A comparative appraisal of access and quality of sexual and reproductive health services for gays and lesbians in Bulawayo (Zimbabwe) and Pretoria (South Africa).

A Thesis Submitted in Fulfilment of the Requirements for the Degree of

Doctor of Philosophy in Social Sciences

by

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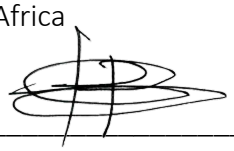

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Dedication

Dedicated to the glory of God, the Highest,

And to my three girls,

Becky, SRJ 1 and SRJ 2.

Definition of Terms

Abstinence: Not having sex with anyone.

Acquired immune deficiency syndrome (AIDS): The most advanced stage of HIV.

Adolescence: The period of physical and emotional change between the beginning of puberty and early adulthood.

Anal sex: Sex in which the penis or a sex toy goes in the anus.

Antiretroviral: A medicine that fights viruses. Antiretroviral therapy (ART) is a treatment for HIV patients that can help them stay healthy and lower their chances of passing HIV to someone else.

ART (antiretroviral therapy): A combination of medicines that works to keep people living with HIV healthy by lowering the amount of the virus in their bodies.

Bisexual: A person whose primary sexual and affectional orientation is toward people of the same and other genders, or towards people regardless of their gender.

Cancer: A disease in which abnormal cells grow out of control in a part of the body.

Casual sex: Sex between people who are not in a relationship with each other.

Cervix: The narrow, lower part of the uterus, with a small opening connecting the uterus to the vagina.

Circumcision: A surgical procedure to remove the foreskin of the penis or part of the clitoris.

Clinician: A qualified health care professional, such as a doctor, nurse, nurse practitioner, or physician assistant. Also called “health care provider.”

Coming Out: Refers to voluntarily making public one's sexual orientation and/or gender identity.

Comprehensive sex education: A medically accurate, age-appropriate curriculum or intervention that includes information about abstinence, birth control, STI prevention, healthy relationships, sexual orientation/gender identity, accessing health care services, and helps build skills around communication and healthy decision making.

Condom: Thin, stretchy pouches worn on the penis or inserted in the vagina during sex. Mostly made from latex or plastics (like polyurethane and polyisoprene).

Contraception/contraceptive: Any behavior, device, medication, or procedure used to prevent pregnancy. Also known as birth control.

Dental dam: A thin, square piece of latex that helps prevent the spread of STIs when placed over the vulva or anus during oral sex.

Equality: A state of being equal, especially in status, rights, or opportunities.

Equity: When people and communities have access to the resources and opportunities they need in the way they need them.

Family planning: Making plans and taking actions, like using birth control, to have the number of children you want, when you want them.

Female: One of two possible legal/medical gender categories, assigned at birth. Also describes when someone has XX chromosomes.

Female condom: A polyurethane pouch that goes inside the vagina or anus for pregnancy and/or STI prevention.

Gay: A sexual orientation toward people of the same gender.

Gender: A social construct used to classify a person as a man, woman, or some other identity. Fundamentally different from the sex one is assigned at birth; a set of social, psychological and emotional traits, often influenced by societal expectations

Health care provider: A licensed doctor, nurse, nurse practitioner, nurse-midwife, or physician assistant.

Heterosexual: Being attracted to people of the other gender.

HIV (human immunodeficiency virus): A chronic virus that breaks down the immune system. Can lead to AIDS if not treated.

Hormone therapy: A combination of hormones (like estrogen or testosterone) or hormone-blockers used in transgender care to help patients have secondary sex characteristics in line with their gender identity.

In vitro fertilization (IVF): Any method of assisted reproduction in which fertilization takes place outside the body (usually in a lab) to get someone pregnant.

Infertility: The inability to become pregnant or to cause a pregnancy.

Lube / lubricant: A water-based, silicone-based, or oil-based product used to increase slipperiness and reduce friction during sex.

Heterosexuality: A sexual orientation in which a person feels physically and emotionally attracted to people of a gender other than their own.

Homophobia: The irrational hatred and fear of LGBTQIA+ people. Homophobia includes prejudice, discrimination, harassment, and acts of violence brought on by fear and hatred.

Homosexual/Homosexuality: An outdated term to describe a sexual orientation in which a person feels physically and emotionally attracted to people of the same gender.

Lesbian: A woman whose primary sexual orientation is toward people of the same gender.

PEP (post-exposure prophylaxis): Medicine that helps prevent HIV (or other infections) if started within a few days after being exposed.

Pre-exposure prophylaxis (PrEP): A medicine taken daily to reduce the risk of getting HIV.

Safer sex: Ways in which people reduce the risk of getting sexually transmitted infections, including HIV.

Sex: A categorization based on the appearance of the genitalia at birth.

Sexuality: The components of a person that include their biological sex, sexual orientation, gender identity, sexual practices.

Sex worker: A person who is paid for providing sex or sexually arousing activities, including phone or camera sex, erotic massage, or lap dancing.

Sexual health: Enjoying emotional, physical, and social well-being regarding one's sexuality, including free and responsible sexual expression that enriches one's life. (Sexual health is not only the absence of sexual dysfunction or disease.)

Sexual identity: Your understanding of your own sex, gender identity, sexual orientation, and sexual expression/preferences.

Sexual minority: An individual or group whose gender identity, sexual behavior, sexual orientation, or sexual preference is thought to be outside socially accepted norms.

Sexual orientation: Identities that describe what gender(s) a person is romantically and/or sexually attracted to including gay, lesbian, straight, and bisexual.

Sexual preference: People, activities, or other things that you like, sexually.

Sexually transmitted infection (STI): Infections that are passed from one person to another during vaginal, anal, or oral sex, or sexual skin-to-skin contact and also known as sexually transmitted disease.

Stigma: Severe disapproval/judgment for a behavior that is reinforced by society/culture.

Transgender: A general term used to describe someone whose gender expression/gender identity are different than the sex they were assigned at birth.

Acronyms

ABC	Abstinence, be faithful and use a Condom
AIDS	Acquired Immune Deficiency Syndrome
AMSHeR	African Men for Sexual Health and Rights
ART	Anti-retroviral therapy
CCM	Country Coordinating Mechanism
CDC	Centres for Disease Control
CHAT	Community Harmonized Alignment Tool
CSO	Civil Society Organizations
DOH	Department of Health
DTTU	Delivery Team Topping Up
FGD	Focus Group Discussion
FSW	Female Sex Worker
GALZ	Gays and Lesbians Zimbabwe
GARPR	Global AIDS Response Progress Report
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoZ	Government of Zimbabwe
HBM	Health Beliefs Model
HCT	HIV Counseling and Testing
HIV	Human Immuno-deficiency Virus
HSRC	Human Sciences Research Council
IBM	International Business Machines Corporation
IDU	Injection Drug Users
IEC	Information, Education and Communication
IOM	Institute of Medicine
KII	Key Informant Interviews
KP	Key Populations
LGBTIQ	Lesbians, Gays, Bisexual, Transgender, Intersex and Queer
MAC	Matabeleland AIDS Council
MDG	Millennium Development Goals
MHPSS	Mental Health and Psychosocial Support
MOH	Ministry of Health
NGO	Non-governmental Organization
NHS	National Health Services
NSP	National Strategic Plan
PEP	Post-exposure prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PMTCT	Prevention of mother to child transmission
PrEP	Pre-exposure prophylaxis
PSI	Population Services International
PSZ	Population Services Zimbabwe
R	South African Rand
SAfAIDS	Southern Africa AIDS Information Dissemination Service

SANAC	South Africa National AIDS Council
SANDH	South Africa National Department of Health
SAPS	South Africa Police Service
SDG	Sustainable Development Goals
SFH	Society for Family Health
SPSS	Statistical Package for Social Scientists
SRC	Sexual Rights Centre
SRH	Sexual and Reproductive Health
STATSSA	Statistics South Africa
STI	Sexually Transmitted Infections
SW	Sex Worker
SWEAT	Sex Workers Education and Advocacy Taskforce
TB	Tuberculosis
UAI	Unprotected Anal Intercourse
UCSF	University of California San Francisco
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
US	United States
USA	United States of America
USD	United States Dollars
WHO	World Health Organization
ZDHS	Zimbabwe Demographic Health Survey
ZIMSTAT	Zimbabwe Statistics Agency
ZNASP	Zimbabwe National AIDS Strategic Plan
ZNFPC	Zimbabwe National Family Planning Council

Abstract

This study investigated the extent to which gays and lesbians access quality sexual and reproductive health (SRH) services in Pretoria and Bulawayo. The study also examines the facilitators and barriers for accessing the same services. Theoretically, the study was grounded in the Health Belief Model (Hochbaum, 1958, modified by Rosenstock, 1974 and Siddiqui, 2016). To answer the research questions, a mixed methods approach was applied involving both qualitative and quantitative data collection methods. A total of 30 key informant interviews, eight focus group discussions and 387 questionnaires were administered using purposive, time location and snowball sampling approaches in the two cities.

The study found that the most commonly available sexual and reproductive health (SRH) services were contraceptive services, sexually transmitted infections (STI) services and Human immunodeficiency syndrome (HIV) services. The services were provided at public health facilities, drop-in centres and through outreach activities operated by Civil Society Organizations (CSOs). The least available services that gays and lesbians required as part of a comprehensive package were access to information, education and communications (IEC) materials and mental health and psychosocial support services (MHPSS). Several service providers were not adhering to the World Health Organization (WHO) guidelines for provision of comprehensive services for key populations including gays and lesbians. Critical gaps noted included the absence of key populations-only service hours, lack of options for clinicians to attend to them, presence of a stigma and discrimination free environment and provision of comprehensive package of services under one roof. Most of the referral facilities had limited drugs, equipment and supplies for cancer screening and they had no HIV prevention, sex change, in-vitro fertilization, and sterilization services and procedures. The quality of physical facilities and SRH services in both cities did not meet the expectations of gays and lesbians, acting as a barrier to their health seeking behaviour. Stigma and discrimination from healthcare workers was a huge barrier affecting access across all public health facilities. The acts of stigmatisation and discrimination affected the perceptions that gays and lesbians had regarding the quality of the services and compromised access of the same.

In view of these health system challenges, the study recommends that there is need for public authorities in both cities to address the bottlenecks and barriers affecting access to SRH services and products such as lubricants, affordable quality condoms, dental dams and latex gloves while

reinforcing the facilitating factors promoting access. Healthcare workers need further training on how to provide comprehensive services for gays and lesbians according to the WHO guidelines. Public health authorities in Bulawayo and Pretoria should build upon the identified factors which facilitated the access to SRH services and use of products such as condoms and lubricants. These factors require strengthening of community-based organizations and networks that work directly with gays and lesbians in both Bulawayo and Pretoria.

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I am also greatly indebted to my wife, Becky, and our two girls, SRJ 1 and SRJ 2 for enduring long periods of time during my absence as I conducted this study. My further appreciations to my three research assistants who worked tirelessly under difficult and intimidating conditions in South Africa and Zimbabwe.

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Mwari akuropafadzei. Dieu te bénisse. God bless you.

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Chapter One

Introduction and Background

1.1 Introduction

South Africa is one of the countries hardest hit by the Human immunodeficiency virus (HIV) and Acquired immunodeficiency syndrome (AIDS) epidemic. The national HIV prevalence rate is 20.4% with an estimated seven million people living with HIV (Avert, 2020). There were an estimated 380,000 new infections in 2018 while 180 000 people died of AIDS related illnesses during the same year (Avert, 2019). Among the key populations most affected by HIV in South Africa are sex workers, with an HIV prevalence of 57.7% and gay men with an HIV prevalence of 26.8% (UNAIDS, 2017).

South Africa does not have sufficient national data on HIV prevalence among key population (KPs) groups such as lesbians, gays, bisexuals, transgender, intersex and queer (LGBTIQ) persons. However, there are studies that have been conducted with limited representativeness. For example, one study estimates that national HIV prevalence among gays is between 22% and 48% (Avert, 2016) while another study by researchers from the University of California-San Francisco (UCSF) notes that the HIV prevalence among gays is 22% in Cape Town and 48% in Durban (UCSF, 2015). The University of California-San Francisco study further points out that these figures surpass the HIV prevalence among males in the general population by between 2% and 5%.

While there is lack of data on HIV prevalence among lesbians, a few studies have given estimations based on self-reported prevalence. According to Sandfort et al (2013), 10% of lesbians self-reported being HIV positive in South Africa. In this study, it emerged that rape was one of the biggest risk factors given that 31% of lesbians in South Africa reported that they had experienced rape before (Sandfort et al. 2013). While little attention is being given to lesbians as a high risk KP group in South

Africa, Matebeni et al (2013) found that 21% of HIV positive lesbians in South Africa acquired HIV and other sexually transmitted infections (STIs) from their female partners.

Since the 1990s, the HIV epidemic in South Africa has been characterized mainly by heterosexual transmission. Research and HIV prevention have focused primarily on HIV surveillance and intervention programs for the prevention of HIV heterosexual transmission and prevention of mother-to-child transmission (PMTCT). Key populations such as LGBTIQ, sex workers and injection drug users (IDUs) have traditionally not received attention in terms of their sexual and reproductive health (SRH) needs in the context of a generalized HIV epidemic. In South Africa, the National Strategic Plan (NSP) on HIV, STIs and Tuberculosis (TB) covering the period 2017 to 2021 promotes a broad framework for addressing HIV and health issues, focusing on prevention, care, treatment and support interventions based on risk and need. The NSP (2017-2021) recognized the importance of targeting key populations and marginalized groups, explicitly identifying gays and transgender people as key populations.

The World Health Organization (WHO) explains that SRH services are not only family planning clinics with some treatment of sexually transmitted infections (WHO, 2017). The five core components of sexual and reproductive health care include the improvement of antenatal, perinatal, postpartum, and new-born care; provision of high-quality services for family planning, including infertility services; elimination of unsafe abortions; prevention and treatment of sexually transmitted infections, including HIV, reproductive tract infections cervical cancer, and other gynaecological morbidities and promotion of healthy sexuality. Sexuality is at the core of provision of SRH services, and all genders and sexual orientation should be considered.

In Zimbabwe, the 2018 Global AIDS Response Progress Reporting (GARPR) report showed that the epidemic in Zimbabwe is continually declining in new infection rates as well as AIDS related deaths

(Zimbabwe Ministry of Health, 2019). UNAIDS (2019) reported that Zimbabwe had 40,000 new HIV infections and 30,000 AIDS-related deaths. There were 1,3 million people living with HIV in 2019, among whom 75% were accessing antiretroviral therapy (ART). Among the key populations most affected by HIV in Zimbabwe were sex workers, with an HIV prevalence of 57% and prisoners, with an HIV prevalence of 28%, gays with a prevalence of around 18%. Since 2010, in Zimbabwe, new HIV infections have decreased by 49% and AIDS-related deaths have decreased by 45% (Avert, 2019).

The successes highlighted above have been realised through intervention programmes that discourage unprotected heterosexual sex which has traditionally been the major contributor to HIV infections in the country. Health access in Zimbabwe has traditionally been a high priority and large investments in the public health care sector in the 1980s led to impressive improvements in key health indicators. Provision of health care services is offered by government, church missions and other NGOs, industries and mines, private practitioners, and traditional healers. The services are well placed to cater for the general population but are not tailored to service the needs of the key population groups in the country (Hansen and Chapman, 2016). However, since the turn of the century, transmissions have shifted to key populations including among the LGBTIQ community and the macro-economic instability and structural adjustment programmes led to a serious erosion of the gains recorded in the health sector since the year 2000.

In Zimbabwe, just like anywhere else in the world, gays, including those who do not identify themselves as homosexual, and lesbians contribute to the spread of sexually transmitted infections, including HIV, yet the health needs of homosexual men and women are especially neglected since homosexuality is taboo or illegal. However, Zimbabwe cannot afford to continue this programmatic

path given that UNAIDS (2017) reported that there are now growing epidemics among key populations who are at higher risk of HIV.

South Africa and Zimbabwe both face a plethora of issues affecting KPs in relation to accessing SRH services. The issues relate to the policy and institutional framework for KPs, HIV knowledge and prevalence, sexual behaviour and associated risk factors, current responses to the HIV and SRH situation in terms of prevention, testing and treatment and general access to sexual and reproductive health services.

Against this background, this study examines the barriers and facilitating factors to access sexual and reproductive health services among key populations in two cities, Pretoria in South Africa and Bulawayo in Zimbabwe. The study explores the quality of the services and their alignment to the global recommended package of SRH services for gays and lesbians. The study also investigates how the current public health systems in Pretoria and Bulawayo can be improved to cater for gays and lesbians' sexual and reproductive health needs.

1.2 Statement of the Research Problem

There is a dearth of research about sexual and reproductive health (SRH) access and quality of care for key population communities in Southern Africa in general, and South Africa and Zimbabwe specifically. While there is some data on female sex workers (FSWs) in both countries, there is a stark paucity of data on men who have sex with men and women who have sex with women (Hivos, 2016). For example, there are no current or credible HIV prevalence rates data for gays and lesbians. In South Africa, key population (KP) organisations such as African Men for Sexual Health and Rights (AMSHeR) and the Gay and Lesbian Network have been spearheading some research efforts. In Zimbabwe, despite the hostile legal and policy environment against KPs, there is some fragmented research and data generation by Southern Africa AIDS Information Dissemination

Service (SAfAIDS) and the Gays and Lesbian Association of Zimbabwe (GALZ). However, all these research endeavours have not yet explored gays' and lesbians' access to sexual and reproductive health services. Neither have any of the research efforts attempted to understand the barriers faced by gays and lesbians as they seek key SRH services.

Despite evidence that same-sex sexualities are not only indigenous but also widespread in African contexts, same-sex sexualities are still widely perceived as '*unAfrican*'. In this context, gays are a 'hard-to-reach' population and are consequently thought of as epidemiologically invisible. In the context of a generalized epidemic where the primary mode of HIV transmission is heterosexual, HIV research in South Africa and Zimbabwe remains overwhelmingly heteronormative. There are a limited number of empirical studies in South Africa on HIV risk for LGBTIQ populations. Although there is now increasing attention given to LGBTIQ populations and HIV in South Africa, research remains largely concentrated on gays. Further research with lesbians is needed as the complexities of risks still need to be uncovered for this diverse population. Research with lesbians, bisexual, other queer folks as well as with transgender populations is especially needed as there is currently a huge gap in the HIV literature with respect to those at-risk populations.

