may either facilitate or hinder utilisation of health services (Aday and Anderson 1974: 213).

a) Predisposing factors are variables that occur prior to an individual's sickness and describe the individual's propensity to use health services. These variables include age, race, sexual orientation, religion, beliefs and the attitude about health services and sickness, in this study it would be homosexuality.

b) Enabling factors imply the means and resources individuals have available to make use of the services. These factors include the availability of facilities and health care providers, personal knowledge of how to access health services, income, distance, travelling means and health insurance. All these factors are applied in this study except for health insurance as PHC services are offered free of charge to all South African citizens.

c) Need factors refer to an individual's ability to perceive his or her health care needs such as the severity of symptoms, pain and concerns that a person has about his or her health. Homosexual men and women do perceive their health needs and go to health facilities but what the study aimed to find out is how they are received at these facilities.

3.3.4 Utilisation of health care services

According to Aday and Anderson (1974: 215), health care services are measured by patient outcomes and later by consumer satisfaction. Utilisation of health care services may be typified and evaluated in terms of its type namely; site, purpose and the time interval (from arrival at a health facility till being treated) included. *Type* refers to the form of services received that can be in the hospital, by a physician, pharmacist, dentist and clinic. *Site* refers to the place where the service is obtained. *Purpose* consists of three clear reasons or purpose for seeking health care services as discussed below:

- Preventive: the prophylaxis/preventive measures (check-ups and immunisations).
- Illness-related: minor or chronic diseases.
- Custodial care: the care given to patients but with no effective treatment that is palliative care which is usually provided for terminal patients and old age patients.

Time interval consist of three features namely contact, volume or continuity.

- Contact is described as the individual's ability to enter or not to enter the health care system at a given point in time. That period is weighed by users and has an effect on the patient's resulting of satisfaction with the services.
- Volume is described as the number of individual contacts and repeat contacts within a given period of time. This measure gives an idea of who accesses the system and how often he/she utilises it.
- Continuity defines the degree of relation and maintenance of health care services associated with the specific illness experience. If the process of obtaining care has no continuation or is fragmented, to patients it may reflect dissatisfaction or lack of appropriate access to the health system.

In this study the site was the PHC facilities in Umlazi which provide both preventive and curative health services. Continuity of care and time interval would be verbalised by homosexual men and women when responding to questions during interviews.

3.3.5 Consumer satisfaction

Customer satisfaction measures how well the expectations and happiness of a customer, regarding a product or services provided by a company or organisation, have been met (Sokhela 2011: 23). Consumer satisfaction in this study is defined by the individuals who have experiences of and who have developed attitudes towards health care services utilisation. Consumer satisfaction is used to measure any particular episode experienced by individuals with the health care services and is used as the measure of client outcome. The convenience of care received by clients, its coordination and cost, the courtesy displayed by health care providers, the health education given to the client about the illness and the client's evaluation of such service depends on the quality of care experienced (Aday and Anderson 1974: 215). This gives an idea of satisfaction or dissatisfaction about the health service received. PHC services are free and available to all South African citizens.

3.4 STUDY SETTING

This study was conducted in Umlazi Township, which is located 23 km south-west of Durban in KZN. It has a population of 404 812 (Frith 2011) and covers 47.46km^2. Mangosuthu high way is the main road in Umlazi which links the area to the N2 freeway (north-south) and N3 (east-west). The township has both formal and informal settlements divided into sections and named according to the letters of the alphabet from A-Z and AA-CC. This is the second biggest township in South Africa. It comprises one regional hospital, and eleven clinics, six falling under the KZN provincial health authority and three falling under eThekwini Municipality and two private clinics. Two of these clinics render 24 hour services. There is one big stadium, King Zwelithini Stadium and many small sports grounds which are

located within school premises; others are within the township sections. The study was conducted at a gay club house which is the only social club known to gays and lesbians in Umlazi and has been in existence for five years.

3.5 STUDY POPULATION

The population is the whole group of informants that fits the specific criteria that the researcher is aims to study (Brink, Van der Walt and Van Rensburg 2012: 131). It is defined in advance in order to identify the legibility of the sample known as the 'target population'. In this study, the population comprised all homosexual men and women in Umlazi and the target population were all male and female homosexuals in Umlazi who had accessed a PHC facility. The accessible population were participants who attended the gay club house (which is where they usually hang out) and had accessed a clinic. Participants were first asked questions according to the inclusion criteria to see if they met the study's inclusive criteria before being requested to participate in the study by being interviewed. The researcher was available on Saturdays and Sundays which were the busy days at the club between 5pm and 8pm from September to November 2014.

3.6 SAMPLING PROCESS

Purposive sampling was used to select the study participants. In qualitative research purposive sampling is used to recruit participants for whom the research topic is relevant and the goal is to gather information about their experiences (Knudsen, Laplante-levesque, Jones, Preminger, Nielsen, Lunner, Hickson, Naylor and Kramer 2012: 85). Purposive sampling was used because it enabled the researcher to select informative cases that could provide rich and thick information based on their personal experiences of accessing and using PHC services in the Umlazi area. This would enable the researcher to gain in-depth information about the experiences of lesbians and gays who accessed PHC services in the Umlazi area.

Time-space probability based sampling was also used for this study. This technique is used when there is a relatively small number of people who usually gather at a specific place and time and who experience stigma and discrimination. These samples are often called hard-to-reach populations and include MSM and LGBTs (Semaan 2010: 61; Berry *et al*. 2013: 39). Potential participants were approached at a gay club with the permission of the club owners. The recruitment flyers were posted at the club house one week before the researcher began data collection. The recruitment flyers specified the inclusion criteria of the potential participants as explained in section 3.6.2 of this dissertation.

3.6.1 Sample size

According to (Polit and Beck 2012: 521), qualitative research has no direct fixed sample size; it is driven by the information needs of the research. The sample size was guided by the principle of data saturation. This point is reached when no new information is obtained from participants during the later stages of data collection when subsequent interviews produce repetitions of information indicating the completeness of the data gathered. In this study, data saturation was reached after interviewing 10 participants but the researcher continued with interviews up to 12 participants and there was no new information gained.

3.6.2 Inclusion criteria

Persons could only be considered as potential participants in the current study if they met all the inclusive criteria, namely:

- Identified ‘lesbian and gay’ residing in Umlazi.
- Consenting ‘lesbian and gay’ aged 18 and older.
- Have accessed PHC services in Umlazi KZN, within the past year.

3.6.3 Exclusion criteria

The following persons could not participate in the current study because they would not be able to provide information about accessing PHC in the Umlazi area as a homosexual or lesbian person:

- Heterosexual men and women.
- Homosexual men and women classified as other forms of homosexual and not lesbian and gay such as transgendered individuals.
- Homosexual men and women not residing in Umlazi.

3.7 DATA COLLECTION

Data collection took place from September to November 2014. The researcher approached the club-goers whom she did not know personally and introduced herself and screened them based on the inclusion criteria. If the participant met the study's inclusive criteria, the researcher explained the purpose and the importance of the study (Grove *et al.* 2013: 375). Potential participants were given an information letter and consent form to read thoroughly (Appendices D-G) and were encouraged to ask questions from the researcher if they required clarifications. Semi-structured interviews were conducted using an interview guide (Appendices H and I) to remember areas to be covered in the interview. Individual interviews allowed the participants freedom to express their opinions or understanding of the phenomenon without the restrictions of close ended questions or the interviewer's opinions (Grove *et al.* 2013: 271). All interviews were conducted by the researcher in English or isiZulu whichever language the participant preferred. Interviews were conducted privately to allow each participant to converse freely with the interviewer and interviews lasted 30-45 minutes. Interviews began with a broad descriptive question (Appendices H and I) which was followed by probing questions to facilitate discussions and to elicit further details from the participants to uncover further information or to draw attention to what had not mentioned. The research participants were interviewed until it was

determined that no new information emerged. All interviews were voice recorded and the field of notes were kept safety.

3.8 PRE-TESTING OF THE DATA COLLECTION TOOL

The data collection tool was pre-tested to assess whether the research questions were realistic and understood by the participants. Grove *et al.* (2013: 343) clarify that it assists to assess the feasibility and acceptability of the design, its procedures, analyses sample size and makes it easy to conduct the study. The interview questions were pre-tested on two consenting participants at the clinic where researcher worked. The two interviews were not included to the data analysis. No amendments were made to the interview questions.

3.9 DATA ANALYSIS

According to Polit and Beck (2012: 556), data analysis implies organising the data that the researcher has collected, providing structure and eliciting meaning from it. Data were analysed using content analysis. Content analysis is designed to analyse and interpret the data by classifying the words in text into categories in order to give it meaning. Repeated ideas or patterns of thought were grouped by organising data into categories and concepts that the researcher has created (Grove *et al.* 2013: 281). Content analysis uses three stages to analyse the data namely description, analysis and interpretation.

3.9.1 Description phase

In this phase, the researcher listened and re-listened to the audio taped interviews in order to understand data before transcribing it. Data obtained from interviews were transcribed verbatim and those interviews which were conducted in isiZulu were translated into English by the researcher. The isiZulu and English teacher with Further Diploma in Education, Seniors Teachers Diploma and Bachelor of Education Honours checked the

translation. The researcher read and re-read notes and transcriptions, listened to recordings until the researcher became immersed in the data (Grove *et al.* 2013: 280-281).

3.9.2 Analysis and organisation phase

The transcripts were carefully read and reread line by line while paraphrasing and coding the information. After the researcher was immersed in the data, the transcriptions were coded, named and labelled according to the created categories. Themes and subthemes were identified from the established patterns (Grove *et al.* 2013: 281).