Furthermore, the legal environment for the survival of key populations' networks and members (gays and lesbians) in South Africa and Zimbabwe has many obstacles. For example, the Sexual Offences Act of 2007 (South Africa) criminalises sex work, while a similar piece of legislation (Criminal Law Codification Act, 2007) criminalises same sex relationships in Zimbabwe. Sex workers, gays and lesbians' organizations often clash with law agencies while conducting their routine activities (GALZ, 2018). The 'heavy-handedness' of the law enforcement and security agents when dealing with key populations has led some to argue that different government institutions are working against each other. For example, in South Africa the Department of Health distributes

condoms among female sex workers (FSWs) while the South Africa Police Service (SAPS) confiscate the same condoms from them (Motana 2016). Similarly, Zimbabwe has no specific key population policies in place and its legal and national policy approach does not promote access to sexual and reproductive health (SRH) services by key populations such as gays and lesbians. Given this context and paucity of empirical evidence about gays and lesbians, this study therefore addresses a glaring knowledge gap through a comparative appraisal of the extent to which gays and lesbians access quality sexual and reproductive health services in Pretoria and Bulawayo. The study further explores the socio-economic, cultural, legal and political barriers that gays and lesbians encounter as they seek access to sexual and reproductive services.

1.3 Research Questions

The study answers the following questions:

1. To what extent do men who have sex with men (gays) and women who have sex with women (lesbians) access quality sexual and reproductive health services in Pretoria and Bulawayo?
2. What are the facilitators and barriers for accessing sexual and reproductive health services by gays and lesbians in Pretoria and Bulawayo?
3. How can the current public health systems in Pretoria and Bulawayo be improved to cater for gays and lesbians' sexual and reproductive health needs?

1.4 Research Aims and Objectives

Through a comparative lens, this study explores the extent to which gays and lesbians access quality sexual and reproductive health services in Pretoria and Bulawayo within the context of a public

health system. Its specific objectives are to:

- Understand the quality of sexual and reproductive health services accessed by men who have sex with men (gays) and women who have sex with women (lesbians) in Pretoria and Bulawayo
- Examine the barriers and facilitators for accessing sexual and reproductive health services by gays and lesbians in Pretoria and Bulawayo
- Explore how the current public health systems in Pretoria and Bulawayo can be improved to cater for gays and lesbians' sexual and reproductive health

1.5 Research Setting

Data collection was conducted in Bulawayo (Zimbabwe) and Pretoria (South Africa). South Africa is currently progressing towards becoming a flagship nation for key populations programming. The legislative environment and the policies in place are largely supportive of gays' and lesbians' activities; however the local level interventions and sexual and reproductive (SRH) services are yet to be fully aligned to the legal and policy provisions. Pretoria (as the capital) was chosen as the study site from which lessons can be drawn and recommendations made regarding gays' and lesbians' programming. Gauteng was ranked as the province with the highest number of networks for the LGBTIQ community and therefore Pretoria was selected on that basis (OUT Wellbeing, 2018).

On the other hand, Zimbabwe is one of the Southern African countries with very punitive and restrictive legislation regarding gay and lesbian programming and activities. The sentiment from the national to local levels is clear, that activities of gays and lesbians are not tolerated. Bulawayo is the second largest city in Zimbabwe and serves as a city in the transport corridor for tourists,

truck drivers and citizens travelling from the upper Southern African countries such as Zambia, the Democratic Republic of Congo, Angola through Bulawayo to Botswana, South Africa, Lesotho and Swaziland. In Zimbabwe, data from Population Services International (PSI), GALZ and Hivos indicated that the city had the highest population of the LGBTIQ members who accessed different SRH services that they provided (GALZ, 2018). PSI data also showed that Bulawayo had the highest number (12) of networks for gays and lesbians in Zimbabwe and therefore there was a high probability of reaching the target respondents in Bulawayo than any other city in the country. The legal environment between Bulawayo and Pretoria is different which makes it possible to understand the influence of different legal environments on the provision of SRH services for gays and lesbians. There are also cultural similarities between the two cities and the relatively short distance between them provides a level of similarity that makes for good comparative analysis. It was upon this basis that it was chosen as a study site to enable inter-city comparison of the issues of access to sexual and reproductive services by gays and lesbians.

1.6 Significance of the Study

This study adds to the growing body of knowledge on sexual and reproductive health services for gays and lesbians in Zimbabwe and South Africa. Theoretically grounded in the Health Belief Model (HBM) developed by Hochbaum (1958), modified by Rosenstock (1974) and Siddiqui (2016), the study's arguments make use of the six constructs namely risk susceptibility, risk severity, perceived benefits and barriers to action, self-efficacy and cue to action that the HBM postulates.

This study can be used to influence the review and implementation of new gays and lesbians policies and legislation in the two countries and as an advocacy tool benchmarked against the WHO guidelines on the comprehensive package of services for key populations. The empirical evidence

generated offers a practical guide on implementing KP appropriate SRH best practices for gay and lesbian programmes in Pretoria and Bulawayo.

Due to the similarities in the criminalization of gay and lesbian activities across most of the countries in Southern Africa, the study results have potential to inform and assist the rest of the countries understand the challenges and solutions to the issues surrounding access to sexual and reproductive health services for gays and lesbians. That way, the findings can be used to address the bottlenecks and barriers affecting access to SRH services and products while reinforcing the facilitating factors promoting access. Addressing these barriers will create a more conducive environment for gays and lesbians to access and utilise SRH services in the two cities without fear of stigma and discrimination.

The study seeks to promote the utilization of SRH services by gays and lesbians to contribute to the decline in the incidence and prevalence of HIV and STIs, cancers and alcohol and drug abuse going forward. This can be done through sustained health education to raise awareness and respect on the health, constitutional and policy rights of gays and lesbians and ensure enforcement of the same by public health and security officials.

for the study shed light on what public health authorities in Bulawayo and Pretoria can do to build upon the identified positive factors which facilitated access to SRH services and use of products such as condoms and lubricants. These include promoting the use of drop-in centres as one stop service delivery points for comprehensive SRH services required by gays and lesbians. Access to platforms for discussion of SRH issues with their social networks and KP community support systems motivate gays and lesbians and more community-based organizations or networks need to be established or strengthened to play this role. Networks facilitate easier mobilization of resources and can be utilized to implement comprehensive services for these key populations.

The study notes that the complementarity between static and outreach activities by civil society organizations (CSOs) such as Population Services International (PSI), Population Services Zimbabwe (PSZ), Society for Family Health (SFH), Gays and Lesbians Zimbabwe (GALZ), OUT Well Being and Health4Men should be strengthened in Bulawayo and Pretoria. The health ministries and the central government should actively support and strengthen the referral systems to ensure that the referral centres are fully functional. Linked to this, the CSOs need to ensure that their mobile outreach teams return to the communities for follow up and link the gays and lesbians to community-based support networks for continuum of health care.

Lastly, the study highlighted a combination of positive facilitators and positive behaviours by gays and lesbians in Bulawayo and Pretoria that can be supported to further promote the effective utilisation of SRH services.

1.7 Limitations of the Study

The study was conducted in two major cities in South Africa and Zimbabwe. While the study findings may be relevant in other cities of the study countries, the findings are largely applicable within the context of Pretoria and Bulawayo cities. The quality of SRH services accessible to KPs may be variable by location even within the same country therefore each unique geographical setting requires its own investigation.

The criminalisation of the sexual activities of gays and lesbians in both countries posed some protection challenges to the research subjects. Hence, some targeted persons could not freely participate in the focus group discussions and individual interviews for fear of victimisation after the research team had left. The use of well-trained research assistants and rapport established with KP network organisations in the two countries was crucial in ensuring their effective participation and addressed the safety concerns.

The study made use of non-probability sampling methods in the selection of target respondents due to the absence of a sampling frame. This is a limitation of the thesis as the findings may not be generalized beyond the study sites. The most ideal sampling method for the quantitative component would have been a probability-based sampling to enable generalisability, however, generalisability even within the cities may be a challenge because of the sampling method used. It was impossible to know how well the key populations were represented in the sample because of the absence of a master sampling framework, making the findings only applicable to the study sites and not beyond. However, the used of mixed methods and in-depth analysis of the SRH access and utilization issues by gays and lesbians make the findings very useful and critical to policymakers and future researchers who can adapt the methodology for other localities.

1.8 Synopsis of the Chapters

The study is organised into seven chapters and below is the synopsis of the chapters.

Chapter One: Introduction and Background

The introduction Chapter which has set out the research problem, justification of the study and outlined the aims and objectives of the study. The HIV and AIDS epidemic has had a devastating effect among population groups in South Africa and Zimbabwe. Key population groups have not been spared from the scourge with some isolated studies having noted higher rates of sexual infections, including HIV and AIDS, among key populations compared to the general population. Most conventional SRH and HIV-AIDS research has tended to focus primarily on heterosexual relations and barely on homosexual population groups. It is noted that the key population groups in both countries face several hurdles in accessing SRH services that include an unfavourable social and legal environment. The paucity of documented research work on the quality and accessibility of sexual and reproductive health services for key population groups, particularly gays and lesbians

warrants an in-depth assessment. This study examines the quality of SRH services accessed by gays and lesbians, assesses the barriers and facilitators for accessing quality SRH services and explores how public health systems in Bulawayo (Zimbabwe) and Pretoria (South Africa) can be improved for the benefit of gays and lesbians groups in the two countries.

Chapter Two: Literature Review

This chapter focuses on a review of literature pertinent to the study. The foregoing shows that South Africa's constitution is amenable to same sex relationships through the Bill of Rights which protects against all forms of sexual discrimination. However, reports of hate crimes, violence, and discrimination towards LGBTIQ people continue in South Africa, suggesting a disjuncture between legislation declaring the right to equality and the realities of everyday life. In Zimbabwe, although the constitution stipulates that no one should be discriminated or unfairly treated based on sex or gender, the experience of gays and lesbians shows that homosexuality is criminalised. The literature reveals higher STIs and HIV prevalence among KPs in both countries compared to the general population. Consequently, the health needs of gays and lesbians are often excluded from relevant policies and programmes. This often leads to stigma and discrimination when gays and lesbians attempt to access services from the public health facilities that serve the general population. The chapter also reviewed different interventions and health care challenges faced by gays and lesbians in the two countries and shows the gaps that exist in ensuring that the key populations access quality SRH services.

Chapter Three: Health Belief Model – A Theoretical Framework Appraisal

This chapter presents the study's theoretical framework. The theoretical issues surrounding access to quality health services reveals that services and products should be available, affordable, and

accessible provided in an effective, efficient, equitable, patient centred, safe and timely manner. The Chapter reviews four models of health systems frameworks namely descriptive, analytical, deterministic and the converged health systems framework and the Health Belief Model (HBM), developed by Hochbaum (1958), modified by Rosenstock (1974) and Siddiqui (2016) is the model of choice to understand the factors affecting access to health services by gays and lesbians in Bulawayo (Zimbabwe) and Pretoria (South Africa). The model argues that a person's belief in a personal threat of an illness or disease together with a person's belief in the effectiveness of the recommended health behaviour or action will predict the likelihood that the person will adopt the behaviour. The Chapter reviews the six constructs namely, risk susceptibility, risk severity, benefits to action, barriers to action, self-efficacy, and cues to action that describe how the model predicts health behaviour.

Chapter Four: Research Methodology

This chapter outlines the research methodology and explains and justifies the research methodology and data collection methods used in this study. The study used a mixed methods approach, as the research questions could only be meaningfully addressed using a mix of qualitative and quantitative methods. The key data collection methods used in the study include the survey questionnaire, key informant interviews, and focus group discussions. Purposive sampling, time-location sampling and snowball sampling methods were used to reach the required sample sizes; 194 in Bulawayo and 193 in Pretoria. A total of eight FGDs were conducted, and 30 key informants were interviewed, 15 each in Bulawayo and Pretoria. The study adopted sound research practices during the preparation and execution of the data collection process, firstly by ensuring that ethical approval was granted, by the University of Fort Hare's Research Ethics Committee (Certificate Number: MOYO11SJAS01) and the local administrators and health directors in the two cities gave

permission to undertake the study. At each study site, the same approval processes were followed, and all the respondents participated after fully understanding the importance of the study. The researcher ensured that the whole study process considered all the international benchmarks of sound and ethical research practices.

Chapters Five: Access to Quality Sexual and Reproductive Health Services

This chapter describes the study findings regarding access to quality SRH services for gays and lesbians in Bulawayo and Pretoria. Grounded in the Health Belief Model developed by Hochbaum (1958) and modified by Rosenstock (1974) and Siddiqui (2016), the Chapter answers two key questions about the extent to which gays and lesbians access quality SRH services and the facilitators and barriers for accessing the same in the two cities. The findings show that despite availability of health products, services and associated programmes to enhance access to health services by gays and lesbians, use of condoms and preferred lubricants is low partly due to the low-risk perceptions among the respondents. Several barriers are cited which include the unavailability of preferred affordable condoms and lubricants for gays and user-friendly types of condoms such as dental dams and latex gloves for lesbians. Distances to drop-in centres, which provide services in an environment that is comfortable to gays and lesbians, is another barrier mentioned. The study shows that there is a high-level use of water-based lubricant amongst gays and lesbians in the two cities as there is high risk susceptibility to developing bruises if lubricants are not used. However, the public health system in both cities does not supply lubricants to the community level where they are required, a barrier that needs to be looked at focusing on improving the supply chain to the last mile. The Chapter also reveals that regarding coverage of SRH services, commonly known and available services by most gays and lesbians in Bulawayo and Pretoria are contraceptive services, STI services, HIV and general counselling services. Stigma, discrimination and abuse by the

societies and health care workers against gays and lesbians in the two cities comes out strongly in this Chapter with the major recommendation that healthcare workers should be retrained on responding to the needs of key populations according to the WHO guidelines which encourages sensitivity and non-judgemental approaches.

Chapter Six: Public Health Systems Limitations: Pathways for Adjustments

This chapter answers the study's third question which is to explore ways that the current health systems in Bulawayo and Pretoria could be improved to meet the SRH needs of gays and lesbians. The study explored the public health, socio-economic, legal and policy barriers that gays and lesbians encounter as they seek to access sexual and reproductive health services, summarized the different limitations and the possible strategies that different stakeholders can implement to improve health systems to effectively provide quality SRH services to gays and lesbians in Pretoria and Bulawayo. The analysis was guided by the Health Belief Model (HBM) as postulated by Hochbaum (1958) and modified by Rosenstock (1974) and Siddiqui (2016) to understand the barriers, facilitators and the limitations affecting access to SRH services. The study finds that there is a gap between policy and implementation in both cities. For example, in Zimbabwe, the criminalization of homosexuality forces gays and lesbians to use underground methods to acquire some of the products such as lubricants from pharmacies and services they require as their cues to action. Gaps identified also include the quality of the SRH services, the poor state of public health facilities and the absence of comprehensive services in both cities but are more prominent in Bulawayo than in Pretoria. The use of the HBM revealed that five of the six constructs are applicable to the findings of the study. These are risk susceptibility, perceived barriers, perceived benefits, self-efficacy and cues to action which were used to explain the limitations and the facilitators of the public health systems in Bulawayo and Pretoria. The final construct, perceived severity, is less

applicable as most of the respondents do not regard the seriousness and dire consequences of contracting illnesses such as STIs and HIV.

Chapter Seven: Conclusions and Recommendations

This is the last chapter of the study which provides key conclusions and recommendations arising from the study. To address the gaps and limitations discussed in Chapter Six, various strategies have been proposed. Firstly, it is recommended that the Ministries of Health need to include SRH products such as lubricants, dental dams and latex gloves in their basket of the products transmitted through the delivery system to reach all public health facilities in the two cities. Secondly, the healthcare workers need further information, mentoring and training on implementing the WHO guidelines on provision of comprehensive services for key populations, including gays and lesbians to ensure that they discharge their duties without prejudices in a stigma free environment. Thirdly, promoting equal access to health services in national policies and legislation and strengthening universal comprehensive social protection policies, including health promotion and health care should be prioritized by both state and non-state actors. Fourthly, public health facilities need to be continuously upgraded and maintained to ensure that the standards are not deteriorating and act as barriers to gays and lesbians intending to utilize them. The chapter also discusses the need to strengthen gays' and lesbians' networks and platforms that disseminate tailored messages to address their SRH issues, and CSOs and public health facilities to adopt the model of drop-in centers in Pretoria which provide a one stop center for all SRH services and products. The chapter concludes by highlighting some interesting areas that require further research that were identified in the execution of this study.

Chapter Two

Literature Review

2.1 Introduction

Despite being neglected within the Millennium Development Goals (MDGs) in 2000, sexual and reproductive health (SRH) was included in the Sustainable Development Goals (SDGs) from 2015. Unsafe sex is the second most critical risk factor for disability and death in the world's poorest communities and the ninth most important in developed countries (WHO, 2016). Sexual and reproductive health services for vulnerable groups such as key populations are not available or are of poor quality and underutilized in many countries because sexual intercourse and sexuality issues are not discussed in communities and families.

In 1994, the Cairo Conference defined reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people can have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant," (WHO, 2016)

Sexual and reproductive health services are not only family planning clinics with treatment of sexually transmitted infections. The core areas of sexual and reproductive health care are:

improvement of antenatal, perinatal, postpartum, and newborn care; provision of high-quality services for family planning, including infertility services; elimination of unsafe abortions; prevention and treatment of sexually transmitted infections, including HIV, reproductive tract infections, cervical cancer, and other gynecological morbidities; and promotion of healthy sexuality, regardless of sexual orientation of individuals. The WHO (2016) also defines sexual health as a state of physical, emotional, mental, and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health needs a positive and respectful approach to sexuality and sexual relationships, and the possibility of having pleasurable and safe sexual experiences that are free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all individuals must be respected, protected, and satisfied.

The United Nations Office of the High Commissioner for Human Rights (2012) identified five key state obligations to prevent and address human rights violations related to sexual orientation and gender identity. These relate to the (i) protection of individuals from violence LGBTIQ people, (ii) prevention of torture and cruel, inhuman and degrading treatment of LGBTIQ people, (iii) repealing laws criminalizing homosexuality and cross-dressing, (iv) prohibition of discrimination based on sexual orientation and gender identity and (v) safeguarding freedom of expression, association and peaceful assembly for all LGBTIQ people (UN, 2012).

Having access to the highest attainable health is a human right and not being discriminated by the state on grounds of sexual orientation in relation to health and health determinants is also a right, as it is to have access to services and information (UNDP, 2017). A few countries have started to abolish discriminating judicial systems and laws in these countries no longer reward privileges only to heterosexual couples when it comes to the possibility of forming families. Protection against

state and civil discrimination is guaranteed while in most countries, work of this nature has not progressed very far.

In South Africa, the legal environment is amenable to same-sex relationships and the constitution of South Africa, through the bill of rights, offers protection against all forms of sexual discrimination. Section 9 of the Constitution prohibits discrimination on the grounds of gender, sex, and sexual orientation and South Africa was the fifth country in the world and the first in Africa to legalize same sex marriage in 2006. Under the bill of rights, LGBTIQ people have visibility and protection in South Africa compared to many other countries around the world. These laws pronounce the rights of different key population (KP) groups and how these must be observed always. Many of South Africa's national policies place an emphasis on social justice and equity for all, regardless of sexual orientation and choices of safer sexual behaviours (Rispel et al 2011). Such national policies include the National HIV Counselling and Testing (HCT) Policy Guidelines and Ethical Guidelines for Good Practice regarding HIV (van Dyk 2012).