3.9.3 Interpretation phase

During this phase, the data were interpreted by using categories, themes and sub-themes identified during the organisation and analysis phases. According to Grove *et al.* (2013: 280), interpretation is an activity that happens in the mind of the reader. It is the process of reorganising, combining words and actions of the participants to make sense so that readers and end users can understand the information (Grove *et al.* 2013: 280).

3.10 TRUSTWORTHINESS

Trustworthiness refers to the extent to which a study is worth paying attention to, worth taking note of and the extent to which others are convinced that the findings can be trusted (Hilla *et al.* 2012: 171). There are four suggested criteria for determining trustworthiness of qualitative data namely: credibility, dependability, conformability, and transferability as cited by Polit and Beck (2012: 584) developed by Lincoln and Guba in 1985. The aim of trustworthiness in a qualitative study is to support and raise significant arguments that the study can be recognised as being worthy of paying attention to it (Polit and Beck 2012: 584).

3.10.1 Credibility

Credibility refers to the confidence in the truth of the data and the interpretation thereof (Brink *et al.* 2012: 172). Credibility was maintained through using the same interview guide for all participants. The researcher visited the club house over a period of three months meeting with different participants. Member checks were conducted whereby the researcher returned to give feedback to the clubhouse's visitors who were the study participants interviewed and chatted with them and checked their reactions towards themes emerging from the data.

3.10.2 Dependability

According to Brink *et al.* (2012: 172), dependability is the provision of evidence. The researcher developed the audio trail by keeping all original audio records of interviews and discussions on a disc. Original written and summarised interviews and those translated into isiZulu and all correspondence regarding the study, such as consent forms, were kept under lock and key, so that they could be produced if it becomes necessary for an audit.

3.10.3 Confirmability

Confirmability is the potential for congruence between two or more independent people about the accuracy of data, relevance and meaning (Lincoln and Guba 1985 as cited in Brink *et al.* 2013: 172). The researcher interpreted and analysed the data through identifying themes and subthemes which were supported by the use of direct quotations from the interviews in order to eliminate subjectivity and bias.

3.10.4 Transferability

Lincoln and Guba (1985 as cited in Brink *et al.* 2013: 172) refer to transferability as the generalisability of the study's findings, the extent to which the findings could be transferred to have applicability in other settings

or groups. A thorough description of the research report was provided so that other researchers could evaluate and test the applicability of the data in other contexts.

3.11 ETHICAL CONSIDERATIONS

Before conducting a study, there are three fundamental ethical principles. guiding the research process, that need to be taken into consideration (Brink *et al.* 2012: 34). Firstly respecting individuals' dignity, secondly justice and thirdly maintaining the quality of being beneficent to participants. These aspects are derived from human rights, remembering the needs and the importance of keeping participants safe throughout a research process; and respecting the participants' right to privacy and anonymity (Brink *et al.* 2012: 34).

All consenting participants were given written and verbal information about the process of the study. They signed consent forms after reading and understanding the information letter. Assurance of privacy was maintained by not disclosing participants' information. Justice was maintained because participants who wished to decline participation at any stage of the research could do so without incurring any negative consequences whatsoever. The right to anonymity and confidentiality was ensured throughout the research process as participants were assured that their names would be known only to the researcher; codes were used to identify them. The master list of participants and their codes were kept under lock and key. No family member, health worker or any other person would have access to the raw data to a prevent breach of confidentiality. Only the research report and the summary of the findings would be shared. The participants were assured that participating in the study would not result in barriers to access health care services nor to compromise their health care needs in future. The Durban University of Technology Institutional Research Ethics Committee cleared the research proposal (see Appendix A). Permission was obtained from the club house owners to conduct interviews on their premises (see Appendix C).

3.12 SUMMARY

This chapter described how the study was carried out and how data were collected. The sample chosen was appropriate for the data to be collected as it targeted homosexual men and women who had accessed PHC services in the Umlazi area during the year preceding the interviews. A qualitative research methodology was implemented.

CHAPTER 4

PRESENTATION OF THE RESULTS

4.1 INTRODUCTION

This chapter presents the study's findings. The aim of the study was to explore and describe the accessibility of PHC services to lesbians and gays in the Umlazi area in the province of KZN. The objectives of the study were to:

- Determine the accessibility of health care services to lesbians and gays.
- Assess the experiences of lesbians' and gays' access to health care services in the Umlazi area.

The results are arranged in line with Anderson and Adays' (1974) framework which determines access of different groups to health services. The following four elements of Anderson and Adays' (1974) framework were used to explore and describe access to PHC facilities:

a) Health care delivery system, which is the health care plan for rendering health services to the customers.

b) Characteristics of a population at risk, determining which characteristics enable or hinder utilisation of health services.

c) Utilisation of health services in terms of its type, site, purpose and the time interval.

d) Consumer satisfaction as described by individuals who have experienced the services.

4.2 DEMOGRAPHIC DATA

Face to face semi-structured interviews were conducted with 12 participants, eight lesbian and four gay participants. Table 4.1 presents the demographic data of the participants.

Table 4.1: Demographic data of the participants

Participant	Age in years	Sexual orientation	Marital status	Level of education	Occupation
1	35	Lesbian	Single	Matric	Self employed
2	29	Gay	Single	Degree	Photographer
3	26	Lesbian	Single	Diploma	Human resources administrator
4	27	Lesbian	Single	Diploma	Graphic designer
5	34	Gay	Single	Diploma	Teacher
6	30	Lesbian	Single	Matric	Bus driver
7	25	Gay	Single	Matric	Self employed
8	31	Lesbian	Single	Diploma	Technician
9	23	Lesbian	Single	Tertiary student	Unemployed
10	24	Lesbian	Single	Matric	Cashier
11	22	Gay	Single	Tertiary student	Unemployed
12	32	Lesbian	Single	Diploma	Technician

4.3 PRESENTATION OF THE RESULTS

Four major themes emerged from the data analysis:

Theme 1: Discrimination of homosexual men and women by health care providers and community members in PHC facilities.

Theme 2: Attitudes of homosexual men and women towards health care providers.

Theme 3: Homophobic behaviour

Theme 4: Equality of PHC services.

Several sub-themes emerged from the interview in line with the five major themes. The themes and sub-themes are presented in Table 4.2.

Table: 4.2 Elements, themes and sub-themes

ELEMENT	THEME	SUB-THEMES
Characteristics of health care delivery system • **Organisation** ✓ Entry ✓ Structure	Discrimination of homosexual men and women by health care providers and community members in PHC facilities	• Stigma from health care providers • Rejection by the society
Characteristics of the population at risk • **Predisposing** ✓ Attitudes ✓ Beliefs	Attitude of homosexual men and women towards health care providers	• Positive attitudes • Negative attitudes

Utilisation of health care services ✓ Type ✓ Site ✓ Purpose ✓ Time interval	Homophobic behaviour	• Lack of understanding of homosexuality • Heteronormativity among health care providers • Perceived attitudes of health care providers towards homosexual men and women. • Curiosity of health care providers regarding homosexuality. • Personal involvement of health care providers with homosexuality.
Consumer satisfaction • Convenience • Coordination • Courtesy • Information • Quality	Equality of PHC services	• Satisfaction with the service • Dissatisfaction with the service

4.4 DISCRIMINATION OF HOMOSEXUAL MEN AND WOMEN BY HEALTH CARE PROVIDERS AND COMMUNITY MEMBERS IN PHC FACILITIES

The theme discrimination emerged as the participants described their experiences of visiting a PHC facility. Participants cited discrimination as one of the reasons for not getting fair treatment from the health care providers after gaining entry to such services. This discrimination was experienced from other patients as well as from health care providers. The sub-themes were a) stigma from health care providers and b) rejection by the society.

4.4.1 Stigma from health care providers

Participants reported that they felt stigmatised by health care providers' bias towards homosexual men and women. They were being judged because of their personality and through the way they dressed, talked or walked. Their expressions of stigmatisation are shown in the following quotations:

"…Are you here for family planning? The nurse asked me while she was holding and reading my card. As I was getting ready for the injection she continued to say "you are also wearing men's underwear? I was there for a different injection…" [Participant 08].

"…from the nurses, umm you get lots of questions? In the consultation room, the first question that the nurse asked me was what type of a person I was. I ignored the question and told her that I was sick…" [Participant 01].

"…at the PHC facility people have their own prejudices and there is a lot of stigmatisation. If you are a homosexual you go there looking for help about your sickness but they always include things that are unnecessary. Despite telling the nurse that you are a male and gay, they always make you to explain yourself and emphasise that you are different. They ask now and again if you are female or male." [Participant 11].

4.4.2 Rejection by the society

Participants also reported that they felt rejected by the society, by other people in the PHC facility's waiting area These people made comments that made some participants to get scared and left the PHC facility before they received care. Rejection by the society is revealed in the following quotations:

"When I was still sitting in the queue there were women behind me who were laughing, but I did not know what they were laughing at, but I noticed when the woman next to me also started laughing. When I listened carefully they were debating about homosexuals. Someone said it was a fashion. The other woman added; if I can see a homosexual here I can put a tyre around her neck and burn her. I could not stay long, I decided to go back home because these people made me uncomfortable and I felt that they could harm me. I decided that when I have money I will go to the private doctor" [Participant 02].

"…I felt very disturbed and unhappy because people were sitting away from me because I am gay" [Participant 05].

4.5 ATTITUDES OF HOMOSEXUAL MEN AND WOMEN TORWARDS HEALTH CARE PROVIDERS

The theme “attitudes of homosexual men and women towards health care providers” emerged as the participants described their attitudes before visiting PHC facilities. The sub-themes were positive attitudes and negative attitudes.