The Constitution of Zimbabwe views all nationals as equal and protected by the law and this provision is outlined in section 56 of the Constitution which states that "all persons are equal before the law and have the right to equal protection and benefit of the law". Even though the Constitution makes it clear that no one should be discriminated or unfairly treated because of their sex or gender, the reality and lived experiences of LGBTIQ people are different from what the Constitution guarantees them on paper. For example, sexual activities between men are criminalised under section 73 of the Criminal Code and Reform Act, 2006 (Chapter 9 and 23). LGBTIQ people in Zimbabwe are exposed to discrimination and their freedoms are limited and under this prevailing societal environment, state led HIV and AIDS programming for KPs is difficult to roll-out as it could be taken as reflecting endorsement.

Secondary data in the two countries shows that key populations have higher HIV prevalence rates compared to the general population. Jin H et al (2021) mentioned that across Africa, the HIV epidemic is most severe among key populations including women and men who sell or trade sex, men who have sex with men, people who inject drugs, transgender women who have sex with men and prisoners and detainees. These groups account for most new infections in West and Central Africa, and an estimated 25% of new infections in East and Southern Africa, despite representing relatively small proportions of those populations. In Zimbabwe, data shows that comprehensive knowledge about HIV prevention is generally low among gays and lesbians because existing HIV education and information sharing services do not seem to address the specific needs of gay and lesbian communities (NAC, 2016). Many current SRH information dissemination programmes focus more on heteronormative sexual partnerships and less on homosexual partnerships. The openly anti-homosexual legal environment and policy hostility in Zimbabwe and often in South Africa negatively affects the provision of SRH awareness, prevention and treatment services 'tailor-made' for the specific needs of KPs (Cowan, 2013).

UNAIDS (2016) acknowledged that if men who have sex with men (MSM) and transgender people are not treated as equals and do not have access to SRH services, it will be difficult to get to zero new HIV infections, an important target in the HIV response. South Africa and Zimbabwe must prioritize these vulnerable groups in health guidelines, strategies, and policies at national, regional and community levels and chief among these is tackling homophobia and transphobia. Stone et al (2021) indicated that in generalized epidemic settings, there is insufficient understanding of how the unmet HIV prevention and treatment needs of key populations, such as sex workers, gays and lesbians contribute to HIV transmission. In such settings, it is typically assumed that HIV

transmission is driven by the general population, yet evidence shows that the key populations play a significant role.

2.2 Health Issues Faced by Gays and Lesbians

Considerable evidence exists that gays and lesbians experience worse health disparities and outcomes than heterosexuals in every country in the world (Muller, 2017). According to Daly (2015), these include higher rates of depression, anxiety, smoking, alcohol abuse, substance abuse, suicide, and suicidal ideation because of chronic stress, social isolation, and disconnectedness from a range of health and support services. Gays and lesbians generally use preventive health services less frequently than heterosexual women and are at greater risk of obesity, cervical, penile, anal and breast cancers, HIV and other STIs, including viral hepatitis. Inadequate support from families or communities' drives LGBTIQ youths to more likely be homeless, which results in other social and health problems (Duby, 2018).

Key populations have specific needs which require adequate and holistic societal responses (WHO, 2017). Gays and lesbians are more vulnerable to health challenges such as sexually transmitted infections, tobacco and drug abuse and mental health disorders than their heterosexual counterparts. If the needs of key populations remain unmet, society cannot guarantee the realization of the universal right to health and health care by members of gender and sexual minorities (Avert, 2019). Members of sexual minorities have specific needs because their sexual practices and lifestyles are perceived as deviant acts from normal sexual expression, which privilege heterosexuality as the dominant pattern of sexual orientation. Heterosexuality rests on heteronormative assumptions that define gender relations and identities (Albuquerque et al (2016). Mukandavire et al (2018) concluded in a study in Senegal that unprotected sex between men may be an important contributor to HIV transmission in Dakar, due to suboptimal coverage of

evidence-informed interventions. Even though existing interventions have effectively reduced HIV transmission among adults, it is crucial that further strategies address the unmet need among MSM.

There is a lack of knowledge around the issues faced by gays and lesbians in South Africa and this makes it difficult for them to disclose their sexuality to healthcare workers and get the healthcare they need (Avert, 2019). In 2017, the South African government released a national LGBTIQ HIV strategy which recognised that these groups have specific needs that were overlooked in the past. Among the recommendations made in this strategy was increasing the availability of lubricants for the LGBTIQ people and providing them with pre-exposure prophylaxis (PrEP) to protect them from infection (Avert, 2019). Sullivan et al (2020) noted in a study conducted in South Africa that where PrEP uptake was high, the observed incidence of HIV in those who started PrEP was about half the incidence in those who did not and there was need to focus on decisions to start and continue PrEP for those at highest risk, including young gays and lesbians.

In 2016, the Avert reported that nearly one-third of gays population at the time were living with HIV and not yet on care and treatment. Stigma and discrimination, including in health care settings, violence and other human rights abuses were common experiences of gays and lesbians. Differential vulnerability, exposure and consequences of HIV infection and STIs were linked to the social determinants of HIV, including social and cultural norms, high-risk sexual practices and limited access to appropriate, targeted SRH interventions and these contribute to the concentrated epidemics within South Africa's generalized HIV epidemic.

Consequently, while heteronormative behaviours overlap practices of homosexual expression, sexual minority groups continue to experience discrimination, stigmatization and exclusion from workspaces, domestic settings, and other spheres of life (Hivos, 2016). These are some of the

barriers that exist at different levels, which negatively impact on the demand and uptake of health services and support by members of the sexual minorities. The right to quality health and health care will remain an ideal for members of the sexual minorities unless their specific needs are addressed in a holistic and adequate manner. In a study assessing access of SRH services by key populations in Uganda, Nakanwagi (2016) found that facilitators for linkage to HIV care included the perceived good quality of health services with same day results and immediate initiation of treatment, community peer support systems, individual's need to remain healthy, and having alternative sources of income. Linkage barriers included perceived stigma, fear to be seen at outreach HIV clinics, fear and myths about antiretroviral therapy, lack of time to attend clinic, and financial constraints.

Recent research shows that globally, HIV prevalence among lesbians is 3.5 times higher than that of women aged 15–49 years. Even in countries with a generalised epidemic, the HIV prevalence among gays and lesbians is much higher than among the general population. Similarly, gays are 19 times more likely to be living with HIV than the general population and the incidence of HIV among gays is rising in several parts of the world (Avert, 2019). In Zimbabwe there is no credible nationally representative data on the HIV and AIDS epidemic among gays and lesbians. The Zimbabwe Government through the Zimbabwe National AIDS Strategic Plan (ZNASP) III acknowledged this data gap as it noted that: "there are currently no local data on the population size estimate or HIV prevalence among gays and lesbians in Zimbabwe" (GoZ, 2015:26). This paucity of data is a result of a restrictive policy and legal environment that reigns in Zimbabwe which makes research among this group problematic as discussed further.

2.2.1 Understanding Barriers and Facilitators for Accessing Health Services

There have been some theories that have attempted to explain the issues surrounding health care challenges faced by gays and lesbians. The Minority Stress Model (Meyer, 2003) posits that members of the sexual minorities experience severe stress related to the stigmatization and discrimination they suffer with undesirable impacts on health. Being a member of a minority group results in stress because one tries too hard to prove oneself and one's identity. Members of gender and sexual minority groups have internalised stigma which society directs at them, and they experience fear even as they expect rejection (Scarinci et al., 2012). This means that homosexual people internalise homophobia and stigma which leads to stress-related health problems such as depression and other mental health disorders. These conditions of living with stress may be connected to low demand and uptake of health services by members of the sexual minority population groups.

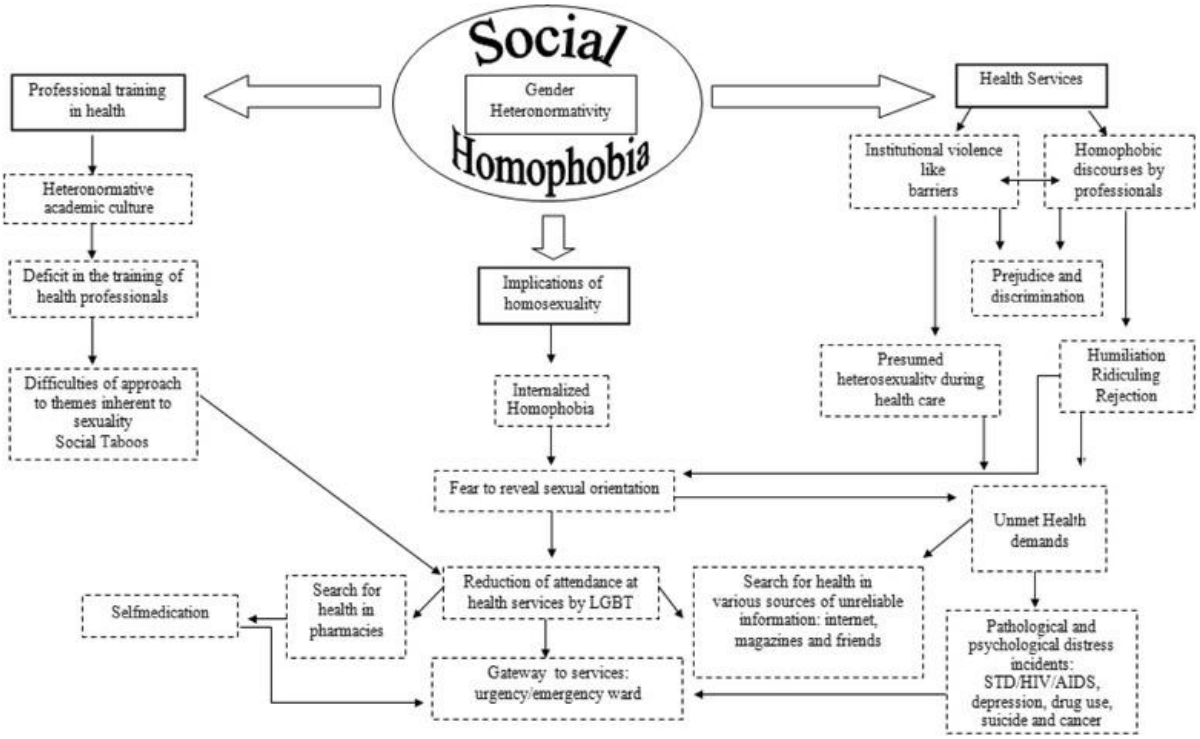
The second theory is the Social Ecology Model (Bronfenbrenner, 1979) which complements the Minority Stress Model in that it underscores the interactional nature of social behaviour. It proposes that there is a bi-directional relationship between social collectives and the broader environment. The behaviour of a social group does influence the environment and is, in turn, influenced by it. Social structures such as family, religion and education are affected by sexual minority groups, and they also affect gender and sexual minority groups through various social arrangements that not only shape access to health care but also the realisation of the universal right to health. Bronfenbrenner (1979) noted that the Social Ecology Model has been used to conceptualise low demand of services among sex workers and non-heterosexual minorities.

The Model of Barriers to Health Access by Sexual Minorities (Albuquerque et al, 2016) was formulated after a thorough systematic literature review of access to health services by members

of the LGBTIQ community. They used the findings to generate a hybrid model to demonstrate ‘‘how identities and cultural and social arrangements influence the access to health care, status results of sexual minorities” (Albuquerque et al., 2016).

The framework conceptualises that multi-level barriers stem from heteronormative assumptions that privilege heterosexuality as the dominant sexual orientation. It conceptualises three main barriers to desirable health access and health status namely, implications of homosexuality, professional training in health and health services. The three main barriers result in unmet demand for health services manifested as diminished uptake of health services, use of unreliable sources of health information, over-reliance on the pharmacy and use of emergency medical services as a gateway to healthcare. The model is presented in Fig 1 below.

Figure 1: Model of Barriers to Health Access by Sexual Minorities by Albuquerque et al (2016)



The model helps to conceptualise barriers that affect access to health services and health care by members of the sexual minorities on various levels. On the micro-level, the model frames some of

the main internal barriers (psychological factors such as internalised homophobia and stigmatization and fear of disclosure) that negatively affect access to health and health care leading to unmet health needs. The model conceptualises the structural factors that impacts negatively on access to health by members of gender and sexual minorities. For example, the way in which health services are packaged and delivered such as the presumption that health care clients are heterosexual, is an aspect of institutionalised violence. Albuquerque et al (2016) mentioned that since it is built into the system, institutionalised violence is manifested as everyday prejudicial and discriminatory practices by health care workers which results in humiliation, ridiculing and rejection of members of gender and sexual minorities. Consequently, members of sexual minorities remain with unmet health needs due to institutionalised violence and the behaviours of health care professionals.

Heteronormative social constructions directly influence professional training of health staff which, in turn, encourages the reduction of attendance at health services by members of sexual minorities. The model conceptualises that the training of health care workers results in a reduction of attendance by key populations because it is grounded in heteronormative academic culture. This falls short on sexual themes required to guarantee the universal health right of the target population (Chersich et al., 2018).

Albuquerque et al (2016) argued that diminished attendance at health services by key populations cause them to seek health information from unreliable sources such as partners, networks and the internet. There is also an over-reliance on the pharmacies and self-medication that dominates their health seeking behaviour. Members of key populations procrastinate the visit to the health care facility until the health problem requires emergency attention. Additionally, unmet health demands

that result from structural barriers tend to increase psychological distress incidence, mental health problems, and sexually transmitted infections including HIV.

However, this model falls short in that it focuses more on exogenous factors to explain access to health services, with a strong bias against healthcare workers' training. The internal factors that relate to key populations' own prejudices, knowledge, attitude, beliefs and practices and their interactions within their network are not adequately captured in the theory (Chersich et al., 2018).

The final model that will be reviewed under this study is the Health Belief Model (HBM) to understand the factors affecting access to health services by gays and lesbians in Pretoria and Bulawayo. The HBM was developed in the early 1950s by social scientists at the United States (US) Public Health Service to understand the failure of people to adopt disease prevention strategies or screening tests for the early detection of disease (Siddiqui, 2016). The HBM suggests that a person's belief in a personal threat of an illness or disease together with a person's belief in the effectiveness of the recommended health behaviour or action will predict the likelihood the person will adopt the behaviour (Hochbaum, 1958).

The model was originally formulated to understand the adoption of preventive health behaviours in the United States of America (USA) and was differently adapted to fit diverse cultural and topical contexts (Griffin, 2012; Scarinci et al., 2012). The HBM was based on efforts to integrate stimulus-response theory with cognitive theory in explaining human behaviour. Influenced by Kurt Lewin's theories that perceptions of reality and not objective reality influence human behaviour, the HBM postulated that health behaviours are influenced by a person's desire to avoid illness or to get well, and by their confidence that the recommended action will achieve this. This approach was an extension of the descriptive models of associating health behaviours with demographic factors and acknowledged the role of personal attributes and perceptions (Gulliford et al, 2002).

As one of the most widely applied theories of health behaviour (Glanz & Bishop, 2010), the Health Belief Model (HBM) posits that six constructs predict health behaviour. These are risk susceptibility, risk severity, benefits to action, barriers to action, self-efficacy and cues to action (Becker, 1974; Champion & Skinner, 2008; Rosenstock, 1974). This means that the probability that an individual will adopt a preventive behaviour is influenced by evaluating the costs and benefits of the action and the balance between these two influences the person's likelihood of acting and their preferred course of action. The model explains that when a person is motivated and perceives a beneficial action to take, actual change occurs when some external or internal cue such as a change in their health status, doctor's advice, or a loved one's illness or death forces them to act.

Siddiqui (2016) further elaborated that the HBM derives from psychological and behavioural theory with the foundation that the two components of health-related behaviour are: 1) the desire to avoid illness, or conversely get well if already ill; and 2) the belief that a specific health action will prevent, or cure illness. This model will be utilized in analysing the access of SRH issues by gays and lesbians in Bulawayo and Pretoria and therefore will be reviewed in detail in Chapter Three.

2.3 Context of Health Access by Gays and Lesbians in South Africa

South Africa is a populous country with 58.8 million people and a growth rate of 1.4% per annum (STATSSA, 2020). According to Avert (2019), South Africa was experiencing a concentrated HIV epidemic among key populations including gays and lesbians. There were no indications of stabilization of this epidemic in the general population as most indicators showed an advancing epidemic, with HIV prevalence estimates among population sub-groups of between 13-49% and 240,000 new infections per year. The country has high levels of self-reported STI symptoms, with over one-third of men who have sex with men (MSM) surveyed in 2017 reporting recent symptoms of one or two STIs (Avert, 2019).

Gays and lesbians had several behavioural risk factors such as inconsistent condom use, despite high use of condom-compatible lubrication within their communities. Heavy alcohol use was common among them with Illegal substance use, including cannabis (dagga), methamphetamine and other stimulants. Such substances were used during sexual encounters and are likely to increase the frequency of high-risk sexual practices (Avert, 2019).

South Africa National AIDS Council, SANAC, (2017) estimated that 18.1% of gays in South Africa were living with HIV. This varies considerably between urban and rural areas and according to socio-economic status. The Human Sciences Research Council's Marang Men's Study found HIV prevalence among gays of 22.3% in Cape Town, 48.2% in Durban and 26.8% in Johannesburg (HSRC, 2017). Despite a constitution that protects the rights of LGBTIQ communities, many gays and lesbians face high levels of social stigma and homophobic violence because of traditional and conservative attitudes. One study found that 24.5% of gays in Cape Town reported experiencing at least one human rights violation in their lifetime (SANAC, 2017)

There is lack of knowledge around the issues faced by gays and lesbians in South Africa and this makes it difficult for them to disclose their sexuality to healthcare workers and get the healthcare they need (Avert, 2019). In 2017, the South African government released a national LGBTIQ HIV strategy which recognised that these groups have specific needs that were overlooked in the past. Among the recommendations made in this strategy was increasing the availability of lubricants for the LGBTIQ and providing them with pre-exposure prophylaxis (PrEP) to protect them from HIV infection (Avert, 2019). Pettifor et al (2015) argued that PrEP could offer a highly effective, time-limited primary prevention for young key populations if it is implemented in combination with other programs to increase access to health services and encourage the reliable use of PrEP to those who are at risk of HIV exposure.

However, reports of hate crimes, violence and discrimination towards LGBTIQ people remain persistent suggesting a disjuncture between legislation declaring the right to equality and the realities of everyday life (SANAC, 2017). There is evidence of socio-cultural and structural risk factors that play a role in increasing HIV risk for gays, lesbians, and other members of the LGBTI community. This places gays, lesbians and other key population groups at a higher risk for HIV infection because of individual level risks such as unprotected anal intercourse (UAI), having multiple sexual partners and drug use and abuse (SANAC, 2017).