4.5.1 Positive attitudes

Participants went to the PHC facility with different attitudes towards health care providers or health facilities. Participants expressed their attitudes in the following ways:

> *“….nurses are not the same, I had a lot of complaints from my homosexual friends who had visited the clinic about being mistreated. The nurse that attended me did not treat me differently, I did not feel discriminated, nurse did not put it in her mind that I am a homosexual client. However I went there with that attitude”* [Participant 06].

4.5.2 Negative attitudes

Some participants had negative attitudes prior to reaching the clinic because of preconceived ideas about health care providers which might or might not have been factual. This caused problems for the participants as they became agitated without provocation from the health care providers. Participants that had negative attitudes had this to say:

> *“….Umm….It is not easy to use the clinic; you end up getting hurt. I am very short tempered, whenever I go to the clinic, I need to be ready for disappointments because I know the attitude of nurses towards homosexuals is not right”* [Participant 07].

"…what I don't like most with the clinic, is the attitude nurses have towards homosexuals, I always see it, but with me it is not easy to be discriminated against because they cannot easily identify me as a homosexual…" [Participant 06].

"….Umm….It is not easy to use the clinic; you end up getting hurt" [Participant 07].

4.6 HOMOPHOBIC BEHAVIOUR

Participants reported that they experienced a range of homophobic behaviours during interaction with health care providers and in the waiting area from other patients. Six sub-themes emerged from the theme homophobic behaviour among health care providers and society namely: (a) lack of understanding of homosexuality, (b) religious and cultural beliefs, (c) heteronormativity, (d) attitudes of health care providers, (e) curiosity, and (f) personal involvement.

4.6.1 Lack of understanding of homosexuality

The findings of the study revealed that health care providers and the society lacked understanding about homosexuality. This was evident from the questions they asked and sometimes disbelieved what they were told. Participants were not believed nor taken seriously when they reported that they had been infected with STIs as noted in the following excerpts:

"…I have been sick for a long time, now I want to check my HIV status, the nurse then took me to another room for a test. Unfortunately, my results were…… positive. The nurse asked me [how come I am positive, and how did I contract HIV while sleeping with the same sex partner? And that made me felt so uncomfortable and I was hurt" [Participant 01].

"…when I got into the consultation room a nurse asked what I was suffering from and I told her that I had a problem in my private part and I think it is sexually transmitted infection. She asked me how come I have a sexually

transmitted infection while I am in a relationship with a female and asked me to explain how I have sexual intercourse. I told her that I could not explain something like that, can she please help me with treatment, and I need to leave…"[Participant 09]*. Continues below…*

"...the nurse asked me about my HIV status as I was having some sort of sexually transmitted infection and I told her that I am negative. She asked if I am using condoms and I told her that I am not, and I don't even know homosexuals condoms, I have never seen them before" [Participant 09]*.*

The community members at the PHC clinics also lacked understanding and knowledge about homosexual men and women. They did not believe that like them, they are living human beings who require medical assistance at some stage in their lives. Participants expressed the way they were treated and perceived by the community members as follows:

"…they asked one another if lesbians come to the clinic and if they get sick too…" [Participant 01]*.*

"…our communities are not educated and do understand homosexuals' life. They are putting us in difficult situation, sometimes they make sure that we don't reach the important services that we need. The sad thing is that we are also affected by many disease such as cancer as well as infectious diseases which heterosexuals suffer from" [Participant 02]*.*

"…while I was waiting in a queue for family planning, people were busy talking and pointing fingers at me, as it was obvious that I wanted contraceptives, they were asking among themselves if lesbians practice family planning. However, I just ignored them because I did not have a choice I needed help" [Participant 10]*.*

4.6.2 Influence of religious and cultural beliefs of health care providers on their perceptions of homosexual men and women

The religious beliefs of health care providers were perceived as problematic by participants. Health care providers tended to want to convert or impose their religious beliefs on the participants and expected them to behave and lead their lives according to these beliefs. These views were expressed in the following excerpts:

> *"…a nurse laughed at me and asked if I do go to church dressed as I was dressed. I said yes, she then started telling me that at church this is not allowed. She told me about Adam and Eve, that God created a man and woman, which side do I belong to? I did not like that question, 'it caught me off guard because I was not sure how to answer it, I said I was a lesbian that is all I know and I was born like this. It is hard at the clinic and I will not go there again, there are too many personal questions"* [Participant 09].

> *"…it wasn't good news to a nurse to discover that I am a lesbian. The nurse started preaching saying she feels sorry for my mother, I need to go to church and pray because what I am doing is against God's will…"* [Participant 12].

> *"…she continued with questions telling me that she is also a parent and she will never allow her children to be homosexuals because it is against God's bible…"* [Participant 04].

Community members had different perceptions about homosexual men and women and believed that homosexuality could be "corrected or healed" using cultural methods according to which they lived.

> *"The conversation continued until a person next to me said, being homosexual is not right, because it is Satanism and it is kind of a fashion. They debated and someone said homosexuals need slaughtering of goats because this is against cultural. The situation was getting worse in such a*

way that the other woman adds… if I can see one of the homosexuals' here I can put her tyre around the neck and burn her …" [Participant 01].

4.6.3 Heteronormativity among health care providers

When health care providers managed patients, they never seemed to give a thought to the fact that there could be homosexual women seeking medical assistance. They tended to treat everyone as if they were heterosexual women. However, there is evidence of a few health care providers who were open minded about different sexual orientations. Participants witnessed heteronormativity in the following instances:

"…I told the nurse that I wanted to do an HIV test. The first question was; why do you want to do HIV test? I told her that I want to know my status; she then asked if I use condoms. Hey! I was taken aback for a moment, seriously I was confused by the question…I answered no, now a nurse gave me health education on using condoms and asked if am not aware of the importance of using condoms, I told her I knew. She did not ask me about the type of partner I have or the reason for not using condoms. Later on, she asked me if my partner has tested, and I told her that she's outside. She then asked me to call him so that she will give us both health education about the use of condoms. When my partner got inside the nurse just changed her facial expression [frowning] she was surprised and looked very shocked to see that it was a female. And she said: 'this is the reason you are not using condoms', I said 'yes' [Participant 03].

"…the nurse asked the usual questions as to a female, she asked about pregnancy, my last menstrual periods, and use of condoms? When I said no to using condoms, she immediately educated me on the importance of using them. I explained my sexuality to her and she was taken aback and was speechless for some time" [Participant 12].

4.6.4 Perceived attitude of health care providers towards homosexual men and women

Participants reported negative attitudes from health care providers. They verbalised moments where their sexual orientations seemed to upset the health care providers. The negative attitudes of health care providers towards homosexual men and women are portrayed in the following excerpts:

> *"…when I entered to a consultation room the first thing a nurse said to me was " what's going on here"?, and I looked back because I thought maybe there was something happening behind me, and a nurse said no I am asking you "what type of a person are you really"?* [Participant 08].

Refusal of treatment has been reported in some circumstances due to ignorance and sexual prejudice. This participant reported not being treated by a health care provider due to her homosexuality:

> *"…when I got into the consultation room I explained to a nurse that I needed contraceptives, a doctor had referred me because of my abnormal menstrual periods, a nurse refused to give me contraceptives, no matter how hard I tried to explain that I am not sleeping with males I need it for abnormal periods. A nurse said I am a lesbian and I don't need contraceptives and she did not give them to me"* [Participant 10].

Homosexual men and women reported that they were sceptical of going to the health care facility for fear of being discriminated against from others' previous experiences. However this participant was happy to meet a health care provider who acknowledged and respected her sexual orientation. The positive meeting with the health care provider is expressed in this quotation:

> *"…actually I wanted to do HIV test and the nurse asked why I want to do HIV test? I told her that I just wanted to know my status. She also asked if I was using condoms, I just laughed and looked down. The nurse said I must feel free to talk because we are just chatting. I then told her that I don't use condoms, I am in a relationship with a female. She then*

laughs…and asked what do I use to protect myself? I told her that I was not using anything. The nurse gave me health education on how and what I can use to protect myself. We chatted a lot and she did advise me on bringing my partner to check her HIV status so that we will know that we are both safe" [Participant 06].

4.6.5 Curiosity of health care providers regarding homosexuality

The majority of participants reported to have been asked about how they engaged in sexual intercourse by health care providers. Participants perceived this to be curiosity on the part of the health care providers, and they felt that this question was irrelevant to the history taking or the diagnosis and treatment as noted in the following excerpt:

"…if things were done my way, I wish lesbians and gays had a dedicated clinic in order not to get tortured by nurses with lots of questions, that are private like asking how do we engage in sexual intercourse with the person of the same sex? And you see that these questions are not going to help with anything when it comes to treatment. And the worst thing is I was asked this question after receiving my HIV test results, at the time I could not think straight" [Participant 01].

"…the question that followed was; how do you engage in sexual intercourse as you're both female?" [Participant 08].

"…the nurse asked me to explain about sexual intercourse between me and my partner. I told her that I could not explain something like that, and I asked her to please help me with treatment as I wanted to leave the room" [Participant 09].

4.6.6 Personal involvement of health care providers with homosexual men and women

Sometimes health care providers were somewhat personally affected by homosexuality either having a child that is male or female homosexual or the health care provider admitting to having feelings for homosexual men and women. Participants reacted differently to this, some felt offended while others made the health care provider understand homosexuality better. This was expressed in the following excerpts:

> *"…in the consulting room, while I was still trying to explain what I was suffering from, the nurse asked why I was gay. I told her that this was how God had created me. The nurse then told me about her child who is gay and that she and her husband chased the child away from home. I then told the nurse that she should not have judged the child for who he or she is, I am happy with who I am and proud of it. The nurse said she was going to talk to her father and ask that the child comes back home. We spent over 15 minutes discussing her fears and anxiety about her homosexual child"* [Participant 05].

> *"…when I got inside the consulting room the male nurse asked if he should write female or male, I told him that I am a gay male, I am not a female. After that he told me that he was married but wished to have relations with a gay person like me. I became so angry because I thought that he was provoking me. He then told me that we will book a place where we can sleep. I was so annoyed and uncomfortable as he was continuing with the conversation……"* [Participant 07]

4.7 EQUALITY OF PHC SERVICES

Participants shared different experiences concerning health care utilisation. The theme equality of services emerged with two subthemes, satisfaction and dissatisfaction with the services received. Participants felt treated differently from heterosexual men and women, referring to the standard of treatment as being unfair when it comes to homosexual men and women.

4.7.1 Homosexual men and women satisfaction with the PHC service

Only one participant reported satisfaction with the treatment received from the health care provider who had good communication skills and treating all patients the same. This was expressed in the following excerpts:

> *"…I don't want to lie; I was so satisfied with the treatment that I got from the health care provider who was helping me. I did not feel discriminated. That nurse did not treat me differently from heterosexuals. She did not have that in her mind that I am a homosexual client"* [Participant 06].

4.7.2 Homosexual men and women dissatisfaction with the PHC service

The majority of participants reported dissatisfaction with the treatment received from health care providers. This was mainly from the health care providers' attitudes toward homosexual men and women and not treating them same as heterosexual men and women. That is expressed in the following quotes:

> "…i*t is so difficult to use PHC facility, I was so dissatisfied with the treatment that I received and please do not ask how it ended, I just left the clinic without receiving any help"* [Participant 04].

> *"…I was uncomfortable, as a result I could not disclose my real problem because I had an anal problem, I decided to go to a private doctor"* [Participant 07].

> *"Our clinics are not in a good standard they don't accommodate all of us as we having different sexual orientations…"* [Participant 08].

4.8 SUMMARY

In this chapter, the results of data analysis were presented. These findings will be further discussed in the next chapter where the results will be presented and supported with relevant recommendations that will help to improve LGBTs access to PHC services in the Umlazi area of the KZN province.

CHAPTER 5

DISCUSSION OF THE RESULTS

5.1 INTRODUCTION

This chapter presents the discussion of the study's findings that were reported in the previous chapter. The discussion is organised following the study objectives and the Aday and Anderson theoretical framework's major concepts. Literature which has been used in previous chapters, and relevant new literature, will be incorporated to contextualise the meaning of themes and subthemes that have developed and emerged during the data analysis process of the current study's findings.

5.2 OVERVIEW OF THE RESEARCH DISCUSSION

The aim of this study was to gain in-depth knowledge into the accessibility of PHC services to lesbians and gays in the Umlazi area in the province of KZN. The objectives of the study were to:

- Determine the accessibility of PHC services to lesbians and gays.
- Assess the experiences of lesbians and gays of their access to health care services.

In this study five major themes were identified during the analysis of the study's findings:

Theme 1: Discrimination of homosexual men and women by health care providers and community members in PHC facilities.

Theme 2: Attitudes of homosexual men and women towards health care providers.

Theme 3: Homophobic behaviour

Theme 4: Equality of PHC services

The four themes will be discussed in the following sections of this chapter and contextualised by using references to relevant literature sources.

5.3 DISCRIMINATION OF HOMOSEXUAL MEN AND WOMEN BY HEALTH CARE PROVIDERS AND COMMUNITY MEMBERS IN PHC FACILITIES

The findings of the current study revealed that men and women homosexual felt the pressure of discrimination because of their sexual orientation by health care providers and by community members. Discrimination was identified as an obstacle for them to utilise health care services. Rosenstreich, Comfort, and Martin (2011: 02), concur that throughout the world, health care providers and communities still discriminate and marginalise lesbians and gays. Even the WHO's Commission on Social Determinants does not address issues related to LGBTs or sexual orientation specifically when addressing their social factors of health (Rosenstreich, *et al.* 2011: 02).

Participants in the current study reported being mistreated from the point of entry into the PHC facilities to where they reached the health care providers. Health care providers reportedly displayed unethical behaviour towards homosexual men and women by not respecting and treating them as human beings. There was stigmatisation because of their personality for example the way they dressed, walked and talked. Other studies (Rosenstreich, *et al.* 2011: 02; Kennedy *et al*. 2013: 3) report that homosexual men and women face stigma when accessing health services. Female and male homosexuals experience dual stigma associated with both their sicknesses and their sexual orientations from health care providers, especially those who engage in MSM and who suffer from STIs and HIV when they need to acquire health care services.

Participants in the current study also reported high levels of stigmatisation in their communities. When the community realises that a participant was a homosexual, the attitude towards that individual changed. Participants verbalised that society sometimes showed signs of stigma when rejecting homosexual men and women in the waiting areas at the clinics where all patients queued in while waiting for assistance from the health care providers. Some participants reported that they were able to ignore remarks of rejection made by the community members but others could not wait any longer as they felt threatened by these remarks, and left the PHC clinics without receiving treatment. They reported leaving the PHC facilities before reaching the health care providers. According to Araujo, Montagner, Da Silva, Lopes and De Freitas (2009: 667), homosexual men and women usually experience situations of prejudice in the community. Even though they might not be verbally discriminated against, they might be nonverbally offended. These authors further state that homosexual men and women might be humiliated and mocked by the society even in the health care settings because of their homosexuality. The burden of stigma might be more severe to individuals who look like homosexual men and women compared to those homosexual men and women who are not easily identifiable (Araujo *et al*. 2009: 667).

5.4 ATTITUDES OF HOMOSEXUAL MEN AND WOMEN TOWARDS HEALTH CARE PROVIDERS

Participants in the current study revealed trepidation and expected judgement from the health care providers prior to visiting PHC facilities. Expectations of being treated unfairly existed due to the pre-existing knowledge from their previous experiences or what they had heard from other homosexual men and women. The results of the current study revealed both negative and positive attitudes of homosexual men and women towards the utilisation of PHC services. According to Rounds *et al.* (2013: 99), when lesbians and gays need to access health care services they still experience fear and hesitation because of the possibility of discrimination by health care providers due to their previous experiences.

According to Rondahl (2009: 146), the insecurities of homosexual men and women sometimes affected their interaction with health care providers as not all health care providers displayed negative attitudes towards homosexuality. Some health care providers lacked tolerance of working with homosexual men and women due to their personal affiliations which interfered with their professionalism. This resulted in the untoward treatment of homosexual men and women who in turn end up delaying or avoided seeking health care services (Rondahl 2009:147).

5.5 HOMOPHOBIC BEHAVIOUR

The participants in the current reported experiences of homophobia during the utilisation of health care services. The homophobic behaviour from health care providers was perceived by homosexual men and women and it was expressed in numerous ways including a lack of understanding of homosexual men and women by health care providers and society, influence of religious and cultural beliefs, heteronormativity, attitudes of health care providers, curiosity and personal involvement of health care providers with homosexual men and women. According to Akhan and Barlas (2013: 435), the significant reason behind the judgements, negative attitudes and unfair treatment towards homosexual men and women is due to homophobia. They describe homophobia as the fear or negative feelings and attitudes towards homosexual men and women expressed by the communities. In the communities, whether homophobia is shown in an open or hidden manner, homosexual men and women are prone to daily humiliation (Akhan and Barlas 2013: 435). Health care providers are from their communities, so they are also affected by the communities' attitudes.

Findings of the current study revealed that health care providers lacked knowledge when dealing with lesbian patients' STIs. Health care providers did not take adequate histories and did not do assessments to make the final diagnosis due to their cultural beliefs and ignorance. In this study's findings it became clear that women, who have sexual interactions with other women,

were perceived to be at low risk of contracting STIs. Health care providers were found asking female homosexuals about “how can they have STIs while they were sexually active with the same sex”. Furthermore, health education by health care providers was not provided for this group, yet they reported suffering from STIs. Even when a client verbalised that “she does not know homosexual condoms and has never seen them before”, health care providers did not try to offer any precautionary measures to a client for protecting herself from STIs. Matebeni *et al*. (2013: 34), agree that women’s sexual practices have led to many misconceptions about the transmission of STIs and HIV between women. The authors emphasise that health care providers might believe in the myth that lesbians are not at risk of STIs while STIs and HIV infections have been reported from women-to-women sexual relationships. However Barnes (2012: 29) emphasised that those STIs that are usually seen in lesbians, women who only have sex with women (WSW) are herpes, gonorrheoa, genital warts, chlamydia and human papillomavirus (HPV). Many health care providers are not aware that these can be spread between WSW. The author further asserts that the most common STI found in WSW is bacterial vaginosis.

Participants perceived that communities lack understanding and knowledge about homosexual men and women. Moreover, Berry, Go, Quan, Minh, Ha, Mai, Sarin and Beyrer (2013: 40) agree that communities are not educated and lack understanding of homosexuality once they discover someone as homosexual men or women; they change their attitudes towards them and start looking down upon that person.