There is also a widespread misconception that lesbian, bisexual and other key populations are not at risk of HIV and other STIs and such misconceptions are held not only by the public but even by healthcare providers and lesbians themselves and this myth is reinforced by policies and programs that continue to exclude lesbians from any form of interventions (Avert, 2018). For example, although the terminology “lesbians” is defined in the South African National Strategic Plan (NSP) on HIV, STIs and TB (2017-2021), lesbians are not identified as a population at risk of HIV and other STIs. Due to misconceptions that lesbians are not at risk of HIV or other STIs, many may not practice safer sex strategies or have knowledge about barrier methods (SANDH, 2011).

Lesbians have been found to be more likely to have high risk partners, including gays and intravenous drug users (IDUs), compared to women who had never had sex with other women (WHO, 2019). A study by Sandfort et al (2013) showed that lesbians are at high risk of violence (including sexual violence and rape), discrimination, and substance use which can augment risk of HIV infection. In South Africa, homophobic and transphobic sexual violence targeted at lesbian, bisexual and other KPs, as well as toward transgender populations (colloquially referred to as “corrective rape”) is an especially concerning risk factor (Sandfort et al, 2013).

Transgender women have long been known to be at especially high risk for HIV infection and transmission (Rispel et al, 2011). The high risk of infection is driven in part by frequently reported engagement in unprotected receptive anal intercourse with cisgender men. Because of this shared biological risk, in the past transgender women have been subsumed under the category gays. However, transgender women have specific needs and risk factors different from gays. Lack of data on the HIV, health and sexuality issues among transgender women remains a challenge. In a systematic review and meta-analysis, HIV data on transgender women were only available for countries with HIV epidemics concentrated among gays, including the United States, six Asia-Pacific countries, five Latin American countries, and three European countries (WHO, 2017).

Ricardo et al (2015) mentioned that in addition to biological and behavioural risk factors, widespread homophobia and heterosexism, as well as transphobia and cissexism, marginalizes gays, lesbians and other LGBTIQ populations across the world but mainly in Africa. This social vulnerability can increase risk for HIV and other STIs and compromise access to quality SRH services. It is well-documented that social exclusion and stigmatization increase vulnerability to ill health in a variety of ways, such as by increasing risk-taking behaviour or by being targeted for physical or sexual violence and by negatively impacting mental health.

Sexual identity and behaviour are complex and gays, lesbians, and LGBTIQ populations are diverse. HIV and STIs risks overlap between LGBTIQ populations and the general heterosexual population, as some heterosexual-identified individuals engage in same-sex sexual practices and some LGBTIQ identified individuals engage in heterosexual practices (Daly, 2015). Inequalities of sexuality and gender identity are compounded by intersecting inequalities such as race, class, and ability, all of which can complicate risk to HIV and STIs. The Health Systems Trust (2016) indicated that to appropriately manage the HIV epidemic, the research agenda, sub-Saharan countries should

address the SRH risks and needs of LGBTIQ populations, and not only HIV within the general heterosexual cisgender population. Research among and with LGBTIQ populations is necessary to appropriately inform HIV prevention policies, strategies, and programs.

Although the HIV epidemic among key populations such as sex workers and LGBTIQ community members in South Africa preceded the onset of the generalised HIV epidemic by several years, current policies and programmes focus on heterosexual transmission and mother-to-child transmission. A study by Butler and Astbury (2005) which used an adaptation of the UNAIDS Country Harmonised Alignment Tool (CHAT) to assess whether existing HIV policies and programmes in South Africa address the needs of gays revealed that current policies and programmes are unresponsive to the needs of gays and that epidemiologic information is lacking, despite policy on gays in the National Strategic Plan (SANAC, 2017). The study covered mapping of key risk factors and epidemiology of HIV among gays, participation of gays in the HIV response, and an enabling environment for service provision, funding and human resources and recommended sentinel surveillance to determine HIV prevalence among gays, social science research on the contexts of HIV transmission among gays, and appropriate HIV prevention and care strategies.

Despite a liberal legal and policy environment, there is still some social and cultural resistance to KPs among some sections of the South African population. Many among the general population still struggle to accept the sexual orientation and reproductive health choices of KPs. For example, in a 2013 study by the Pew Research Centre, 61% of respondents maintained that homosexuality should not be accepted in South African society (Poteat et al, 2017). Furthermore, while gays and lesbians enjoy a favourable legal environment in South Africa, the same cannot be said about sex workers. A study among gays in rural Limpopo Province assessed perceptions of HIV risk among gays. Using thematic analysis of interview and discussion data, two overarching global themes that

encapsulated participants' understandings of HIV risk and the HIV risk environment in their communities were developed. In the first theme, "community experience and the rural social environment", factors affecting HIV risk within the broad risk environment were discussed. The second global theme, "HIV/AIDS knowledge, risk and experience", focused on factors more immediately affecting HIV transmission risk. The exploratory results suggested that rural South African gays, like their urban and peri-urban counterparts, are at high risk of contracting HIV due to compromised access to health care services (Muller, 2017).

2.3.1 South Africa's Health System and Services for Key Populations

At independence in 1994, South Africa inherited a highly fragmented health system, with separate public and private health sectors and a multiplicity of health departments in the public sector. While public sector health services had been officially desegregated in 1988, historically 'black' health care facilities and the 'homelands' health departments had been systematically underfunded during the apartheid era (Di McIntyre and John Ataguba, 2017). The health system was not only fragmented but had large disparities in resource distribution between geographic areas and between individual facilities within the public sector. To address the situation, a range of legislation and policies have been introduced. These include the National Health Act 61 of 2003 and National Health Amendment Act 12 of 2013. The Act addresses the rights and duties of health personnel and service users (SANAC, 2017).

The National Health Act of 2003 mandates the Department of Health to provide a framework for a structured and uniform health system for South Africa. The Department directly contributes to Outcome 2 *(A long and healthy life for all South Africans)* of the government's 2014-2019 Medium Term Strategic Framework. The department focuses on sustainably expanding HIV and AIDS treatment and prevention, revitalising public health care facilities and ensuring the provision of

specialised tertiary health services. The Bill of Rights in Section 27 of the Constitution states that access to health care is a basic human right.

South Africa signed up to the Joint United Nations Programme on HIV and AIDS targets of reaching 90-90-90 for HIV by December 2020. This means the Department must find 90% of those that are HIV positive, initiate 90% of these on treatment and ensure that 90% of those on ARVs are virally suppressed (Avert, 2018).

2.3.2 Rights, Policies and Legislation Governing Homosexuality

The constitution of South Africa, through the Bill of Rights, offers protection against all forms of sexual discrimination (Ricardo et al 2015). This legal recognition and protection is enunciated in different Acts of Parliament. These laws pronounce the rights of different KP groups and how these must be observed always.

Over the years, there have been policy shifts to include LGBTIQ-related health concerns into some South African healthcare policy recommendations. For instance, following extensive lobbying by transgender organisations and individuals, transgender people were identified as one of the most-at-risk populations in the 2012–2016 National Strategic Plan for HIV, STIs and TB [SANAC, 2017).

Given this enabling policy and legal environment, South Africa is thus at the forefront of respecting and protecting the rights of different key populations in Southern Africa. Furthermore, many of South Africa's national policies place emphasis on social justice and equity for all, regardless of sexual orientation and reproductive health choices. Such national policies include but are not limited to the National HIV Counselling and Testing (HCT) Policy Guidelines, and Ethical Guidelines for Good Practice regarding HIV (van Dyk 2012).

However, even with such a liberal legal and policy environment, there is still some social and cultural resistance to KPs among some sections of the South African population. Many among the general population still struggle to accept the sexual orientation and reproductive health choices of KPs. For example, in a 2013 study by the Pew Research Centre, 61% of respondents maintained that homosexuality should not be accepted in South African society (SANAC, 2017). Furthermore, while gays and lesbians enjoy a favourable legal environment in South Africa, significant proportions of them experienced human rights violations and violence across the country. Between 10-20% of gays in Johannesburg and Cape Town, and 35% in KwaZulu-Natal and Eastern Cape experienced sexual violence at some point after they disclosed that they were gay (SANAC, 2017).

The legal environment for gay or lesbian sex work in South Africa has many obstacles. For example, the Sexual Offences Act of 2007 criminalises any form of sex work. Gay and lesbian sex workers often clash with law enforcement officers while doing their work on the streets and there are reports that some police officers abuse them (Women's Legal Centre, 2012). The 'heavy-handedness' of the police when dealing with these groups has led some to argue that different government institutions are working against each other since the Department of Health distributes condoms among the LGBTIQ while the police confiscate the same condoms from them (Motana, 2016).

However, gay and lesbian sex workers' right to work is not being totally ignored in South Africa. There are calls to decriminalise sex work to reduce the sex workers' vulnerability to HIV and other STIs given that some are excluded from health services owing to their profession (Motana, 2016). Furthermore, civil society organisations such as Sex Workers Education and Advocacy Taskforce (SWEAT) continue to advocate for the rights of sex workers (Avert, 2018).

From the foregoing, South Africa has liberal laws and national policies that emphasize equality and equity regardless of sexual orientation and reproductive health choices. The country has potential to be a trendsetter in Africa with regards to KP rights and the equitable provision and access to HIV prevention and treatment services by LGBTIQ individuals (Hivos, 2016).

South Africa adopted several international human rights and HIV declarations and commitments that recognize the rights of the LGBTIQ, their unique vulnerability to HIV and the need for focused interventions. These commitments are reflected in South Africa's legal framework and policies, including the South African Constitution and the National Strategic Plan on HIV/AIDS, STIs and TB (2017-2021). There has been commitment and increased collaboration between SANAC, the Department of Health (DOH) and civil society organizations to implement LGBTIQ-related policy. In 2014, the DOH developed a Framework for HIV, STI and TB Programmes for Key Populations which included gays and lesbians-specific interventions including HIV prevention, treatment, care and support, peer groups formation, access to condoms and lubricants, contraceptives and other SRH services (SANAC, 2017).

Research led by an LGBTIQ organization, AMSHeR, found that there is need to strengthen the legal and policy environments for reducing HIV risk and improve sexual and reproductive health (SRH) for young key populations in eight countries in Africa, including South Africa (Gender Dynamix, 2013). Evidence from the study showed that the capacity of national governments to put in place HIV/SRH-related legal, policy and strategy environments that respect the rights of young key populations was compromised (Hivos, 2016)

2.3.3 Programmes and Access Issues for Gays and Lesbians

The civil society sector in South Africa pioneered the policy revisions and subsequent programming for LGBTIQ interventions in the country. Civil society organizations in Pretoria and Cape Town have

been providing SRH and related services to gays and lesbians for over 15 years (UCSF, 2015). Several organizations were established across the country and initiated health service provision, funded largely by bilateral and multilateral donors. Gap analyses conducted in 2009, 2011 and 2013 highlighted the need for increased government support and increased coverage of LGBTIQ-focused services beyond the three major metropolitan areas (SANAC, 2017). Government funding for LGBTIQ related support has been increasing, through its High Transmission Areas Programme. These programmes are not only LGBTIQ specific but include young women, sex workers, small scale miners and other populations at high risk of HIV infections and other STIs.

The government through the SANAC has improved funding for the LGBTIQ community since 2013 to complement financial resources from the Global Fund to Fight AIDS, TB and Malaria (GFATM) and U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through gay and lesbian focused programmes supported by the U.S. Centres for Disease Control (CDC). Further programming at community level was funded by other bilateral donors and development partners, including HIVOS, The Alliance and Population Services International (PSI) and others. The UCSF (2015) reported that gay and lesbian-focused programming has increased since 2013 largely because of more funding channels and the formation of several LGBTIQ network organisations in most major urban areas, with at least one in each province.

Regarding condom and lubricant programming, SANAC aimed to increase the number of male condoms distributed per year to 850 million by 2019 against a current volume of 220 million and over 26 million female condoms were distributed in 2017, hoping to increase this to 40 million by 2022 (Avert, 2019). South Africa's 2017 National HIV Impact Survey reported that about 56% of adults aged 15-64 years with two or more sexual partners used a condom the last time they had sex (SANAC, 2017). Several challenges were noted in the survey in ensuring that condom

programmes were able to serve all groups, particularly those with higher HIV risk such as gays and lesbians and sex workers.

Developing acceptable and appropriate policy and programmes to cover the full diversity of sexual practices among the LGBTIQ is essential for an effective public health and human rights approach to reduce HIV infections and SRH problems. This should be done in the context of understanding the barriers such as social norms and perspectives that are not supportive of homosexual practices and often contribute to internal and external homophobia. Internalized homophobia refers to negative perceptions about oneself for being homosexual which negatively affects mental health, contributes to substance use and risk taking and may prevent access of SRH-related information and services (SANDH, 2011). In Pretoria, a study found higher levels of internalized homophobia among gays from lower socio-economic status than among individuals who had identified as bisexuals. These men had lower levels of understanding SRH and HIV-related risks compared to individuals with less internalized homophobia (Ricardo et al, 2015).

External homophobia refers to an irrational aversion to homosexuals which manifests through verbal, emotional or physical abuse. High levels of external homophobia have been documented among gays and lesbians in a range of contexts. This negatively affects their well-being and increases their risks to infections and failure to access SRH services due to perceived or real stigma and discrimination from health care workers.

2.4 Context of Health Access by Gays and Lesbians in Zimbabwe

Zimbabwe has a total population of 13 million, with a population growth rate of 1.1% (ZIMSTAT, 2012). The country's HIV prevalence is one of the highest in Southern Africa at 12.7%, with 1.3 million people living with HIV in 2018, a huge decline from a prevalence rate of 26% in 1997 (UNAIDS, 2019). The country has a generalized HIV epidemic and is largely driven by unprotected

heterosexual sex. Heterosexual people in stable unions account for around 55% of all new HIV infections. Women are disproportionately affected, particularly adolescent girls and young women and so are key populations, such as sex workers and men who have sex with men, who have an elevated risk of HIV. Data and information on these populations is lacking as only a minimal amount is collected and included in national documents (Avert, 2019).

Zimbabwe's multi-faceted efforts of reducing this undesirably high HIV prevalence rate have registered impressive gains, even on the incidence rate and mortality rates (Avert, 2019). The 2018 Zimbabwe Global AIDS Response Progress Reporting (GARPR) report showed that the epidemic in Zimbabwe is continually declining in new infection rates as well as AIDS related deaths. Between 2011 and 2018, the national HIV incidence rate declined from 1.29% to 1.1% (Zimbabwe Ministry of Health, 2019).

Between 2010 and 2018, there was a decline in new HIV infections from 62,000 to 38,000 per year and deaths declined from 54,000 to 22,000 over the same period (UNAIDS, 2019). The decline has been attributed to social behaviour change communication, high treatment coverage and prevention of mother-to-child transmission and these have contributed to a good progress towards the UNAIDS 90-90-90 targets. By 2018, 90% of people living with HIV in the country had been tested for HIV and over 95% of those diagnosed were on treatment. Among those diagnosed and on treatment, 87% were virally suppressed, meaning that they were not infectious and enjoying good health (Avert, 2019).

As indicated earlier, homosexual acts are illegal in Zimbabwe, strictest for gays but somewhat relaxed for lesbians. Consequently, national level data and statistics are rarely available for both groups. Criminalizing gays and lesbians had the effect of driving these vulnerable groups away from sexual and reproductive health services including HIV care and management. According to Avert

(2019), many do not know their HIV status or access treatment for STIs including HIV. In 2018, it was estimated that a third (31%) of gays in Zimbabwe were HIV positive (NAC, 2019).

In 2018, 50% of HIV positive gays in Zimbabwe were aware of their status while 77% were on treatment and about 72% had access to HIV prevention programmes. However, these results were based on limited data and do not portray the reality of the situation in the country. International donors such as GFATM and PEPFAR have ensured that some of their funding is earmarked for programmes that address the needs of the key populations, including gays and lesbians (Avert, 2019).

To this end, the GoZ (2015:iii) averred that "in the last decade the country has registered over 50% reduction of new HIV infections among adults and 80% in children born to HIV positive mothers". This success was attributed to a cocktail of strategies anchored on prevention, treatment and support programmes. Notwithstanding, the highlighted successes in the fight against HIV and AIDS, the country is intent on building on this momentum as demonstrated by its commitment to sustain and accelerate the gains made by undertaking to fast track 90.90.90 targets by 2020 (Government of Zimbabwe, 2017).

The successes highlighted above were realised due to intervention programmes that were directed at discouraging unprotected heterosexual sex which has traditionally been the major contributor to HIV infections in the country. However, Zimbabwe cannot afford to continue this programmatic path alone given that UNAIDS (2016) reports that there are now growing epidemics among key populations who are at higher risk of HIV.

2.4.1 Zimbabwe's Health System and Services for Key Populations

Zimbabwe's public health system in principle does not discriminate against key populations including gays and lesbians and all population segments are expected to access services from any nearest facility of their choice. Regarding HIV and AIDS, the ART guidelines produced by the Zimbabwe's Ministry of Health and Child Care (2013:12) stated that its "ultimate aim is to provide universal access to ART to those who need it by 2015." By universal access, the Ministry of Health and Child Care was referring to "establishing an environment in which HIV prevention, treatment, care and support interventions are available, accessible and affordable to all who need them." The same applies to all providers of SRH services who indicate that the health system is open for all and rely on the principle of the SDGs that advocates for 'leaving no one behind (UNAIDS, 2019).

The implication of this policy position is that key populations are also covered in the country's SRH and HIV testing and treatment services. In line with this blanket public health policy approach, Zimbabwe currently has over 880 000 people on ART but there is limited data on how many are gays or lesbians. In addition, the 2015 Zimbabwe GARPR report notes that more than 9,000 people are initiated into ART every month. The same report shows that unmet treatment needs will decline from 147,416 in 2014 to 102,575 in 2016 (Avert, 2017).

Despite significant gains in getting people on ART, several challenges remain in accessing HIV and SRH services. For example, there is a low uptake among gays and lesbians at only 35% compared to the target of 85% (Zimbabwe Ministry of Health, 2019). Furthermore, the country's policy position on SRH, HIV and AIDS programming as guided by the ZNASP III is largely silent on issues relating to access to services by key populations. There is no national strategy in place for making treatment easily and universally accessible to gays, lesbians and transgender people. As a result,

there is very little that is known about the extent to which these key population groups access the broad range of SRH services including HIV and AIDS treatment (Government of Zimbabwe, 2017).

Some sex workers, both male and female receive SRH services from CeSHHAR Zimbabwe. According to the 2017 GARPR of Zimbabwe, this programme coordinates various activities such as health education and HIV testing and by end of 2017 had reached more than 24 000 sex workers (Zimbabwe Ministry of Health, 2018).

Regarding condom and lubricant programming, there were 120 million male and 5.3 million female condoms distributed in 2018 in the country (Avert, 2019). Condom use in multiple concurrent partnerships was low and from survey data, this was only 50% of women and 37% of men used a condom the last time they had sex (ZDHS, 2015). The National AIDS Council (NAC) conducted an evaluation in 2017, during which they found that most users disliked the free condoms provided by government through the Zimbabwe National Family Planning Council (ZNFPC). This brand had reportedly an unpleasant smell and was not as strong as the socially marketed and the private sector condom brands such as Protector Plus, Carex and Durex.