According to the findings of the current study, some heath care providers perceived homosexuality as being sinful and that prayers were needed to get rid of homosexuality. Participants reported that there were moments where the health care providers preached to them instead of providing the services that they required. Rondahl (2009: 149) argues that the religious health care providers remain problematic in the nursing context especially when nursing homosexual men and women. They became more concerned about

influencing homosexual men and women to become heterosexual men and women instead of treating patients holistically. This attitude is also noted from the married health care providers who associate homosexuality as against God's will and something that needed to be taken care of (Akhan and Barlas 2013: 435). Lesbians and gays sometimes feel uncomfortable to disclose their sexual orientations and might prefer to pass as heterosexuals because health care providers judge homosexuality as something abnormal and against God's will (Rondahl 2009: 146).

Participants in the current study also reported that the community was aggressive towards homosexual men and women due to cultural beliefs. Some community members believed that homosexuality was against the cultural background of African people. Some community members referred to homosexuality as a fashion, and they believed that homosexuality could be cured by slaughtering animals. According to Akhan and Barlas (2013: 435), these homophobic attitudes are influenced by the social aspects of countries and the patriarchal structures derived from their backgrounds. Both health care providers' and the communities members' beliefs contributed to the mistreatment of homosexual men and women.

The findings of this study also revealed the heterosexual assumptions from health care providers. Participants in the current study were assumed to be heterosexual because health care providers did not ask about their sexual behaviours. There was a lack of communication between the health care providers and participants. A health care provider gave health education about the use of condoms to a lesbian and that was considered inappropriate information. When a health care provider discovered that the information given was irrelevant, that resulted in embarrassment and ended up not meeting the homosexual's health needs. Health care providers always gave health education on condom use without first checking the sexual orientation of the patient. This came from two participants who were given health education about use of condoms, when a nurse realised that a patient was lesbian, she was shocked. Hayman, Wilkes, Halcomb and Jackson (2013:

121) agree that female homosexuals are still marginalised by health care providers. Although there is strong evidence of visibility of lesbians around the continent, health care providers still treat females as heterosexuals. Moreover, homosexual females remain marginalised despite being a vulnerable group due to not being recognised and treated with dignity and empathy (Hayman *et al*. 2013: 121).

The findings of the current study identified different approaches from health care providers, when treating homosexual men and women, which resulted in both negative and positive attitudes towards homosexual men and women. Participants reported unprofessional behaviours from health care providers when they were not treated humanely. The manner in which health care providers spoke to participants showed no respect for their sexual orientation. Health care providers lacked awareness of and did not know how to deal with homosexual men and women which decreased the quality of care. In a Scandinavian study, Rondahl (2009:147) reported that participants described different behaviours from health care providers; some were respected by health care providers while others experienced isolation from the health care providers and displayed no kindness. According to Rondahl (2009: 147), lesbians and gays do not disclose their sexuality due to negative attitudes from health care providers.

In the current study, refusal of treatment was reported where ignorance and sexual prejudice existed among health care providers. Health care providers were sometimes not providing services to female homosexuals due to misconceptions and a lack of understanding of female homosexuals' medical conditions. Lesbians can suffer from the same diseases that heterosexual women can suffer from. The fact that lesbians are not at risk of falling pregnant, implied to some health care providers that lesbians did not need contraceptives even if contraceptives could be used treating for hormonal imbalances. There was a lack of good history taking from and thorough assessments of both female and male homosexuals. According to Hayman *et al*. (2013: 121), participants were also denied health services several times

because of their sexual orientations, health care providers verbalised that same sex relationships were unacceptable, and felt that it would be unethical to attend to their health care needs.

On the other hand, one participant in the current study verbalised that she was treated as an ordinary client due to a positive meeting with the health care provider. A health care provider showed good communication skills and acknowledgement of homosexuality. A health care provider was found to no discrimination, sexual prejudice, stigmatisation or negative assumptions about treating homosexuals. According to Rondahl (2009:146), the insecurities of homosexual men and women sometimes affects their interaction with health care providers as not all health care providers display negative attitudes towards homosexual men and women.

The findings of the current study revealed that female and male homosexuals encountered one persistent question about how they engaged in sexual intercourse, especially when they presented with symptoms of STIs. Health care providers were insensitive when asking this questions when a client was in a vulnerable position after the client had heard news of her positive HIV status when a client's thinking capacities might have been clouded. This was either prompted by curiosity, lack of knowledge or some kind of sexual discrimination on the part of the health care providers. Participants were annoyed with and felt uncomfortable about this question and that the question was perceived as being very inappropriate. Participants expected medical help, not interrogations about their sexuality. More time was spent on questioning about their sexual activities than on history taking for the purpose of reaching a diagnosis and giving health education about the sickness and administering treatment for the illness. According to Hayman *et al*. (2013: 120), inappropriate questions were asked by health care providers from lesbian mothers during antenatal visits or immediately after giving birth about how conception took place/occurred. Some health care providers laughed and joked about pregnancies among homosexual women. Such questions were asked out of curiosity not for health-related purposes.

The findings of the current study also revealed that some health care providers saw an opportunity to satisfy their needs for or feelings about homosexuality. Health care providers sometimes asked homosexual men and women about their sexuality and sexual activities in order to understand their personal issues. One health care provider reportedly asked to be intimate with the participant. This caused embarrassment making the participant feel vulnerable and unsafe in the care of this particular practitioner. Participants ended up being uncomfortable and unable to disclose their sickness to health care providers who focussed on their homosexuality instead of on their health-related complaints. Akhan and Barlas (2013: 435), also argue that such personal involvement and questioning are due to a lack of knowledge. When health care providers meet homosexual clients, they might seize the opportunity to educate themselves and their families about homosexual men and women lifestyles, their health care needs and also the terminology they might prefer to use.

5.6 EQUALITY OF PHC SERVICES

Participants in the current study felt that they were not treated in the same way as heterosexual clients, referring to the standard of treatment as being unfair. Only one participant reported to have been treated fairly. Other researchers also reported that LGBTs received substandard care from health care providers (Rounds *et al.* 2013: 99). This group still faces the reality of disturbing homophobic attitudes when accessing health care services. According to Rondahl (2009: 146), most health care providers found it difficult to render care to homosexual men and women since they could not tolerate their sexuality and ended up failing to give quality nursing care equal to that given to heterosexuals. However homosexual participants in the current study verbalised that some health care providers were kind and caring though others saw homosexuality as being abnormal. Health care providers are different but the health systems' aim is equity of services for all patients irrespective of their sexual orientation which might not be what is practised at facility level (Rondahl 2009: 146).

Participants in the current study reported satisfaction with the treatment received due to health care providers' open mindedness. Some health care providers did not treat clients differently because of their sexuality. Many studies reported that patients verbalised satisfaction with health care services when their health needs were met (Tjepkema 2008: 82; McNair, Szelacha and Hughes 2011: 5). These authors further assert that satisfaction is reported to be higher when health care providers show acceptance and respect towards clients' homosexuality and display good attitudes towards them.

According to the findings of the current study, participants reported more dissatisfaction than satisfaction with the PHC services. That was from different experiences of treatment and care received from health care providers and the community which were negative. These participants verbalised difficulties when using PHC services and reported high levels of discomfort during utilisation of these services because they felt not accommodated due to their sexual orientations. McNair *et al.* (2011: 5) agree that dissatisfaction verbalised by homosexual men and women is associated with difficulty in accessing health care services, due to poor communication from health care providers, assumptions of heterosexuality, discrimination and negative attitudes resulting in dissatisfaction with health care services. When health care needs were not met, patients were dissatisfied (Tjepkema 2008: 82).

5.7 CONCLUSIONS

The findings of the current study indicated that discrimination still remains problematic with homosexual men and women when utilising health care services. There is still a high possibility of stigmatisation in the PHC facilities. Seeking health care services remains challenging to homosexual men and women due to their experiences. There were high levels of dissatisfaction regarding health services provided to homosexual men and women and very low satisfaction levels. Gays and lesbians delayed or avoided seeking PHC

services due to discrimination, stigmatisation and homophobic attitudes from both health care providers and community members.

5.8 LIMITATIONS OF THE STUDY

Homosexual men and women are not an easy group to be targeted; they were hard to reach as many have not 'come out' about their homosexuality, especially gays. Research was conducted on homosexual men and women residing in Umlazi only, other areas were excluded. The experiences of health care providers were not studied only that of homosexual men and women.

Only homosexual men and women who visited the gay club, where the interviews were conducted, during the time of data collection and who were willing to be interviewed participated in the study. No guarantees can be granted that homosexual men and women, who did not visit the gay club during the data collection phase and those who refused to be interviewed, had similar experiences about accessing and using PHC services in the Umlazi area as the participants.

No participants were interviewed about their experiences of accessing and utilising private health care services, but this aspect fell beyond the scope of the current study.

5.9 RECOMMENDATIONS

The following recommendations, based on the findings of the current study, could help to enhance homosexuals' accessibility and utilisation of PHC services in the Umlazi area:

- Intervention by the Department of Health, Department of Education, curriculum planners and Health Professionals Councils is required wherein homosexuality education should be addressed during pre-service and in-service education sessions, so as to familiarise health

care providers with such clients' health care needs and to decreased homophobic attitudes. It is further recommended that these stakeholders should work collaboratively in addressing the challenges facing the homosexual men and women.

- Health care providers should differentiate between sexual orientations and sexual behaviours when taking patients' histories, in order to offer relevant and appropriate health information and management.

- Guidelines on history taking for homosexual clients should be compiled for health care providers that are culturally relevant for specific communities surrounding the PHC clinic.

- Health care providers need to behave in professionally appropriate manners by not being judgemental, putting their own beliefs aside, not being inquisitive about the homosexual men and women private lives, assuring homosexual patients about confidentiality of information obtained during history taking.