A study conducted by Hivos (2018) indicated that knowledge of where to get condoms was universal, with 95% knowing where to get male condoms, 39% being from a health centre and 44% mentioning an organization. Free condoms were accessed by 96% of the respondents, while 69% felt that the condoms were affordable. However, condom use at last sex with a high-risk partner was only 52%, revealing a gap between availability of the condoms and their use.

The ZNFPC, however, does not distribute lubricants as they are not considered as a family planning product (Hivos, 2013). However, according to the same study and among the key populations, 85% knew where to obtain them, predominantly from Organizations (58%,) and from PSI and GALZ

operated health centres (24%). Most of the lubricants accessed were free (96%) from organizations, while among those who bought at pharmacies, 63% felt that they were not affordable, both in terms of access and the cost (Hivos, 2018). However, about 55% used a lubricant the last time they had sex and this was the same between gays and lesbians. The failure of the public health system to stock these critical products was bemoaned by gays and lesbians as they had to use more resources to access lubricants (Government of Zimbabwe, 2017).

A study conducted by GALZ in 2018 revealed that stigma and discrimination against gays and lesbians were still very high across communities with several cases of being excluded from social events, abandoned by family members or verbally abused. Denial of health services was also noted where about 16% of the key populations reported that they were denied health services, 23% mentioned that they were ignored by health care workers, 20% felt that they were denied health care they deserved while 31% reported that they received less care than they deserved because they were gays or lesbians. Close to half (47%) reported that the health care workers who served them were uncomfortable with them because they were key populations, and a third (33%) felt disrespected at the last health facility they visited (GALZ, 2018).

Pettifor et al (2015) recommended that combination prevention packages that include effective, acceptable and scalable behavioural, structural and biologic interventions are needed for all key populations to prevent new HIV infections. Interventions in these packages should meaningfully involve the key populations in their design and implementation and consider the context in which the interventions will be delivered. Additionally, the interventions will likely be most effective if implemented in conjunction with strategies to facilitate an enabling environment, including increasing access to HIV testing and health services for PrEP and other prevention strategies,

decriminalizing key populations' practices, increasing access to prevention and care, reducing stigma and discrimination, and fostering community empowerment.

2.4.2 Rights, Policies and Legislation Governing Homosexuality

The Constitution of Zimbabwe views all Zimbabweans as equal and protected by the law. This legal provision is outlined in s.56 of the Constitution which states that "all persons are equal before the law and have the right to equal protection and benefit of the law". The Constitution goes further to clarify that "every person has the right not to be treated in an unfairly discriminatory manner on such grounds as their… sex, gender…or social status" (Goz Constitution, 2013:29). Even though the Constitution makes clear that no one should be discriminated or unfairly treated because of their sex or gender, the reality and lived experiences of LGBTI people are different from what the Constitution guarantees them on paper. For example, sexual activities between men are criminalised under s.73 of the Criminal Code and Reform Act, 2006 (Chapter 9, 23). Anal intercourse as well as any physical contact that could be seen as indecent between men is pronounced as an offence in the penal code of Zimbabwe (Ricardo et al 2015). Persons found in contravention of this law can serve a jail sentence of up to one year or alternatively pay a fine (Ricardo et al 2015).

Despite the criminalisation of sodomy, there is nothing mentioned in Zimbabwean law about same sex relationships between females (Hivos, 2016). However, this does not mean that same sex activities between females are tolerated or condoned by society and the state. The public disapproves of any kind of same sex relationships. Furthermore, public officials are well-known for publicly voicing their prejudice and discontent about homosexuality (Ricardo et al 2015). In addition, the media and religious groups also do not hide their disapproval of same sex relationships (Ricardo et al 2015). As a result, LGBTI people are exposed to discrimination and their freedoms are

limited. Under this prevailing societal environment, state-led HIV and AIDS programming for KPs such as LGBTIQ and sex workers is difficult to roll-out as it could be taken as reflecting endorsement.

Given the above legal environment, it is no surprise that Zimbabwe has no specific KP policies. However, according to the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP, 2015:49) the lack of a national policy framework for the support of KPs has not deterred stakeholders' efforts as "...Zimbabwe has allowed the existence of informal lobby groups for these populations. In the meantime, efforts are being made to scale up HIV services to most-at-risk populations using a public health approach." Hence as much as there is no supportive legal and policy environment, stakeholders lean on s56 of the Constitution (Hivos, 2016).

Notwithstanding the challenges highlighted in the foregoing discussion, it is encouraging that there are positive signals emanating from government authorities regarding KPs' access to HIV prevention, testing and treatment services. This is evident in ZNASP III Strategic Plan (2015:57) where some of the priority focus areas are "active social dialogue on inclusion, morality, selling sex and gays" as well as the "implementation of comprehensive HIV prevention programmes for sex workers...". These initial positive steps by the government of Zimbabwe are perhaps an indication of the slow 'thawing' of the previously ultra-conservative anti-LGBTI policy position. In the years to come, there will be enough evidence to show whether these ZNASP III Strategic Plan KP focus areas represented a genuine policy direction change or not (Ministry of Health and Child Care, 2019).

However, it is on public record that in Zimbabwe, the long-standing ruling party Zanu-PF and civil society organizations (CSOs) working on human rights and governance issues have had an adversarial relationship with mutual mistrust. The government has continued to constrain the work by CSOs through restrictions on some activities deemed contrary to government position on any issue and has criminalized activities that promote LGBTIQ rights. In 2019, CIVICUS acknowledged

that the state's attack on civil society was systematic and several CSOs were under surveillance with their leaders being abducted, arbitrarily arrested and detained (Avert, 2019).

2.4.3 Programmes and Health Access Issues for Gays and Lesbians

The Gays and Lesbians of Zimbabwe (GALZ), TREAT, Transmart, Population Services International (PSI), Voice of Hope and Sexual Rights Centre (SRC) are organisations that work closely in Zimbabwe to deliver SRH services for gays and lesbians, mainly in cities and towns. These programmes are delivered in various platforms and parts of the country, but they all encounter problems because of the legal issues. GALZ documented several human rights violations against gays and engaged relevant stakeholders, especially in the health sector, to improve the delivery for SRH services as required. A total of 48 human rights violations against gays and lesbians were documented across Zimbabwe in 2018 (GALZ, 2018).

The focus of organizations like GALZ, CeSSHAR and PSI on community-based health services, screening, diagnosis and treatment for HIV and STIs, contraceptives provision and condom and lubricant programming under one roof in urban areas of the country was lauded by the key populations' groups. This community-based approach promoted access to services for vulnerable key populations, especially adolescent and young sex workers (both male and female) who were often shunned by the traditional service providers (Cowan et al., 2013).

GALZ has been instrumental in facilitating the formation of community-based organizations in the country. They reported that there were many gay sex worker organizations that have been formed in the country specifically to deal with how they can be empowered against a discriminative society and promote access to health care services (Hivos, 2016). The groups such as Zimbabwe Sex Workers Alliance, Male Sex Workers of Zimbabwe and Rainbow Leaders cater for gay sex workers' rights and health needs (Hivos, 2016). GALZ reported that the main challenges that the gay sex

workers face in Zimbabwe are mostly health issues, the ability to negotiate for safe sex, sexually transmitted diseases and accessing health services. The attitude of nurses at public health institutions was raised as a strong cause of concern (GALZ, 2018).

As a result, LGBTIQ people are exposed to discrimination and their freedoms are limited. Under this prevailing societal environment, state-led HIV and AIDS programming for KPs such as gays, sex workers, lesbians and transgender persons is difficult to roll-out as it could be taken as reflecting endorsement.

Given the above legal environment, it is no surprise that Zimbabwe has no specific KP policies. However, according to the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP, 2015:49) the lack of a national policy framework for the support of KPs has not deterred stakeholders' efforts as "...Zimbabwe has allowed the existence of informal lobby groups for these populations. In the meantime, efforts are being made to scale up HIV services to most-at-risk populations using a public health approach." Hence as much as there is no supportive legal and policy environment, stakeholders lean on s56 of the Constitution. This view is buttressed by an officer in Zimbabwe's Country Coordination Mechanism (CCM) who noted that 'the legal environment is not yet enabling enough to actually target especially gays, so what the country is actually doing is to use the public health approach, whereby we say everybody must be able to access health intervention activities despite one's sexual orientation' (Hivos, 2016).

Furthermore, sex work is criminalised in Zimbabwe and according to Scorgie et al (2013), soliciting, procuring and living off the earnings of sex work is a crime under s81-87 of the Criminal Law (Codification and Reform) Act. Several studies have found that criminalisation of sex work discourages and restricts some sex workers from seeking health care (Scorgie et al 2013; Mtetwa et al 2013). Sex workers are discriminated against in some hospitals and clinics as well as exposed

to abuse and rape from clients and police owing to the criminalisation of their trade (Chersich et al 2013; Cowan et al 2013). Criminalisation of their work thus makes it difficult for them to be legally recognised and protected. Despite this criminalisation, it is public knowledge that there are many people (especially females) who survive through sex work in Zimbabwe. Moreover, considering the prevailing economic challenges in Zimbabwe, many women engage in sex work as a livelihood and survival strategy.

Havnar (2019) pointed out that because of the punitive laws, national statistics on key populations are rarely available in the country. Criminalising gays and lesbians drives them vulnerable group away from HIV services and many do not know their HIV status let alone access treatment. However Zimbabwean organisations that support the rights of the LGBTIQ community and their access to HIV services do exist and are routinely punished and shutdown or have their members arrested.

Notwithstanding the challenges highlighted in the foregoing discussion, it is encouraging that there are positive signals emanating from government authorities regarding KPs' access to HIV prevention, testing and treatment services (Chersich et al, 2018). This is evident in ZNASP III Strategic Plan (Government of Zimbabwe, 2015) where some of the priority focus areas are active social dialogue on inclusion, morality, selling sex and gays as well as the implementation of comprehensive HIV prevention programmes for sex workers. These initial positive steps by the government of Zimbabwe are perhaps an indication of the slow 'thawing' of the previously ultra-conservative anti-LGBTI policy position. In the years to come, there will be enough evidence to show whether these ZNASP III Strategic Plan KP focus areas represented a genuine policy direction change or not.

2.5 Conclusion

The foregoing literature review shows that South Africa is amenable to same sex relationships. This stance is supported by the Constitution, through the Bill of Rights, that offers protection against all forms of sexual discrimination. Under this legislative framework, lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) people have a certain degree of visibility and protection in South Africa compared to many other countries around the world. However, reports of hate crimes, violence and discrimination towards LGBTIQ people remain persistent suggesting a disjuncture between legislation declaring the right to equality and the realities of everyday life.

In Zimbabwe, although the Constitution stipulates that no one should be discriminated or unfairly treated because of sex or gender, the experience of Key Population is quite different. The Criminal Code and Reform Act, 2006 (Chapter 9) criminalises sexual activities between men. Although there is no law in Zimbabwe criminalising same sex relationships between females, this does not mean that such relationships are tolerated or condoned by the society and the state. The public and state officials disapprove all kinds of same sex relationships. Under this societal environment, state-led HIV and AIDS programming targeting KPs such as gays and lesbian persons is difficult to roll-out as it could be taken as reflecting endorsement.

It has been noted that HIV prevalence among key populations in both South Africa and Zimbabwe is higher than the general population. In addition, comprehensive knowledge about HIV prevention is generally low among gays and lesbians because existing HIV education and information sharing services do not seem to address the specific needs of KP communities.

Widespread misconception by the public and health care providers that lesbian, bisexual and other KPs are not at risk of HIV and other STI s has been noted in South Africa. Consequently, the health needs of lesbians are often excluded from relevant policies and programmes. Due to

misconceptions that lesbians are not at risk of HIV or other STIs, many may not practice safer sex strategies or have knowledge about barrier methods.

Studies have also shown that lesbians are at high risk of violence (including sexual violence and rape), discrimination, and substance use which can augment risk of HIV infection. Although South Africa inherited a highly fragmented health system at independence, the Department of Health is mandated to provide a framework for a structured and uniform health system for all South Africans. The Bill of Rights of the Constitution states that access to health care is a basic human right.

Chapter Three

Health Belief Model: A Theoretical Framework Appraisal

3.1 Introduction

A classification of health systems frameworks is crucial in understanding the key components, functions and processes of a health system that ultimately affects the quality of health services and access of the same by key populations (KPs). In situations where the public health system is replete with a multiplicity of flaws and challenges, access to quality health services by KPs (who are largely regarded as an 'invisible and hidden population') becomes a daunting task. Within this context, this study uses the Health Belief Model (HBM) to understand the behavioural characteristics of gays and lesbians towards accessing sexual and reproductive health services from public health systems in Bulawayo (Zimbabwe) and Pretoria (South Africa). The HBM was developed in the early 1950s by the U.S. Public Health Service to understand the failure of people to adopt disease prevention strategies or screening tests for the early detection of diseases. The model was modified by Rosenstock (1974) and Siddiqui (2016).

The HBM is one of the most widely applied theories of health behaviour (Glanz & Bishop, 2010), and it posits that six constructs predict human health behaviour. These are: risk susceptibility, risk severity, benefits to action, barriers to action, self-efficacy and cues to action (Becker, 1974; Champion & Skinner, 2008; Rosenstock, 1974). This means that the probability that an individual will adopt a preventive behaviour is influenced by evaluating the costs and benefits of the action and the balance between these two influences the person's likelihood of acting and their preferred course of action.

3.2 Overview of health access and quality frameworks

3.1.1 Access to Quality Health Services

Rosenstock (1974) mentions that access relates to the opportunity to obtain and appropriately use quality health services and is concerned with the compatibility between the health system on the one hand and individuals who need to use these services on the other hand. Access is generally seen as being multidimensional or having different elements. Access dimensions are summarised as: the availability (or physical access), affordability (or financial access) and acceptability (or cultural access) of health services (McIntyre D et al, 2009)

Glanz (2010) mentioned that the availability dimension of access deals with whether the appropriate health services are present in the right place and at the right time to meet the needs of the population. Affordability concerns the 'degree of fit' between the full costs of using health care services and individuals' ability-to pay in the context of the household budget and other demands on that budget. Acceptability is concerned with the fit between provider and patient attitudes towards and expectations of each other and is influenced by beliefs and perceptions.

Facilitating access involves assisting people to command appropriate health care resources to improve their health and that "access is a complex concept and at least four aspects require attention namely availability, adequate supply of services, the opportunity to obtain health care and a population to access the services," (Gulliford et al, 2002). Factors such as financial, organisational and social or cultural barriers may affect access and the utilisation of services.

Gulliford et al (2002) further agreed that access measured in terms of utilisation is dependent on the affordability, physical accessibility and acceptability of services and not merely adequacy of supply. Accessibility is therefore multidimensional, and the availability of services, facilitators and

barriers to access vary with individual perspectives, health needs and cultural settings from one society to the next. An intersection of availability, affordability and acceptability is critical to determine utilization of health systems.

The Institute of Medicine (IOM) defines quality health care as: "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge," (Institute of Medicine, 2001). Quality health services should be effective, efficient, equitable, patient-centred, safe and timely. The United Kingdom National Health Service (NHS) provided a useful definition of quality of care, which they see as relating to three areas of clinical effectiveness, patient safety and patient experience (Department of Health, 2008). Similarly, the World Health Organization (WHO) sees quality of care as "the extent to which health care services provided to individuals and patient populations improve desired health outcomes and that in order to achieve this, health care must be safe, effective, timely, efficient, equitable and people-centered,"(WHO, 2016).

WHO (2016) further explained that a service is regarded as safe if it delivers health care that minimizes risks and harm to service users, effective when services provided are based on scientific knowledge and evidence-based guidelines and timely when delays are reduced in providing and receiving health care. Health care is considered efficient if delivered in a manner that maximizes resource use and avoids waste, equitable if care does not differ in quality according to personal characteristics such as gender, race, ethnicity, geographical location or socioeconomic status and people-centered if care regards the preferences and aspirations of individual service users and the culture of their societies. These dimensions are critical in understanding what constitutes a quality health care system (WHO, 2017).

3.1.2 Classification of Health Systems Frameworks

An in-depth understanding of the components and functions of health systems is crucial for assessing the extent to which gays and lesbians access quality health services. Hsiao and Siadat (2008) classified health systems frameworks into descriptive, analytical and deterministic and predictive categories. Descriptive systems are most relevant for general understanding of health systems. They describe health systems in terms of financial and human resources devoted to improving health, existing programmes and how these programmes operate, the key stakeholders involved and the basic institutional arrangements. The descriptive approach tells us the components within the system, but not how the system operates (Hsiao and Siadat, 2008).

Rosenstock (1974) and Siddiqui (2016) indicated that basic descriptive systems apply to both sub-systems and national systems, while more complex, analytical concepts to health systems apply at the national level. At the sub-system level, the descriptive systems can be further subdivided into several categories. These include service delivery sub-systems which are focused on providing services at different levels such as primary, secondary or tertiary care and operational sub-systems which focus on various operational elements such as procurement and distribution mechanisms.

Glanz (2010) argues that analytical systems go beyond mere description of what exists and seek to analyse in detail some major aspects of a system and its complex operations. There are two types of analytical systems namely the fund flow and functional systems. The fund flow systems describe and analyse the flow of funds between patients, government, insurers, hospitals and others. The fund flow system is limited to one component of a national health system.

Functional systems have a more analytical approach that enable examination of all major functions and programmes at all levels. Functional systems describe and analyse the functional components such as inputs (financial, human resources, facilities), governance, institutional arrangements,

policy and regulation frameworks. The functional system offers a more comprehensive analysis of health systems than do fund flow or descriptive systems. However, the main limitation of the functional systems is that they do not tell us what works and what does not, and do not show the interaction among the various health system components (Glanz, 2010).

Deterministic systems seek to establish and explain key factors that influence performance of functions in a health system. They provide answers to two fundamental questions: why do some health systems perform better than others, and how can policymakers make a national health system perform better? Most efforts have been directed towards understanding national health systems to enable predictions about future health expenditures or human resource requirements. Hsiao and Siadat (2008) explained that this system focuses on the needs of policymakers who want to know what policy instruments will allow them to measurably affect desired health outcomes.

Shakarishvili et al (2010) highlighted four key areas of complementarity in existing health systems. These are: health systems goals, overarching principles, processes/control knobs and building blocks/functions. He argues that health system goals are independent variables that remain constant irrespective of the type of the health system or changes within the system and its surrounding environment. There seems to be consensus among the health systems frameworks on the composition of health system goals. These should include improved health status, protection against health-related financial risk, responsiveness to needs and satisfaction of consumer expectations (Shakarishvili et al, 2010).

Overarching principles are intermediate objectives that include equity, efficiency, sustainability, quality, access, coverage, safety, choice and other cross cutting issues. These can be targeted by health system strengthening interventions or they are the very outcomes of these interventions while control knobs either describe what happens within the health system as a course of action

and how it happens (process) or describe the power mechanisms in the hands of health system actors, application of which may result in certain adjustments to the system (control knobs). For instance, resource allocation can be a "process" in itself, and it may be done through cross-subsidization, or through changing providers' reimbursement mechanisms. On the other hand, resource allocation can be a "control knob" if used as an instrument through which certain processes within the health system, such as hospital mergers, can be affected (Shakarishvili et al, 2010).

The fourth component is building blocks/functions where various frameworks tend to address a particular dimension either referred to as "building blocks" (emphasising structural and institutional aspects of the concepts to which they correspond), or "critical health system functions" to emphasize functional aspects. This dimension includes concepts such as service delivery, health information, health workforce, technologies and commodities, demand generation, governance and financing. Table 1 summarizes the four complementary dimensions identified in various health systems frameworks.

Table 1: Complementary Areas of Various Health Systems Frameworks

Dimension	Component
Goals:	• Better Health • Financial Protection • Responsiveness • Satisfaction
Overarching Principles: (Intermediate Objectives, Characteristic Features)	▪ Equity ▪ Efficiency ▪ Sustainability ▪ Quality ▪ Access ▪ Coverage ▪ Safety ▪ Choice
Processes/Control Knobs	▪ Resource Creation ▪ Resource Allocation ▪ Payment ▪ Organization ▪ Integration ▪ Regulation ▪ Behaviour
Building Blocks/ Critical Functions	▪ Services ▪ Health Workforce ▪ Health Information ▪ Technologies & Commodities ▪ Demand Generation ▪ Financing ▪ Governance

Source: Shakarishvili et al, 2010

A classic example of a framework that addresses components from each of the four complementary dimensions identified in various health systems frameworks is the Health Belief Model (Hochbaum (1958), modified by Rosenstock (1974) and Siddiqui (2016).

3.3 The Health Belief Model

The study utilizes the Health Belief Model (HBM) to understand the factors affecting access to health services by gays and lesbians in Pretoria and Bulawayo. The HBM was developed in the early 1950s by social scientists at the U.S. Public Health Service to understand the failure of people to

adopt disease prevention strategies or screening tests for the early detection of disease (Siddiqui, 2016). The HBM suggests that a person's belief in a personal threat of an illness or disease together with a person's belief in the effectiveness of the recommended health behaviour or action will predict the likelihood the person will adopt the behaviour (Hochbaum, 1958).

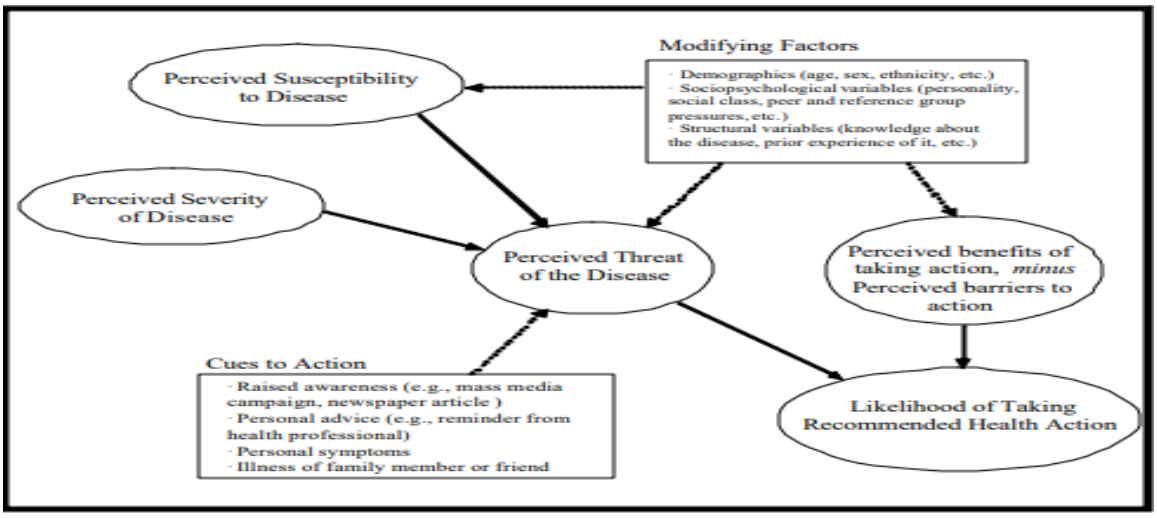
Originally formulated to model the adoption of preventive health behaviours in the United States, the HBM has been successfully adapted to fit diverse cultural and topical contexts (Griffin, 2012; Scarinci et al., 2012). Influenced by Kurt Lewin's theories that perceptions of reality and not objective reality influence human behaviour, the HBM postulated that health behaviours are influenced by a person's desire to avoid illness or to get well, and by their confidence that the recommended action will achieve this. This approach was an extension of the descriptive models of associating health behaviours with demographic factors and acknowledged the role of personal attributes and perceptions (Gulliford et al, 2002).

As one of the most widely applied theories of health behaviour (Glanz & Bishop, 2010), the Health Belief Model (HBM) posits that six constructs predict health behaviour (Becker, 1974; Champion & Skinner, 2008; Rosenstock, 1974). This means that the probability that an individual will adopt a preventive behaviour is influenced by evaluating the costs and benefits of the action and the balance between these two influences the person's likelihood of acting and their preferred course of action. The model explains that when a person is motivated and perceives a beneficial action to take, actual change occurs when some external or internal cue such as a change in their health status, doctor's advice, or a loved one's illness or death forces them to act (Hochbaum, 1958).

Siddiqui (2016) further elaborated that the HBM derives from psychological and behavioural theory with the foundation that the two components of health-related behaviour are: 1) the desire to

avoid illness, or conversely get well if already ill; and 2) the belief that a specific health action will prevent, or cure illness. The six dimensions are explained in Fig 1 below.

Figure 1: The Variables in the Health Belief Model from Rosenstock, Janz et al (1974)



According to Hochbaum (1958), modified by Rosenstock (1974) and Siddiqui (2016), there are six constructs that explain the Health Belief Model. The first construct is perceived susceptibility refers to a person's subjective perception of the risk of acquiring an illness or disease. There is wide variation in a person's feelings of personal vulnerability to an illness or disease. Secondly, perceived severity refers to a person's feelings on the seriousness of contracting an illness or disease (or leaving the illness or disease untreated). There is wide variation in a person's feelings of severity, and often a person considers the medical consequences (such as death, disability) and social consequences (such as family life, social relationships) when evaluating the severity (Siddiqui, 2016).

Thirdly, Rosenstock (1974) further explains that perceived benefits refer to a person's perception of the effectiveness of various actions available to reduce the threat of illness or disease (or to cure illness or disease). The course of action a person takes in preventing (or curing) illness or disease relies on consideration and evaluation of both perceived susceptibility and perceived benefit, such

that the person would accept the recommended health action if it were perceived as beneficial. Fourthly, perceived barriers are a person's feelings on the obstacles to performing a recommended health action. There is wide variation in a person's feelings of barriers, or impediments, which lead to a cost/benefit analysis. The person weighs the effectiveness of the actions against the perceptions that it may be expensive, dangerous (such as side effects), unpleasant (such as painful), time-consuming, or inconvenient (Rosenstock, 1974).

Fifthly, cue to action refers to the stimulus needed to trigger the decision-making process to accept a recommended health action. These cues can be internal (such as chest pains, wheezing) or external (such as advice from others, illness of family member, newspaper article). Finally, self-efficacy refers to the level of a person's confidence in his or her ability to successfully perform a behaviour. Self-efficacy is a construct in many behavioural theories as it directly relates to whether a person performs the desired behaviour (Siddiqui, 2016).

The HBM is based on the understanding that a person will take a health-related action, such as visiting a health facility, if that person feels that a negative health condition can be avoided, has a positive expectation that by taking a recommended action, they will avoid a negative health condition (such as using condoms will be effective at preventing HIV), and believes that they can successfully take a recommended health action (such as using condoms comfortably and with confidence) (Slater & Gleason, 2012). This study uses the HBM as an explanatory framework for understanding the facilitators and barriers to accessing sexual and reproductive health services and to influence communication research regarding quality of the services. This approach enables targeted programming and communication with the key population groups, as the barriers and the facilitators are explored fully to identify the challenges and opportunities.

A few studies have evaluated the HBM to understand how it can be utilized to understand health seeking behaviour. This is relevant for this current study which seeks to understand the barriers and facilitators for accessing sexual and reproductive health services by gays and lesbians in Bulawayo and Pretoria. Rosenstock (1974) reviewed seven studies that had evaluated the HBM where "six supported the importance of several variables in the model as explanatory or predictive variables. However, a seventh major investigation conflicted in most respects with the findings of earlier studies," (Gulliford et al, 2002). Rosenstock (1974) concluded that the HBM can predict voluntary health behaviour in people who are essentially healthy, fitting into the context of this study among healthy gays and lesbians. However, Janz and Becker's review in 1988 showed that perceived barriers appear as the single best predictor of subsequent behaviour, adding that interventions that incorporated the HBM precepts tended to produce better health outcomes (Siddiqui, 2016).

Rosenstock (1974) also noted that positive health beliefs as described in the HBM were more likely to occur among low- and middle-class people who make deliberate plans and long term goals over immediate needs, socio-economic statuses of most gays and lesbians in Africa and indeed in Bulawayo and Pretoria. The HBM has been applied to understand health behaviours and to design intervention programs because of its ability to be adapted to different cultural groups. Tang et al (2011) studied cultural barriers in accessing cancer screening services among Chinese and Asian people in the United States of America (USA).

There have been criticisms of the HBM and one of them was that it successfully describes constructs that predict behaviours but does not explain how these interrelate and whether this follows an additive or a multiplicative model to explain the desired behaviour (Janz et al, 2002). This provides a linear dimension to individual constructs and does not attempt to compare the relationships

between them. In this study, efforts are made to compare how constructs relate to each other in explaining the health seeking behaviour of gays and lesbians.

The second criticism is that the model does not consider a person's attitudes, beliefs, or other individual determinants that determine acceptance of a health behaviour. Human beings have behaviours that are habitual, and this informs their decision-making process to consider a recommended action, such as unprotected sex (Gulliford et al, 2002). In this study, individual human attitudes and beliefs were considered in the analysis using the evidence collected in the preliminary sections of the individual questionnaire. Throughout the analysis, reference was made to some of the background variables such as culture, education level, age, location to understand the various outcomes from the HBM constructs.

Thirdly, the model has been criticized for not taking into perspective behaviours that are performed for non-health outcomes such as social acceptability, environmental or economic factors. These factors may facilitate or prohibit recommended health actions and assumes that everyone has access to equal amounts of information on health problems and solutions (Thaler and Sunstein, 2009). Reference to education levels and disaggregating the study findings by level of education is used in this study to overcome this limitation.

Albarracin et al. (2005) indicated that one of the limitations of the model is that cues to action encourage people to act and that health actions are the main goal in the decision-making process. This makes the HBM more of a descriptive than explanatory model and this study attempts to explain the observed behaviour by asking the questions why some types of behaviour were observed among certain groups and not among all the respondents. For example, a comparative analysis between gays and lesbians and between Bulawayo and Pretoria is a running theme of this study.

Lastly, the HBM has also been criticized for being a rational exchange model where individuals systematically list and weigh the barriers and benefits of a behaviour (Dutta and Basu, 2011). This does not consider findings from behavioural economics that people rarely do mental work necessary to list and weigh all the possible outcomes of a decision. This study uses background variables such as socio-economic status, age and affordability to further explain the findings generated through the HBM constructs to try and overcome this limitation to a certain extent.

3.4 Conclusion

The theoretical issues surrounding access to quality health services have been discussed in this Chapter. Access relates to the availability, affordability and accessibility of health services while quality health services should be effective, efficient, equitable, patient-centred, safe and timely. Three models of health systems frameworks; descriptive, analytical and deterministic and predictive models were also analysed. The converged health systems framework is a comprehensive tool that can be applied as a technical point of reference for designing health system strengthening strategies. This allows consideration of complex interactions among various elements of the health system, and between the health sector and external factors.

It has also been demonstrated that the Health Belief Model (HBM), developed by Hochbaum (1958), modified by Rosenstock (1974) and Siddiqui (2016) is the model of choice to understand the factors affecting access to health services by gays and lesbians in Pretoria (South Africa) and Bulawayo (Zimbabwe). The purpose of the model is to enhance understanding of the failure to adopt disease prevention strategies or screening tests for the early detection of disease. The model argues that a person's belief in a personal threat of an illness or disease together with a person's belief in the effectiveness of the recommended health behaviour or action will predict the likelihood that the person will adopt the behaviour.

According to the HBM, there are six constructs predict health behaviour namely: risk susceptibility, risk severity, benefits to action, barriers to action, self-efficacy, and cues to action. Rosenstock (1974) in his evaluation of the applicability of the HBM concluded that while all the six constructs assist in influencing health behaviour, perceived barriers proved to be the single most important dimension that predicts the lack of adoption of positive behaviours.

Chapter Four

Research Methodology

4.1 Introduction

This chapter outlines and justifies the methodological approach used. It starts by highlighting the mix of the methods and then discusses specific quantitative and qualitative data collection tools used. A combination of qualitative and quantitative methods provides a richer contextual basis for understanding factors affecting access to quality health services for gays and lesbians (Neuman and Robson, 2004). Qualitative data collection consisted of in-depth semi-structured key informant interviews with service providers and governmental officials and focus group discussions with selected members of gays and lesbians in the communities. The quantitative approach involved the administration of a standardized questionnaire to selected gays and lesbians in Bulawayo and Pretoria. The chapter further presents the sampling strategy applied and ethical considerations as well as the various challenges encountered during the research. The thesis is dealing with a hard-to-reach population and therefore common probability-based sampling approaches were not chosen as they would not be able to reach the targeted respondents. It concludes by highlighting the study limitations.

4.2 Mixed Methods Approach

This study applied a mixed methods approach in data collection. This refers to the collection and analysis of both qualitative and quantitative data in a single study in which the data is collected concurrently or sequentially. It also involves the integration of the data at one or more stages in the processes of research (Creswell, 2013). The combination of qualitative and quantitative methods in this study provides the research the requisite rigour, breath and depth in understanding

the factors affecting access to sexual and reproductive health services for gays and lesbians in Bulawayo and Pretoria. The study examines a multi-dimensional phenomenon with complex linkages and variables which require a mixed methods approach.

The study triangulated qualitative and quantitative methods to answer the research questions regarding gays and lesbians' access to sexual and reproductive health services. Qualitative research is defined as a type of social science research that collects and works with non-numerical data that seeks to interpret meaning from these data that help us understand social life through the study of targeted populations or places (Wiley, 2004). The qualitative methods were used because of their focus on the micro-level of social interaction that composes everyday life and allows the study to investigate the meanings that people attribute to their behaviour, actions, and interactions with others. Qualitative research produces descriptive data that the researcher must then interpret using rigorous and systematic methods of coding and analysis of trends and themes.

To complement the qualitative data in this mixed methods approach and ensure reliability and validity of data gathered, quantitative research techniques were also used. Quantitative research is defined as the application of methods that emphasize objective measurements and the statistical, mathematical, or numerical analysis of data collected through polls, questionnaires, and surveys, or by manipulating pre-existing statistical data using computational techniques (Babbie, 2008). Quantitative research focuses on numeric and unchanging data and detailed, convergent reasoning across groups of people or to explain a phenomenon.

The use of the two approaches increased the robustness of the results through cross-validation. This provided a clearer and fuller picture of sexual and reproductive health issues affecting gays and lesbians than would otherwise have been achieved by using either of these methods on their own.

4.3 Qualitative Methods

According to Hammerberg K et al (2016) qualitative methods are used to answer questions about experience, meaning and perspective, most often from the standpoint of the participant. These data are not usually amenable to counting or measuring. Qualitative research techniques include semi-structured key informant interviews and focus group discussions that seek to investigate beliefs, attitudes and concepts of normative behaviour.

4.3.1 Key Informant Interviews (KII)

Key informant interviews (KIIs) are similar to conversations than formal events with predetermined response categories. They can be defined as 'repeated face-to-face encounters between the researcher and the informants directed towards in-depth understanding of the nature, magnitude and distribution (socially and geographically) of the issues under discourse within a given area (Wiley, 2004). According to Marshall (1996) a key informant is an "expert source of information". Specifically, KIIs sought to establish the rate of HIV infections and related deaths among gays and lesbians in both countries. The level of access and barriers or motivators by gays and lesbians to HIV prevention, testing and treatment services were determined through these interactive interviews. A total of 30 KIIs were conducted, 15 in each city and spread among the different identified individuals.

The key informants for this study included officials from gays, lesbians, key population (KP) network organizations and representatives of KP communities within the targeted countries. Government officials from the Ministries of Health in the two countries were also targeted for key informant interviews. In Bulawayo, key informants interviewed included three from the Ministry of Health and Child Care (one each at national, provincial and district levels), two from the Population Services International (PSI), three from GALZ (one at national office and two from Bulawayo office), four

from Voice of Hope, two from Population Services Zimbabwe (PSZ) and one from a local organization TREAT. In Pretoria, the KIIs were done with three Ministry of Health officials, two with Society for family Health (SFH), three with OUT Well Being, two from Health4Men, one from TEN81, one with AMSHeR, one with Hivos and two with Rainbow Coalition.

4.3.2 Focus Group Discussions (FGD)

According to Terre Blanche et al., (2006) a "focus group is typically a group of people who share a similar type of experience, but a group that is not 'naturally' constituted as an existing social group". Babbie (2014) explains that a FGD is a qualitative data collection method where the researcher gathers several people homogenous to what is under study to discuss an issue or a range of issues. Gall and Gall (2003) mention that focus group discussions are based on the concept that humans are social beings and have long been gathering together and discussing important issues in groups. However, there is no consensus amongst authors concerning the number of people who should constitute a focus group discussion. McLafferty (2004:187) argues that there is a '…lack of consensus on how to organize and execute the discussions, including their composition and the appropriate number of participants.'

Focus group discussions (FGDs) were used as one of the primary data collection methods to help validate and give more depth to the data collected through the questionnaires and key informant interviews. These were done with different gays and lesbians to understand the qualitative explanations to observed behaviours and assess their perceived vulnerability to sexual and reproductive health (SRH) problems identifiable in their geographical spaces. A total of eight FGDs were conducted, four in each city, four with gays and four with lesbians. Each group had between 8 and 12 members, and a total of 76 individuals participated in the discussions. Four groups had younger gays aged below 24 years and the other four had those members aged 25 and above.

4.4 Quantitative Methods

Casebeer and Verhoef (1997:2) define quantitative research as 'the numerical representation of observations for the purpose of describing and explaining the phenomena that those observations reflect'. The research seeks to establish cause and effect relationships between variables, but seldom considers the constructed meaning of the variables. This study used semi-structured questionnaires to gather data on sexual and reproductive health issues from 173 lesbian and 214 gay individuals in Pretoria and Bulawayo.