- Health care providers should not show patients that they are surprised about their sexual orientation they need to set a relaxed tone and should be aware of their non-verbal body language. Patients might not give honest answers if the health care provider shows signs of shock during assessment.

- Campaigns to educate communities about homosexuality could create a more conducive environment for homosexual men and women as they would be able to access health facilities without fear of prejudice and discrimination by community members.

- Homosexual men and women should be open minded when visiting health facilities and not have the pre-conceived ideas about the health care providers, so that they respond positively to the questions asked and in turn receive the care they require.

- Every PHC clinic should have a sealed box into which patients can place anonymous compliments and comments about the services utilised at the specific clinic. Any homosexual-related comments and complaints should be addressed during in-service education sessions provided at the clinic concerned.

- The possibility should be investigated of offering PHC services at the gay club, even if only during one evening per week, by health care providers who are willing to treat homosexual men and women without any discrimination.

- Future studies should endeavour to identify the attitudes of health care providers working at PHC clinics towards homosexual men and women, as well as their knowledge about and perceptions of homosexual men and women. Based on such findings, values clarification role play sessions could be offered to health care providers to enhance their knowledge about homosexual men and women.

5.10 CONCLUDING REMARKS

The current study's findings indicated that some homosexual men and women encountered challenges to access and use PHC services in the Umlazi area. The major patient-related challenge was that some respondents feared discrimination at the PHC clinics and consequently they postponed or abandoned their PHC clinic visits. The major service-related challenges involved the non-professional attitudes of some health care providers who discriminated against some respondents' sexual orientations, asked questions out of curiosity and failed to provide adequate services. Community members, especially those sharing the waiting areas with the respondents at the PHC clinics, also discriminated against homosexual men and women causing some participants to fear for their safety to the extent that some participant had left the clinic without consulting any health care professional.

Homosexual men and women should be advised to seek health care services at PHC clinics with open minds and not to allow fear of discrimination to prevent them from doing so. If PHC services could be offered at the gay club, PHC services might become more accessible and user-friendly to the homosexual men and women. Health care providers should receive pre-service and in-service education about the necessity of treating homosexual men and women without discrimination. Community members should also be educated about homosexuality and about avoiding discriminating against homosexual men and women. Such education sessions could be provided in PHC clinics' waiting areas, at women's gatherings and during HIV/AIDS health education sessions. Implementation of some of these recommendations could help to facilitate homosexuals' access and utilisation of PHC services in the Umlazi area of the KZN province.

REFERENCES

Aday, L.A. and Andersen, R.M. 1974. A framework for the study of access to medical care. *Health Services Research*, 9(3): 208-220.

Akhan, L.U., and Barlas, G.U. 2013. Study of health care providers and attitudes against homosexual, bisexual individuals. *International Journal of Human Sciences,* 10(1): 434-445.

Andersen, R.M and Newman, J.F. 1973. Societal and individual determinants of medical care utilization in the United States. *Milbank Memorial Fund Quarterly- Health and society*, 51(1): 95-124.

Andersen, R.M. 1995. Revitalising the behavioural model and access to medical care: Does it matter? *Journal of Health and Social Behaviour*, 36: 1-10.

Ard, K. L. and Makadon, H.J. 2012. *Improving the health care of lesbian, gay, bisexual and transgender (LGBT) people: understanding and eliminating health disparities* (online), Fenway Institute: 1-12. Available: www.lgbthealtheducation.org/up-conted/uploads/12-054-LGBThealtharticlev3 (Accessed 7 March 2014).

Araujo, M.A., Montagner, M.A., Da Silva, R.M., Lopes, F.L., and De Freitas, M.M. 2009. Symbolic violence experienced by men who have sex with men in the primary health service in Fortaleza, Ceara, Brazil: negotiating identity under stigma. *AIDS Patient Care and STDs,* 23(8): 663-668.

Barnes, H. 2012. Health needs of lesbians. *Primary Health Care*, 22(6): 28-30.

Berry, M.C., Go, V.F., Quan, V.M., Minh, N.L., Ha, T.V., Mai, N.V., Sarin, E. and Beyrer, C. 2013. Social environment and HIV risk among MSM in Hanoi and Thai Nguyen. *AIDS Care*, 25(1): 38-42.

Bjorkman, M. and Malterud, K. 2009. Lesbian women's experiences with health care: a qualitative study. *Scandinavian Journal of Primary Health Care*, 27: 238-243.

Brink, H., Van der Walt, C. and Van Rensburg, G. 2012. *Fundamentals of Research Methodology for Healthcare Professionals.* 3rd edition. Cape Town: Juta.

Brown, B., Duby, Z. and Van Dyk, D. 2013. Health care provision for men who have sex with men, sex workers and people who use drugs. *An introductory manual for health care workers in South Africa.* 1st edition. Cape Town: Desmond Tutu HIV Foundation.

Daley, A.E. and MacDonnell, J. A. 2011. Gender, sexuality and the discursive representation of access and equity in health services literature: implications for BioMedCentral: 1-10. Available: www.ncbi.nlm.nih.gov/.../PMC3195712/ (Accessed 5 March 2014).

Fish, J. and Bewley, S. 2010. Using human rights-based approaches to conceptualise lesbian and bisexual women's health inequalities. *Health and Social Care in the community*, 18 (4): 355-362.

Frith, A. 2011. *Top KwaZulu-Natal eThekwini Umlazi, Main Place 599163nfrom Census* (online). Available: censuc2011.adrianfrith.com/place/599163. (Accessed 10 March 2014).

Graves, A. 2009. A model for assessment of potential geographical accessibility: a case for GIS. *Online Journal of Rural Nursing and Health Care*, 9(1): 46-55.

Grove, S.K., Burns, N. and Gray, J.R. 2013. *The practise of nursing research: Appraisal, synthesis, and generation of evidence*. 7th edition. St Louis: Elsevier.

Hayman, B., Wilkes, L., Halcomb, E.J., and Jackson, D. 2013. Marginalised mothers: lesbian women negotiating heteronormative healthcare services. *Contemporary Nurse*, 44(1): 120-127.

Healthy People. 2010. *Companion document for lesbian, gay, bisexual, and transgender (LGBT) health*. Available: www.med.umich.edu/diversity/pd.file/healthpeople.pdf (Accessed 3 March 2014).

Kennedy, C.E., Baral, S. D., Fielding-Miller, R., Adams, D., Dludlu, P., Sithole, B., Fonner, V.A., Mnisi, Z. and Kerrigan, D. 2013. They are human beings, they are Swazi: intersecting stigmas and the positive health, dignity and prevention needs of HIV-positive men who have sex with men in Swaziland. *International AIDS Society,* 16 (3): 1-7.

Kirby, N. 2010. Access to healthcare services as a human right. *Medicine and Law [Med Law]*, 29 (4): 487-496.

Knudsen, L.V., Laplante-levesque, A., Jones, L., Preminger, J. E., Nielsen, C., Lunner, T., Hickson, L., Naylor, G. and Kramer, S.E. 2012. Conducting qualitative research in audiology: a tutorial. *International Journal of Audiology*, 51: 82-92.

Levesque, J., Harris, M.F. and Russell, G. 2013. Patient-centred access to the health care: conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health*. Online. Available: http://www.equityhealthj.com/content/12/1/18 (Accessed 28 November 2014).

Matebeni, Z., Reddy, V., Sandfort, T., and Southey-Swartz. I. 2013. I thought we are safe: Southern African lesbians' experiences of living with HIV. *Culture, Health and Sexuality,* 15(1): 34-47.

Matthes, C. 2010. South Africa: a model for the future. *Lesbians News,* 35(8): 28-28.

McIntyre, L., Szewchuk, A. and Munro, J. 2010. Inclusion and exclusion in mid-life lesbians' experience of the Pap test. C*ulture, Health and Sexuality*, 12 (8): 885-898.

McNair, R., Szelacha, L.A. and Hughes, T.L. 2011. Health status, health services use, and satisfaction according to sexual identity of young Australian women. *Women's Health Issues* (online), 21(1): 40-47. Available: www.plantphysiol.org/external-ref (Accessed 21 March 2014).

Mitra, S. and Globerman, J. 2013. Facilitators and barriers to health care for LGBT people. (online). Ontario. Rapid Review 76. Available: http://www.ohtn.on.ac/pages/Knowledge-Exchange/Rapid-Responses/RR76-Facilitators-and-Barries-to-health-Care-for-LGBT-People.pdf (Accessed 21 March 2014).

Muller, A. 2013. Teaching lesbian, gay, bisexual and transgender health in a South African health science faculty: addressing the gap. *BioMed Central Medical Education*, 13: 1-7.

Mwaba, K. 2009. Attitude and beliefs about homosexuality and same sex marriage among a sample of South African students. *Social Behaviour and Personality: an International Journal,* 32(6): 801-804.

National Department of Health. 2011. *Towards quality care for patients: national core standards for health establishments in South Africa.* Pretoria: Government Printer.

Ochse, A. 2011. Real women and real lesbians: discourses of heteronormativity amongst a group of lesbians. *South African Review of Sociology Association,* 42(1):3-20.

Polit, D.F. and Beck, C.T. 2012. *Nursing research: generating and assessing evidence for nursing practice*. 9th edition. London: Wolters.

Posse, M., Meheus, F., Van Asten, H., Van der Ven, A. and Baltussen, R. 2008. Barriers to access to antiretroviral treatment in developing countries: a review. *Tropical Medicine and International Health*, 13 (7): 904-913.

Republic of South Africa. 1996. *The Constitution of the Republic of South Africa* (Act 108 of 1996). Pretoria: Government Printer.

Republic of South Africa. 2010. *Section 27- Public Interest Litigation Centre. (online).* South Africa. Available: www.section27.org.za/wp-content/uploads/2010/04/10manualpdf (Accessed 12 March 2014).

Rispel, L. C., Metcalf, C.A., Cloete, A., Moorman, J. and Reddy, V. 2011. You become afraid to tell them that you are gay: health service utilization by men who have sex with men in South African cities. *Public Health Policy,* 32 (1): 138-151.

Rondahl, G. 2009. Lesbians' and gay men's narratives about attitudes in nursing. *Scandinavian Journal of Caring Sciences,* 23 (1): 146-152.

Rosenstreich, G., Comfort, J. and Martin, P. 2011. Primary health care and equity: the case of lesbian, gay, bisexual, trans and intersex Australians. *Australian Journal of Primary Health*,17(4): 302-308.

Rutherford, M.E., Mulholland, K., and Hill, P.C. 2010. How access to health care relates to under-five mortality in sub-Sahara Africa: systematic review. *Tropical Medicine and International Health,* 15(5): 508-519.

Rounds,K.E., McGrath, B.B. and Walsh, E. 2013. Perspectives on provider behaviors: a qualitative study of sexual and gender minorities regarding quality of care. *Contemporary Nurse*, 44 (1): 99-110.

Sallar, A. M. and Somda, D. A. K. 2011. Homosexual and HIV in Africa: an essay on using entertainment education as a vehicle for stigma reduction. *Sexuality and Culture*, 15 (3): 279-309.

Semaan, S. 2010. Time-space sampling and respondent-driven sampling with hard-to-reach populations. *Methodological Innovations Online,* 5(2): 60-75. Available: www.methodologicalinnovations.org.uk/ (Accessed 28 July 2014).

Sokhela, D.G. 2011. Assessment of the experiences of users of the fast queue in selected primary health care facilities, in the eThekwini municipality (online). M. Tech: Nursing, Durban University of Technology. Available: ir.dut.ac.za/…/618/ Sokhela_2011.pdf? (Accessed 4 March 2014).

Tjepkema, M. 2008. Health care use among gay, lesbian and bisexual Canadians. *Health Reports*, 19 (1): 53-64.

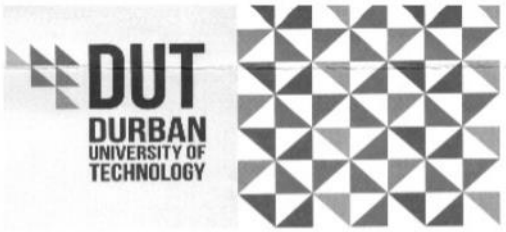
Tucker, A. 2010. The 'rights' (and 'wrong') of articulation race with sexuality: the conflicting nature of hegemonic legitimisation in South African queer politics. *Social and Cultural Geographic,* 11(5): 433-445.

United Nations General Assembly. 2000. *United Nations Millennium Declaration* (A/RES/55/2). New York.

Williams, S.D., Hasten, K., Smithey, M., Burnley, J., Koplitz, M., Koyama, K., Young, J. and Bakos, A. 2014. Using social determinants of health to link health workforce diversity, care quality and access, and health disparities to achieve health equity in nursing. *Nursing in the 3D: Diversity, Disparities, and Social Determinants,* 129(2): 32-37.

World Health Organization (WHO). 1978. Declaration of Alma-Ata, International Conference on Primary Health Care, Alma Ata, USSR, 6-12 September 1978. [Online]. Geneva: WHO. Available on: http://www.who.int/hph/docs/declaration_almata.pdf (Accessed 3 March 2014).

Appendix A: University ethics clearance certificate



Institutional Research Ethics Committee
Faculty of Health Sciences
Room MS 49, Mansfield School Site
Gate 8, Ritson Campus
Durban University of Technology

P O Box 1334, Durban, South Africa, 4001

Tel: 031 373 2900
Fax: 031 373 2407
Email: lavishad@dut.ac.za
http://www.dut.ac.za/research/institutional_research_ethics

www.dut.ac.za

16 September 2014

IREC Reference Number: **REC 61/14**

Ms N H Cele
F32 Umlazi Township
P O Umlazi
4066

Dear Ms Cele

Experiences of homosexuals' access to primary health care services at Umlazi, KwaZulu-Natal

I am pleased to inform you that Full Approval has been granted to your proposal REC 61/14.

The Proposal has been allocated the following Ethical Clearance number **IREC 064/14**. Please use this number in all communication with this office.

Approval has been granted for a period of one year, before the expiry of which you are required to apply for safety monitoring and annual recertification. Please use the Safety Monitoring and Annual Recertification Report form which can be found in the Standard Operating Procedures [SOP's] of the IREC. This form must be submitted to the IREC at least 3 months before the ethics approval for the study expires.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC SOP's. In addition, you will be responsible to ensure gatekeeper permission.

Please note that any deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

Yours Sincerely

[redacted]

Prof J K Adam
Chairperson: IREC

Appendix B: Permission letter to the Gay Club

F32 Umlazi Township
P.O. Umlazi
4066

P1709 Thokozani Football Gay Club
P.O. Umlazi
4066

Dear Madam

I am a student registered at the Durban University of Technology for Masters of Technology in Nursing and practice nursing at Osizweni Q clinic Umlazi as a clinical nurse specialist. My research study is**: Experiences of homosexuals' access to primary health care services at Umlazi KwaZulu-Natal.** The purpose of the study is to gain in depth knowledge into perceptions of homosexual men and women about primary health care services provided at Umlazi, KwaZulu-Natal. The study will assist health care providers to acknowledge, understand and be more aware of the needs of your clientele thus enabling them to provide this community with comprehensive health care.

I am requesting your permission to post recruitment flyers in the club one week before I begin with data collection and on-going throughout data collection. The recruitment flyers will have inclusion criteria: (a) be 18 years of age or older, (b) self-identify as either lesbian or gay, (c) have accessed primary health care services in Umlazi KwaZulu-Natal province within the past year; and (d) able to conduct a conversation in either English or Zulu.

I would like to come on Saturdays and Sundays between 5 and 8 pm. I will also need a private space to meet with study participants in order to ensure their privacy.

I will stop by the club next week to speak with you in person about this request.

Yours sincerely

…… ……

Ms NH Cele (M Tech student)
078 626 9714
luh4lyf@gmail.com

Prof MN Sibiya (Supervisor)
031-373 2606
nokuthulas@dut.dut.ac.za

Appendix C: Approval letter from the Gay Club

TFC 2008
SUPPORT LGBTI

P1709 Thokozane football gay club

P.O. Umlazi

4066

22 September 2014

F32 Umlazi Township

P.O. Umlazi

4066

Dear Ms Cele

We are pleased to inform you that the permission to conduct research for the study: **Experiences of homosexuals' access to primary health care services at Umlazi KwaZulu-Natal** is granted to you.

You are also allowed to post recruitment flyers in the club one week before you begin with data collection and on-going throughout data collection. You will get your privacy room for conducting interviews at any day and time.

We wish you most excellent in your study and if possible please provide us with the full report when you finished.

For further enquiries you can contact the club owner Zanele Muholi on 0739016005, zmuholi@gmail.com or Lizzy Muholi on 0733133493, lizzymuholi@gmail.com.

Yours Sincerely

[redacted]

Lizzy Muholi (Manager)

THOKOZANI FOOTBALL GAY CLUB
DATE: 22/09/2014
UMLAZI "P" SECTION

Appendix D: Letter of information in English

Dear Participant

Thank you for agreeing to be part of this research.

Title of the Research Study: Experiences of homosexuals' access to primary health care services at Umlazi KwaZulu-Natal

Principle Investigator/s/researcher: Ms Nokulunga H Cele (M Tech student)

Co-Investigator/s/supervisor/s: Prof MN Sibiya, D Tech: Nursing, (Supervisor); Ms DG Sokhela, M Tech: Nursing (Co-supervisor)

Brief Introduction and Purpose of the Study: I will be conducting a study and the purpose of the study is to gain in depth knowledge into how accessible health care services are to homosexual men and women at Umlazi area.

Outline of the Procedures: I will ask you few questions about accessibility of health care services. The interview will last for about 30 - 45 minutes. I therefore, kindly request to use a voice recorder for recording the discussions. If you agree to participate in the study I will conduct interview in a private and quiet room.

Discomforts to the Subject: I assure you that you will not experience any risk or discomfort because I will not do anything to you, I will do interview only.

Benefits: The study is going to benefit you in that, if the results of this study show anything that is unmet according to your experiences, recommendations will be made to the Department of Health which might correct the situation. The study might assist the health care providers to acknowledge, understand and be more aware of the needs of this group thus enabling them to provide this community with comprehensive health care.

Reason/s why the Subject May Withdraw from participating in the Study: You are also allowed to withdraw from the study at any stage, because participation is voluntary.

Remuneration: There will be no monetary incentive that you will receive from being part of the study.

Confidentiality: No one will have access to the information that you will provide, codes will be used to identify participants. The master list of participants and the codes will be kept under lock and key, records of the recorded interviews will be kept in a computer locked with password only known to the researcher. Participants will be protected from sexual disclosure of their sexual orientation to others during research process, as the interviews will be conducted in a safe locked room.

Research-related Injury: You will not sustain any injuries because I will not do anything to you, I will only interview.