4.4.1 Questionnaires

A semi-structured questionnaire was administered to purposively selected gays and lesbians, using the registers within their network and respondent driven referrals. The questionnaire provided the researcher an opportunity to collect a wide range of information from many respondents within a short period of time. Both open and close-ended questions were prepared, pre-tested, reviewed and administered. A total of 387 questionnaires were successfully administered across the two cities, 214 among gays and 173 among the lesbians. Out of these, a total of 107 gays and 87 lesbians were from Bulawayo and 107 gays and 86 lesbians were from Pretoria. Thus, in total, 194 respondents were from Bulawayo and 193 were from Pretoria.

Provide a table here showing the number of gays selected by city and the number of lesbians selected by city for the administration of the questionnaire and the response rate.

4.4.2 Sampling strategies

In the two countries, literature revealed that the targeted gays and lesbians were highly stigmatised and hard to reach through conventional population-based survey methods (Hivos, 2016). Previous studies by GALZ (2018), Hivos (2016, 2018), Ricardo et al (2016) revealed that due to the hard-to-reach nature of gays and lesbians, the use of non-probability sampling methods was utilized, and

this thesis follows a similar pattern. The indicated studies have a common thread that gays and lesbians are not ubiquitous in the populations of the two cities but are concentrated in specific localities and networks. As indicated earlier, the targeted respondents are a hard-to-reach population and common probability-based sampling approaches were not chosen as they would not be able to reach them. The study therefore made use of three specialised sampling methods, namely, purposive sampling, time-location sampling, and snowball sampling.

4.4.2.1 Purposive Sampling

Purposive sampling is defined as a non-probability sampling technique where units from a pre-specified group are purposively sought out and sampled (Creswell, 2013). According to Neuman and Neuman (2006), purposive sampling represents a group of different non-probability sampling techniques and can sometimes be referred to as judgmental, selective or subjective sampling. The technique relies on the judgement of the researcher when it comes to selecting the people to participate in the study.

Purposive sampling is applied when the sample being investigated is quite small, especially when compared with probability sampling techniques. The goal of the technique is not to randomly select individuals from a population to create a sample with the intention of making generalisations but to focus on unique characteristics of a population that are of interest, which will best enable the study to answer the critical questions. Bryman and Cramer (1994) noted that the sample being studied is not representative of the population, but for researchers pursuing qualitative or mixed methods research designs, this is not considered to be a major weakness as it is complemented by other methods among this hard to reach and hidden population.

The study used this technique to provide the researcher with the justification to make generalisations from the sample. Priority was given to this sampling method as the researcher made use of the existing gay and lesbian networks in Bulawayo and Pretoria to access the members within them and the entry of the researcher was facilitated by the same network leaders. Andrade (2021) mentioned that a purposive sample is the one whose characteristics are defined for a purpose that is relevant to the study, in this case only gays and lesbians in Bulawayo and Pretoria. The researcher used two special meetings that were held in Bulawayo and four workshops which were convened in Pretoria to access 154 respondents in the two cities and members who attended meetings during that period were targeted as respondents. In Bulawayo, a total of 53 gays and 28 lesbians were recruited while in Pretoria, there were 49 gays and 24 lesbians identified using purposive sampling, giving a total of 102 gays and 52 lesbians (a total of 81 in Bulawayo and 73 in Pretoria) in the two cities

4.4.2.2 Time Location Sampling

Time location sampling (TLS), also known as venue sampling, is defined as a probabilistic method used to recruit members of a hard-to-reach target population at specific times in set venues (Gayet and Ayaceli, 2015). The sampling framework consists of time-location units, which represent the potential universe of venues, days and times that the target population can be reached (Neuman and Robson, 2004). The approach utilizes known time and location settings when the targeted respondents are available. Gayet and Ayaceli (2015) further explained that to execute the TLS, the fieldwork team identifies a range of time-location units to locate the members of the target population through interviews and key informants, service providers, and members of the target population and map all the potentially eligible sites.

Using this approach allows the surveying of informal venues, such as private houses, into the sampling frame, to reach the least visible members of the target population, or those who do not typically frequent public places (Semaan et al., 2002). This technique provides a sampling framework that allows calculation of the probability selection of everyone in the sample and reduces arbitrary selection of venues and individuals.

In this study, places such as restaurants, pubs, red light zones in Bulawayo and Pretoria were mapped with the assistance of the KP network members (Voice of Hope and GALZ in Bulawayo, OUT Well Being and Health4Men in Pretoria). These sites were targeted to identify and recruit participants into the study while observing the highest standards of ethical research as possible. Permission was sought to interview them in a manner that neither exposes nor inconveniences their activities. A total of 135 respondents were recruited using time-location sampling technique. In Bulawayo, a total of 34 gays and 37 lesbians were recruited using this technique while in Pretoria, there were 25 gays and 39 lesbians identified using time-location sampling, giving a total of 59 gays and 76 lesbians (a total of 71 in Bulawayo and 64 in Pretoria) in the two cities

4.4.2.3 Snowball Sampling

Snowball sampling, which is defined as a non-probability sampling technique where initial unit(s) are sampled, and these units then identify more units to be sampled (Seale, 2009), was used to mop up the respondents to yield the desired sample size. Snowball sampling is used when studying hidden and hard-to-reach populations that include populations such as drug addicts, homeless people, LGBTIQ, sex workers and others. Such populations exhibit social stigma, illicit or illegal behaviours, or other traits that make them socially marginalized (Throchim and Donnelly, 2001). The sensitivity of participating in a study is more acute in such research contexts and snowball

sampling takes advantage of individuals with common characteristics and social factors to recruit their peers.

Seale (2009) also added that snowball sampling is the best technique to use when there is no list of the population available, and respondents are obtained through referrals amongst people who share the same characteristics. He further argues, however, that snowballing yields a high possibility of individuals with related knowledge and experiences.

The snowball sampling approach was used to select key members among gays and lesbians who in turn referred the research team to a specific number of other members from their social circles. The number of referral recruits per person was restricted to two to ensure that the chains progress through diverse social networks. A total of 98 gays and lesbians were recruited using this technique. In Bulawayo, a total of 22 gays and 20 lesbians were recruited using this technique while in Pretoria, there were 33 gays and 23 lesbians identified using snowball sampling, giving a total of 55 gays and 43 lesbians (a total of 42 in Bulawayo and 56 in Pretoria) in the two cities.

4.5 Demographic Profile of Respondents

The findings analysed herein are drawn from 387 questionnaires (97% response rate), eight FGDs and 30 KIIs successfully administered among gays and lesbians, network organizations, government officials, service providers and civil society organizations interviewed in the two countries. Their socio-demographics are as follows:

4.5.1 Age of Respondents

The average age of respondents was 25 years for both South Africa and Zimbabwe. Table 2 below shows the proportion of respondents by key population groups and age categories. There were more key population respondents above 24 years in both countries. Comparatively South Africa

had a higher proportion (44%) of lesbians interviewed below the age of 25 years compared to Zimbabwe (40%). Similarly, the proportion of Zimbabwe gay respondents above the age of 24 was lower (57%) than respondents from South Africa (63%). The data confirms what was mentioned by several key informants among service providers that most of the key populations were the young and the economically active group. None of the lesbian respondents was above 35 years, and only 5% of gays were aged 35 years and above.

Table 2: Proportion of Respondents by Key Population Group and Age Category

Variable	Bulawayo (Zimbabwe)		Pretoria (South Africa)		Overall	
	Lesbian	Gay	Lesbian	Gay	Lesbian	Gay
N	87	107	86	107	173	214
Mean Age (Years)	25	24	25	26	25	25
% of Respondents by Age Category						
18-24	40.2	43	44.2	37.4	42.2	40.2
25-34	59.8	55.1	55.8	55.1	57.8	55.1
35+	0	1.9	0	7.5	0	4.7

4.5.2 Highest Level of Education Attained

The survey data showed a high level of literacy among gays and lesbians in both countries as all the respondents had gone beyond primary level education. Table 3 below shows that on average 72% of gays and 57% of lesbians in both countries reached secondary school education. Comparatively, more lesbians (19%) than gays (15%) proceeded to tertiary (technical colleges, polytechnics, teachers' colleges) and university levels in both countries. A significant proportion had first degrees, 24% lesbians and 13% among the gay respondents. During the FGDs, many of gays and lesbians mentioned that they met community members of the key populations during tertiary education, at universities, polytechnics and colleges more than at secondary school or lower.

Table 3: Proportion of respondents by highest level of school completed

Variable	Bulawayo (Zimbabwe)		Pretoria (South Africa)		Overall	
	Lesbian	Gay	Lesbian	Gay	Lesbian	Gay
N	87	107	86	107	173	214
Highest level of school completed						
Secondary	56.3%	70.1%	58.1%	74.8%	57.2%	72.4%
Tertiary (Poly, Colleges)	18.4%	16.8%	19.8%	12.1%	19.1%	14.5%
University	25.3%	13.1%	22.1%	13.1%	23.7%	13.1%

4.5.3 Religion of Respondents

Gays and lesbians were found across almost all religious groups. The only exceptions were the Traditional and Apostolic Sect Religions where there were no gay and lesbian respondents respectively. Table 4 below shows that the highest proportion of lesbians belonged to the Roman Catholic religion (Zimbabwe; 30% and South Africa; 28%). Most of gays interviewed were Protestant (Zimbabwe; 67% and South Africa; 52%).

Table 4: Proportion of Respondents by Religion

Variable	Bulawayo (Zimbabwe)		Pretoria (South Africa)		Overall	
	Lesbian	Gay	Lesbian	Gay	Lesbian	Gay
N	87	107	86	107	173	214
Religion						
Traditional	20.7%	0%	16.3%	0%	18.5%	0%
Roman Catholic	29.9%	6.5%	25.6%	1.9%	27.7%	4.2%
Protestant	25.3%	67.3%	24.4%	52.3%	24.9%	59.8%
Pentecostal	23.0%	25.2%	30.2%	31.8%	26.6%	28.5%
Apostolic Sect	0%	0.9%	0%	10.3%	0%	5.6%
None	1.0%	0%	3.5%	3.7%	1.2%	1.9%

4.6 Data management and analysis

Data management is defined as the care and maintenance of the data that is produced during the course of a research cycle an is an integral part of the research process which helps to ensure that data is properly organized, described, preserved, and shared (Neuman and Robson, 2004). The

process is concerned with the organisation of data, from its entry to the research cycle through to the dissemination and archiving of valuable results (White and Tedds, 2011). The UNDP (2009) defines data analysis as the process of deciphering facts from a body of evidence by systematically coding and collating the data collected, ensuring its accuracy, conducting any statistical analyses, and translating the data into usable formats or units of analysis related to each research question.

In this study, quantitative data analysis involved statistical analysis of data generated through individual questionnaires. The IBM Statistical Package for Social Sciences (SPSS version 25) program was used to analyse this survey data and produced basic descriptive measures of central tendency, frequencies, cross tabulations, analysis of variance and significance testing to explain the responses to the first and second research questions. The data is presented in tables and figures in Chapters Four (demographics), Five and Six. Qualitative data from focus group discussions (FGDs) and key informant interviews (KIIs) was analysed using content analysis to provide and explain the story behind the numbers. This was achieved through identifying and collecting the data, determining coding categories, coding the data by the identified themes, checking reliability and validity, analysing the data to explain the outputs from the quantitative methods. Gall and Gall (2003) noted that good data management practice allows reliable verification of results and it is important to properly manage the data in order to obtain reliable estimates and answers to the research questions.

4.7 Ethical Considerations

This study was done within the confines of internationally benchmarked and accepted research ethics as it was dealing with human subjects. These ethical practices include obtaining informed consent of all respondents, respecting their privacy always and guaranteeing their anonymity and confidentiality in the data collection, capturing, cleaning, analysis and reporting process (Creswell,

2013). Respect for persons, beneficence and justice was always maintained. A good study should respect individual respondent autonomy, minimize harm and maximize benefits (Booth et al, 2003). This strict adherence to the highest standards of research ethics ensured that the study process and results were quality assured and objective.

The researcher applied for and obtained ethical clearance from the University of Fort Hare's Research Ethics Committee (Certificate Number: MOYO11SJAS01) and sought permission from the local administrations before conducting data collection in the two cities. One of the critical annexes of the ethics approval was the use of the informed consent form which obliged the researcher to fully explain the study objectives and how it will affect, negatively or positively, the people participating in the study. Hesse-Biber and Leavy (2011:45) note that 'informed consent is a question of basic human rights; it is intended to safeguard participants from any mental or physical harm that might befall them because of their participation.'

During the data collection, the researcher started by explaining the objectives of the study, expected interview or FGD duration, the sample sizes and where else the study was being conducted. The respondents were given an opportunity to ask any questions or for clarifications before they decided to accept or decline participating in the study. The same procedure was repeated for the individual questionnaires, KIIs and FGDs and all respondents were asked to sign the consent forms if they agreed to participate. However, this process was difficult to follow among the respondents identified through time location sampling, as most of them will be in one place and required that we explain the study to all of them at once before separating for individual interviews with the research team. The study data was also preserved and stored in a lockable cabinet to ensure that it was kept in privacy. The anonymity of the respondents was assured, and

all direct quotes used in this study do not identify the names of the participants in respect of their confidentiality.

4.8 Conclusion

This chapter explained and justified the research methodology and data collection methods used in this study. The study used a mixed methods approach due to the research questions to be answered as they could only be meaningfully addressed using a mix of qualitative and quantitative methods. The key data collection methods used in the study included a survey questionnaire, key informant interviews and focus group discussions. Purposive sampling, time-location sampling and snowball sampling methods were used to reach the required sample sizes; 194 in Bulawayo and 193 in Pretoria. A total of eight FGDs were conducted, and 30 key informants were interviewed, 15 each in Bulawayo and Pretoria. The study adopted sound research practices during the preparation and execution of the data collection process, firstly by ensuring that ethical approval was granted, by the University of Fort Hare's Research Ethics Committee (Certificate Number: MOYO11SJAS01) and the local administrators and health directors in the two cities gave permission to undertake the study. At each study site, the same approval processes were followed, and all the respondents participated through mutual understanding of the importance of the study. The researcher ensured that the whole study process considered all the international benchmarks of sound and ethical research practices.

Chapter Five

Access to Quality Sexual and Reproductive Health Services

5.1 Introduction

This Chapter analyses data which answers two of the three, study research questions. These questions are: (i) to what extent do gays and lesbians access quality sexual and reproductive health services in Pretoria and Bulawayo and (ii) what are the facilitators and barriers are for accessing sexual and reproductive health services by gays and lesbians in the two cities? This analysis is guided by the Health Belief Model (HBM) which postulates that a person's belief in a threat of an illness or disease together with a person's belief in the effectiveness of the recommended health behaviour or action will predict the likelihood that the person will adopt the recommended behaviour (Siddiqui, 2016). According to the model, there are six constructs that predict health behaviour namely risk susceptibility, risk severity, perceived benefits, perceived barriers, self-efficacy and cues to action (Rosenstock, 1974).

Among other findings, the results indicate that all the respondents (100%, n=387) knew where to get condoms, ranging from health centres (55%, n=387), clinics (43%, n=387), drop-in centres (45%, n=387) to shops (only 10% among lesbians and 36% among gays). The types of condoms accessed include the government supplied public sector condoms, the socially marketed condoms distributed by the Population Services International (PSI) in Zimbabwe, Society for family Health (SFH) in South Africa and other partners and private sector condoms supplied by various companies. Secondly, the use of lubricants was quite high among both lesbians and gays in the two countries with almost all gay respondents having used lubricants the last time they had sex. Thirdly, the most commonly available sexual and reproductive health (SRH) services are contraceptive

services, sexually transmitted infections (STI) services (counselling, testing, treatment and prevention), Human immunodeficiency syndrome (HIV) services (Pre exposure Prophylaxis, Pre exposure treatment, HIV testing and counselling, treatment, adherence counselling).

Further, the chapter also explores the key barriers (factors associated with lower access) and facilitators (factors associated with higher access) for accessing the SRH services and the perceptions regarding the quality of the services as guided by the Health Belief Model (Hochbaum, 1958, Rosenstock 1974, Siddiqui 2016). Here, it is notable that even though over 80% of lesbians acknowledged that the facilities had good reputation, only 18% of lesbians and 66% of gays in the two cities would recommend the facility to a friend. Key areas of focus included acceptability of services, social support, self-efficacy, equitability, effectiveness, confidentiality and privacy of the services. Regarding social support as a cue to action, the highest frequency of discussing SRH services was with partners and followed by friends. The results show that discussions acted as a facilitator as it raised the perceived benefits of accessing SRH services as new information was obtained by the respondents from their social support network.

5.2 Health Belief Model: Contextual Synopsis

It will be recalled that this study is theoretically grounded in and framed by the Health Belief Model developed by Hochbaum (1958), modified by Rosenstock (1974) and Siddiqui (2016). The arguments herein are therefore framed in and analysed using Health Belief Model constructs. According to the Health Belief Model, perceived susceptibility refers to a person's subjective perception of the risk of acquiring an illness or disease and there are various feelings of personal vulnerability to an illness or disease while perceived severity indicates a person's feelings on the seriousness or gravity of contracting an illness or leaving the illness untreated. The severity can bring medical consequences such as death or disability or social consequences such as family and

social relationships. In this study, susceptibility and severity were analysed in the context of collateral damage incurred if gays and lesbians do not utilize SRH products and services and severity such as contracting STIs and HIV, missed opportunities for early cancer diagnosis, mental and psychosocial problems and absence of general health prevention practices (Siddiqui, 2016).

The model further explains that perceived benefits refer to a person's perception of the effectiveness of various actions available to reduce the threat or to cure illness or disease. Individuals accept recommended health action if it was perceived as beneficial and in the presence of facilitators to ensure access. Alternatively, perceived barriers are a person's feelings on the obstacles or limitations to performing a recommended health action, which leads to a cost benefit analysis (Siddiqui, 2016). In the context of this study, benefits and barriers were analysed using the facilitators that promote access and impediments that hinder access to quality SRH services and products.

Siddiqui (2016) further explained that the fifth construct, cue to action refers to the stimulus needed to trigger the decision-making process to accept a recommended health action. These cues can be internal or external while self-efficacy refers to the level of a person's confidence to successfully perform a behaviour and it directly influences whether a person performs the desired behaviour or not. In this study, cues to action are how gays and lesbians react to the availability or unavailability of various SRH products and services and self-efficacy evaluated how gays and lesbians were personally able to use the various SRH services and products. Across all the six constructs, the study identified the impediments to adopting the positive behaviours and recommended strategies to overcome the barriers.

5.3 Sexual and Reproductive Health (SRH) Services: Access, Facilitators and Barriers

5.3.1 *Condoms*

All gays and lesbians interviewed in the two cities had knowledge of places or persons from where to get condoms (100%, n=387). Places and persons where condoms were accessed by lesbians and gays in Pretoria and Bulawayo are shown below in Table 5. The health centres (60% among lesbians and 50% among gays), clinics (50% lesbians and 36% gays), drop-in centres (47% lesbians and 43% gays) and shops (only 10% among lesbians and 36% among gays) are the main sources of condoms accessible to most gays and lesbians. Use of shops as sources of condoms is not common among lesbians compared to gays (10% of lesbian compared to 36% of gay respondents) across the two countries.