Persons to Contact in the Event of Any Problems or Queries: If you wish to enquire further, please contact the researcher Ms Nokulunga H Cele 0786269714 study supervisor Prof MN Sibiya, Tel no: 031-373 2606 or Ms DG Sokhela, co-supervisor, Tel no: 031-373 2292 or the Institutional Research Ethics administrator on 031-373 2900. Complaints can be reported to the DVC: TIP, Prof F Otieno on 031 373 2382 or dvctip@dut.ac.za.

Appendix E: Consent form in English

CONSENT

Statement of Agreement to Participate in the Research Study

- I hereby confirm that I have been informed by the researcher, Ms Nokulunga H Cele, about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: 064/14.
- I have also received, read and understood the above written information Appendix A (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth and my initials will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent to participate in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

_____	_____	_____	_____
Full Name	**Date**	**Time**	**Signature/Right Thumbprint**

I, Nokulunga Cele herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

_____	_____	_____
Full Name of Researcher	**Date**	**Signature**
_____	_____	_____
Full Name of Witness	**Date**	**Signature**
_____	_____	_____
Full Name of Legal Guardian	**Date**	**Signature**

Appendix F: Letter of information in isiZulu

Sawubona

Ngiyabonga ukuthi uvume ukuba yingxenye yaloluncwaningo.

Isihloko socwaningo: Ukucubungula indlela abantu abathandana nobulili obufanayo abaphatheka ngayo uma besemitholampilo yaseMlazi, KwaZulu-Natal.

Umcwaningi omkhulu: Nksz Nokulunga H Cele (M Tech: Nursing)

Obheke Umcwaningi: Solwazi MN Sibiya, D Tech: Nursing kanye no Nksz DG Sokhela (M Tech: Nursing**)**

Isingeniso nenhloso yocwaningo: Inhloso yaloluncwaningo ukuthola ulwazi olujulile mayelana nempatho yasemitholampilo yase Mlazi kubantu abathandana nobulili obufanayo.

Uhlaka lokuzokwenziwa: Ngaphambi kokuthi siqale ngizocela ufunde lencwadi yolwazi loncwaningo uyizwe kahle ukuthi ithini ubuze imibuzo lapho ungayizwa kahle khona kumncwaningi, uzokuchazela konke ongakuzwa uze ukuqondisise kahle bese ushicilela isivumelwano sokuthi uyavuma ukuba yingxenye yaloluncwaningo. Ngizobe sengibuza imibuzo embalwa ngisebenzisa inqubo mgomo yesivivinyo.

Amathuba okungaphatheki kahle: Ngithanda ukukuqinisekisa ukuthi awekho amathuba wokuthi ungaphatheki kahle ngoba ngizokubuza imibuzo kuphela mayelana noncwaningo size siqede akukho okunye engizokwenza kuwena. Uma kwenzeka kuba khona okungakuphathi kahle ngesikhathi socwaningo, uzoba khona usonhlalakahle ozosiza kulezozimo ezinjalo.

Inzuzo: Imiphumela yocwaningo izosiza ngokuthi uma kukhona esizozwa ukuthi bekungakuphathi kahle emtholampilo, umcwaningi uzokwazi ukwenza izincomo kwabezempilo ukuthi kulungiswe.

Isizathu sokuhoxiswa kulolucwaningo: Ungakwazi futhi ukuhoxa noma inini ekubeni yingxenye yaloluncwaningo ngeke kube khona izinkinga ngoba ukuba yingxenye yaloluncwaningo ukwenza ngokuthanda.

Iholo: Akukho lutho ozoluthola oluyinkokhelo ngokuba yingxenye yaloluncwaningo.

Imfihlo: Amagama akho ngeke asetshenziswe ezintweni ezibhalwayo, azoba yimfihlo. Kuzosetshenziswa izinombolo esikhundleni samagama ukuze nihlukaniseke. Konke okukhulumile akekho ozokwazi ukufinyelela kukona ngoba yonke into izoyogcinwa ekhabetheni elikhiywayo nokhiye walo awuthintwa muntu ngaphandle kwami.

Ukulimala okungenziwa ucwaningo: Akukho ukulimala ongahlangabezana nakho ngoba ngizobe ngibuza imibuzo kuphela akukho okunye engizokwenza kona.

Ongabathinta uma kunenkinga noma kukhona ofuna ukukubuza: Uma kukhona odinga ukukwazi kabanzi thintana nomcwaningi uNokulunga H Cele kulenombolo 078 626 9714/031-907 1150 (emsebenzini) noma thinta obheke umncwaningi uSolwazi MN Sibiya, kulenombolo 031-373 2606, uNksz DG Sokhela kulenombolo 031-373 2292 noma u Institutional Research Ethics administrator on 031-373 2900. Izikhalo zingadluliselwa naku DVC: TIP, Prof F Otieno kulenombolo 031 373 2382 noma dvctip@dut.ac.za

Appendix G: Consent form in isiZulu

ISIVUMELWANO

Isivumelwano sokuba yingxenye yoncwaningo

Mina…… amagama aphelele, inombolo yamazisi……Ngiyafakaza ukuthi ngichazeleke kahle ngoncwaningo lwa Ms Nokulunga H Cele. Unginike incwadi yolwazi ngayifunda ngokuqonda. Nginalo nolwazi lokhuthi imiphumela yaloncwaningo uzoyibhala ebhukwini kodwa imininingwane yami izoba imfihlo. Ngingahoxa noma kunini kuloluncwaningo angeke kube khona inkinga ngoba angiphoqiwe. Ngaphezu kwakho konke lokhu ukuba yingxenye yaloncwaningo angeke kube nomthelela ongangivimbela ukusebenzisa umtholampilo ngokukhululeka esikhathini esizayo, ngakho ke ngiyavuma ukuba yingxenye yaloncwaningo.

Igama longenela uncwaningo (ngokuhlukanisa)……

Isishicilelo songenela uncwaningo…….usuku……

Igama lomncwaningi (ngokuhlukanisa)……

Isishicilelo somncwaningi…….usuku……

Igama likafazi (ngokuhlanganisa)……..

Isishicilelo sikafakazi…….usuku…….

Appendix H: Interview guide in English

Section A.: Demographic data

1. Age: _____

2. Sexual identification: Lesbian ☐ Gay: ☐

3. Marital Status:

Married	Single	Widowed	Divorced

5. Level of education:_____

6. Occupation:_____

Section B

1. Describe what made you visit the PHC clinic during the past year.
2. Describe your experience at the primary health care clinic. (From the time you entered the clinic, to enquiries, to the point where you waited for help (in the queue) till the time you entered the real service point (the health provider's room) the treatment you received till you left the clinic).
3. How were you treated? Was that the way you would like to be treated? if yes, why? If not, why?
4. Describe how accessible PHC services are to you.

Appendix I: Interview guide in isiZulu

INQUBO MGOMO YEMIBUZO YESIVIVINYO.

Isigaba sokuqala: Ucwaningo lomuntu.

1. Iminyaka: (onayo manje)

2. Ubulili: Owesilisa (Gay) ☐ Owesifazane (Lesbian) ☐

3. Ushadile ngesimo samanje:

Ushadile	Awushadile	Umfelokazi	Uhlukanisile

4. Ibanga lemfundo:_____

5. Umsebenzi:_____

Isigaba sesibili

1. Chaza ukuthi yini ekuyisa emtholampilo kulonyaka odlule.

2. Chaza indlela ophatheka ngayo emitholampilo (kusukela ungena esangweni, uya lakubuzwa khona, uyolinda la uzothola khona usizo uze ufike kumhlekikazi uze uhamba uyophuma ngesango).

3. Uphatheka kanjani uma uye emtholampilo. Iyona indlela obuyifisa ukuphatheka ngayo uma kuyiyona chaza ukuthi kanjani? Umakungeyona chaza ukuthi kanjani?

4. Awuchaze ukuthi umtholampilo usebenziseka kanjani njengoba uyigay/lesbian.

Appendix J: Declaration letter from the English and isiZulu teacher

W 447Umlazi Township

P.O. Umlazi

4066

31 November 2014

F32 Umlazi Township

P.O. Umlazi

4066

Dear Sir/Madam

A VERIFICATION LETTER FOR INTERVIEWS TRANSLATION.

I Lungile Ladyfair Dlamini hereby to confirm that I have checked the translation of the interviews of Ms N.H. Cele for the study: **Experiences of homosexuals' access to primary health care services at Umlazi KwaZulu-Natal**.

The interviews were total of 12, written in isiZulu and English language. All were checked one by one. I verify that the information is true and correct.

Thank you

[redacted]

Ms L.L. Dlamini

Further Diploma in Education (FED (UNITRA), Seniors Teachers Diploma (STD (UNITRA) and Bachelor of Education Honours (B.ED UKZN Westville).

Appendix K: Declaration letter from the English editor

Valerie Janet Ehlers

Nurse Consultant and Researcher

Emeritus Professor and Research Fellow: University of South Africa

Associate Editor: International Nursing Review

(B Soc Sc (University of Natal), Honours B Soc Sc, BA Cur, Honours BA Cur, MA Cur, D Lit et Phil, Diploma in Development Administration, TAALKU-F for Diploma in Translation- Unisa))

CONFIRMATION LETTER: EDITING OF A DOCUMENT

266 Pat Dyer Avenue
ERASMUSRAND
0181

PO Box 65075
ERASMUSRAND
0165

2 March 2015

Tel: 012 347 8287
Cell: 084 587 3303

e-mail: ehlersjh@mweb.co.za

2 March 2015	I hereby certify that I have edited the following master's dissertation entitled: **EXPERIENCES OF HOMOSEXUALS' ACCESS TO PRIMARY HEALTH CARE SERVICES IN UMLAZI, KWAZULU-NATAL** by student NH Cele

Thank you

[redacted]