Table 5: Places/persons where condoms are accessed by proportion of respondents

Places or persons where condoms are accessed	Bulawayo (Zimbabwe)		Pretoria (South Africa)		Overall	
	Lesbian	Gay	Lesbian	Gay	Lesbian	Gay
N	87	107	86	107	173	214
Health Centre	63.2%	50.5%	57%	49.5%	60.1%	50%
Clinic	50.6%	40.2%	48.8%	30.8%	49.7%	35.5%
Drop-in Centre	49.4%	44.9%	44.2%	40.2%	46.8%	42.5%
Shop	0.8%	32.7%	12.8%	38.3%	10.4%	35.5%
Bar	2.3%	2.8%	4.7%	9.3%	3.5%	6.1%
Pharmacy	3.4%	3.7%	4.7%	5.6%	4%	4.7%
Hospital	1.1%	1.9%	8.1%	6.5%	4.6%	4.2%
Guest House	1.1%	0.5%	8.1%	6.5%	4.6%	3.7%
Health Worker	1.1%	2.8%	0	3.7%	0.6%	3.3%
Peer Educator	3.4%	2.8%	2.3%	2.8%	2.9%	2.8%

The respondents mentioned that the types of condoms they accessed include the public sector condoms (free condoms supplied by the governments to all public health facilities) (10%, n=38), the socially marketed condoms (condoms supplied by civil society organizations at a price (Protector Plus in Zimbabwe and Trust in South Africa) (48%, n=186) distributed by Population

Services International (PSI in Zimbabwe) and Society for Family Health (SFH in South Africa) and private sector condoms (42%, n=163) supplied by various companies such as Carex, Durex, Choice, Clicks, Contempo, LifeStyles and Skyn in both cities.

The preferred brands are the private sector condoms (70%), which are highly regarded in terms of their quality followed by socially marketed (22%) then public sector (8%) condoms. The perceived benefit of the socially marketed condoms is that they are regarded as affordable, and their quality is rated as acceptable by most of gays and lesbians (46%). The private sector condoms are reportedly not as easily accessible as the other two types, as they are found in specific pharmacies, designer shops such as Clicks, kiosks located at fuel service stations, bars, guest houses and selected shops which do not open 24 hours in Bulawayo. The distribution of condom use by type and brands confirms previous market segmentation studies done by PSI and SFH on condom use in South Africa and Zimbabwe among the general population. The major difference with findings of this study is that there is a higher degree of preference for private sector condoms (70%) compared to the PSI study (64%) for the general population (Government of Zimbabwe, 2017).

There are barriers and facilitators for accessing condoms at individual, community, organisational and policy levels, using the tenets of the HBM which explains that perceived benefits and barriers affect access of any SRH services and products. The facilitators include affordability and condom pricing of the socially marketed brands, accessibility, condom programming, self-efficacy to condom use while barriers include alcohol use, low risk perceptions and condom quality. The prices of the private sector condom brands (about R 53 in Pretoria and USD 5 in Bulawayo for a pack of 3) are always higher than the socially marketed (about R 20 in Pretoria and USD 2 in Bulawayo for a pack of 3) while the public sector condoms are provided for free. Price of the condoms therefore

are a barrier to gays and lesbians who prefer better quality and flavoured, textured or scented condoms to the basic free condoms ubiquitously found in the two cities.

All the three types of condoms are differently accessible from the various providers and suppliers of the product. Accessing the free public sector condoms is not a challenge at all in both Bulawayo and Pretoria as confirmed by most participants during the focus group discussions.

"We have condoms available at all clinics and also bars and night clubs. These are free. But if one prefers, they can buy other brands from the supermarket or pharmacy, protector plus or from private companies who sell other very good but expensive brands such as Carex, Choice, Durex, Vibe, ESP and many others. These are all high quality but a bit expensive", (FGD participant, Bulawayo).

To confirm the same, in a previous study done by Hivos (2016), it was reported that further to promoting safe sex through condom use, some civic society organisations (CSOs) regularly conduct community-based HIV prevention workshops where condom programming issues were discussed. However, even though there is universal distribution of free male and female condoms in both Bulawayo and Pretoria, there are some individuals among gays and lesbians who do not consistently use condoms every time they had sex due to other factors other than their availability, such as low risk perception.

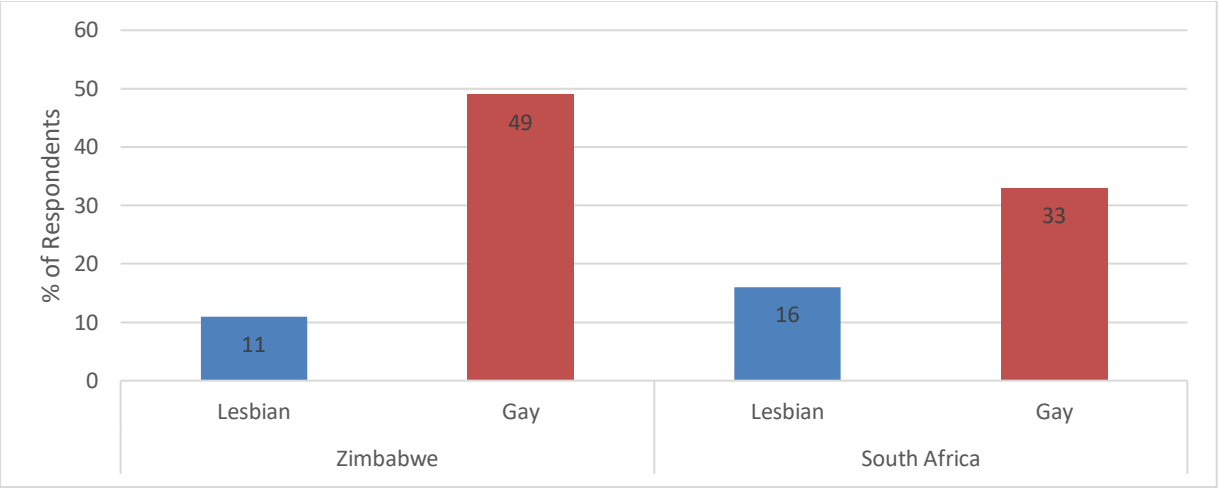
The community-based initiatives reportedly contribute to improving availability of condoms at the local level, as mentioned by one of the key informants that *"the work we are doing with condom holders, who are based in the community has improved the availability of condoms to gays and lesbians as the majority of the condom holders are their peers who are easily accessible to them", (Key informant, Pretoria).* Condom holders are critical in ensuring availability of the condoms at the community level in both cities. However, due to the lack of training and expertise to work with key

populations, some of the condom holders were deemed to be judgemental evidenced by their unwillingness to distribute condoms to same-sex partners or couples within their communities, a barrier that discouraged some of gays and lesbians from accessing the condoms available at community level.

Self-efficacy is having confidence in one's ability to perform a particular behaviour (Rosenstock, 1974), and high self-efficacy for condom use is strongly associated with consistent condom use. Correct and consistent condom use is one of the three HIV prevention methods, along with abstinence and faithfulness to one partner in the Abstinence, Being faithful and Condom use (ABC) and Pre-exposure prophylaxis (PreP) model of HIV prevention. There is lower than average use of condoms among gays and lesbians in both cities because of the low self-efficacy for condom use which exposes them to sexually transmitted infections. The proportion of respondents that used a condom the last time they had sex is shown in Fig 3, proving that the use of condoms was quite low among lesbians (11% and 16% in Bulawayo and Pretoria respectively). There was however a higher proportion of gays in Bulawayo using condoms than in Pretoria (49% and 33% respectively). This is against the national proportions of condom use at last sex which was 36% in Bulawayo and 44% in Pretoria (SANAC, 2017 and MoH, 2017) meaning that condom use was higher among the respondents in Bulawayo than in Pretoria.

The respondents indicated that they did not use a condom every time they had sex after they had drunk alcohol or taken different types of drugs such as marijuana, cocaine and others. Some of the respondents could not turn down having sex if their partner did not use a condom as they felt that they are not sufficiently equipped to negotiate for safe sex with their partners. This confirmed that the low self-efficacy for condom use acted as a barrier to correct and consistent condom use among both gays and lesbians.

Figure 3: Proportion of respondents that used condoms the last time they had sex



There were other reasons for failure to use condoms among gays and lesbians as shown in Table 6 below. The main barriers proffered by lesbians in both countries was that they did not think it was necessary to use condoms (88% of respondents in Bulawayo and 81% of respondents in Pretoria). The necessity of using condoms was also questioned by 41% and 35% of gays in Bulawayo and Pretoria respectively. However, about 30% of gays and 4% of lesbians across the two cities who did not use condoms indicated that they simply do not like them while unavailability of condoms was highlighted by only 3% of lesbians and 11% of gay respondents.

Table 6: Reasons for not using condoms by proportion of respondents

Reasons for not using condoms	Bulawayo (Zimbabwe)		Pretoria (South Africa)		Overall	
	Lesbian	Gay	Lesbian	Gay	Lesbian	Gay
N	77	72	72	55	149	127
Did not think it is necessary	87.7%	40.8%	80.9%	35%	84.4%	37.6%
Do not like them	1.4%	26.5%	5.9%	33.3%	3.5%	30.3%
Not available	2.7%	14.3%	2.9%	8.3%	2.8%	11%
Partner objected	2.7%	2%	4.4%	1.7%	3.5%	1,8%
Did not think of it	4.1%	2%	2.9%	0%	3.5%	0.9%
No Response	1.4%	0	1.5%	3.3%	1.4%	1.8%
Other	0	2%	1.5%	3.3%	0.7%	2.8%

One key informant in Pretoria mentioned that *''It is therefore apparent that the low condom use is largely due to individual risk perceptions and the health practices of these key populations rather than unavailability of condoms in the market'', (Key Informant, OUT South Africa).* This means that the varied rates of condom use are not because of the unavailability of condoms at the right places, prices or good quality but were mainly driven by individual behaviours of gays and lesbians regarding use of protection.

Alcohol use was cited as a barrier to condom access and use and this means that alcohol influenced the decisions of the respondents' regarding their sexual behaviour as being high on alcohol or drugs reportedly increased their sexual urge, made it difficult to maintain self-control and think about condoms when having sex. This was also found in a meta-analysis review done by Carter et al (2011) which showed that alcohol consumption had an impact on the intention of individuals to have unprotected sex leading to a wide range of other unintended actions and decisions. One of the FGD participants reported that;*" Furthermore, although drinking alcohol was associated with condom use, probably due to peer pressure and easy access to condoms in drinking places, condoms may not have been used by the patrons because they may have been too drunk to use them", (FGD Participant, Bulawayo)*

Inconveniences associated with using a condom were also cited as a barrier. One of the gay FGD participant said they were sometimes in a hurry and could not put on a condom and the perception that sex is not enjoyable when a condom is used. He added that; *" If the wrong size of a condom is used, it can slip off or break during sex, and then it does not offer any protection. Sometimes we do not always keep erection during sex making it difficult to use a male condom", (FGD participant, Bulawayo).* In Pretoria, another gay FGD participant indicated that; *"Condom use requires the consent and cooperation of both partners and becomes a challenge when one partner feels that the*

enjoyment of sex is lessened, because they feel the condom or because they must interrupt their sexual contact to wear a condom", (FGD participant, Pretoria).

These factors mentioned by both FGD participants affect both access, uptake and use of the condoms and further explains the higher risk susceptibility that gays and lesbians have to HIV and STIs. The participants who felt that they could not use a condom consistently indicated that they also make sure that they tested for HIV and other sexually transmitted infections to reduce chances of illnesses as their cue to action. Lesbians indicated that condom use is a challenge with the type of sexual activities they engage in, and in several of their relationships, the issue is not even discussed, meaning that self-efficacy to condom use is very low among them in both cities. Several studies confirm that these issues are also the same with factors affecting access, uptake and use of condoms among heterosexuals. (Sandfort et al, 2013; SANAC, 2013; Hivos, 2018).

Further, respondents identified perceived condom quality as contributing to the differences in accessing and using the three categories of condoms. The private sector condom brands such as Carex, Durex, Choice, Clicks, Contempo, Dr. Long's, LifeStyles and Skyn are regarded to be the best quality and additionally come with various flavours and scents making them the most attractive in the market. The socially marketed condoms such as Protector plus and Trust are ranked second in terms of quality and were more widely available in both Bulawayo and Pretoria than the private sector condoms. The issue of quality of condoms has been brought up in several PSI studies done to understand users' perceptions regarding the private, public and socially marketed condoms. The perceptions of gays and lesbians are consistent with those of the general population in that they perceive the private sector condoms to be the strangest and best while the public sector brands are the poorest in terms of quality (PSI, 2014; 2016; 2018).

The free unbranded public sector condoms such as the white or blue panthers are less favoured, despite being the most stocked at drop-in centres and public health facilities. The perceived barrier that the respondents mentioned is that they were basic, unflavoured or unscented and generally perceived as lower quality. Some reservations about condom quality appeared to be related to other issues such as breaking of condoms during sex, anal sex being rough, insufficient or incompatible lubrication, bruises, pain and the low self-efficacy to condom use.

The identified barriers and facilitators contributed to different condom use patterns between lesbians and gays as comparatively, more gays than lesbians used condoms. Age of gays and lesbians was a significant determinant of condom use and as Table 7 below shows, condom use was comparatively higher among gays and lesbians aged 18 years and below than those above 18 years (p=0.000 and p=0.005 respectively).

Table 7: Percent of gays and lesbians who used a condom the last time they had sex

Measurement Variable/ Determinant	18 years or below	Above 18 years	p - value
Lesbian	27.4	4.0	.000
Gay	48.8	27.3	.005

The older gays and lesbians above 18 years of age have higher rates of condom use (49% gays and 27% lesbians) than the younger ones below the age of 18 years (27% gays and 4% lesbians). This was due to access issues and lower risk perception among the younger respondents who were more comfortable and less experienced among their sexual partners than the older gays and lesbians. The older gays and lesbians have higher risk perceptions and tended to indulge in less unprotected sex than the younger ones.

One lesbian FGD participant in Bulawayo mentioned that;

"As lesbians, it is very difficult for us to use condoms because of the nature of the sexual activities we do. Both male and female condoms are not conducive for us, therefore we just do not think it is necessary (to use them). Something needs to be done, because even the few who said they use condoms maybe it's because they are bisexual, otherwise for us condoms are very difficult to use and we just leave them", (FGD participant, Bulawayo).

The issues raised by the lesbians regarding the difficulties associated with using both male and female condoms were pervasive, and this is worsened by the fact that dental dams and latex gloves were not available. As sex among lesbians is not always penetrative, there is always a risk of spreading infections through digital penetration, especially if there are cuts or scratches. This explains the higher risk perceptions among the older lesbians compared to the younger lesbians, as the chances of having had multiple sexual partners are higher than the younger ones.

Both unprotected digital penetration and oral sex carry risks of STIs like chlamydia, gonorrhoea, human papillomavirus, and syphilis, making the use of dental dams and latex gloves imperative amidst the low perceived susceptibility and severity of gays and lesbians to these infections. Few lesbians believed that, unless both partners know they are free from infection, they should be using all available forms of protection. Although neither dental dams nor condoms can fully prevent the transmission of infections, they complement each other, and the non-availability of the dental dams raised the risks among the lesbians in the two cities. The same was observed in a previous study in South Africa that condoms and lubricants were more available than dental dams and latex gloves (Muller, 2017).

5.3.2 Lubricants

The use of lubricants is high among both gays and lesbians in the two cities. Almost all gay respondents (99% in Bulawayo and 100% in South Africa) used lubricants the last time they had

sex. About 90% of lesbians in Bulawayo and 99% in Pretoria used lubricants the last time they had sex. The highest proportion of gays (51%) access lubricants from pharmacies, followed by drop-in centres (45%) while the highest proportion of lesbians access lubricants from friends or partners (36%), followed by drop-in centres (27%) as shown in Table 8 below.

Table 8: Lubricants sources by proportion of respondents

Where respondents purchased lubricants	Bulawayo (Zimbabwe)		Pretoria (South Africa)		Overall	
	Lesbian	Gay	Lesbian	Gay	Lesbian	Gay
N	87	107	86	107	173	214
Pharmacy	11.5%	55.5%%	9.9%	46.3%	10.6%	51.4%
Drop-in Centre	26.2%	49.5%	26.8%	40.2%	26.5%	45.2%
Given by a friend/Partner	32.8%	22.1%	39.4%	17.1%	36.4%	19.8%
Vendor	3.3%	3.2%	11.3%	3.7%	7.6%	3.4%
Free from Health Facility	3.3%	0	5.6%	0	4.5%	0

There were two types of lubricants that gays and lesbians accessed as reported during one FGD in Pretoria;

"Most of the lubricants we use are water-based and they are the most commonly stocked especially at the drop-in centre. They come in two varieties, with glycerine, with a sweet taste, or without glycerine. In some pharmacies there are also silicone-based lubes but these are expensive and we cannot afford them", (FGD participant, Hatfield, Pretoria).

A key informant from a drop-in centre in Pretoria mentioned that;

"Lubricants are taken by both gays and lesbians, more than condoms. They always make recommendations to us that they require silicone-based lubes, but these are a bit expensive to stock, but we will try our best. If we can get support to stock these, it will help to make sure that they all use lubes 100% of the time", (Key Informant, Hatfield Drop-in centre, Pretoria).

There are no significant differences in the use of lubricants between the two cities (p=0.736) and between gays and lesbians (p=0.308). However, it must be noted that age is a significant determinant among gays (p=0.004) but not among lesbians (p=0.196). About 91% of gays above the age of 18 years use lubricants compared to 77% of gays aged 18 years and below. The use of lubricants by the older gays is linked to the higher number of sexual partners they had while both the young and the old lesbians equally used lubricants. Further, the level of education attained was a significant determinant among gays (p=0.000) but not among lesbians (p=0.491). All gays with tertiary/university level education used lubricants compared to 80% of gays with primary/secondary level education. The more educated gays had access to disposable income which facilitated their purchasing of lubricants from the pharmacies and other private product stockists to complement those obtained at drop-in centres. This is not the case among the less educated gays, who only rely on the free lubricants provided by the health service providers at the drop-in centres.

The cost of lubricants, especially oil and silicone-based ones, is also a barrier as reported by the respondents. Water-based lubricants are availed mainly for free from drop-in centres, while the more preferred silicone-based lubricants were sold from pharmacies at around R 96 per 50 millilitres bottle in Pretoria and largely unavailable in Bulawayo. Affordability was a major barrier to accessing the silicone-based lubricants across the two cities and between gays and lesbians, despite being the preferred lubricant. As a cue to action, some gays and lesbians reportedly choose to access only the free product from drop-in centres. This has transport cost implications, which varied depending on distance to target drop-in centre, showing a complex relationship between access, geographic location, monetary and time considerations to determine use of lubricants among gays and lesbians in the two cities.

The availability of lubricants alone is not sufficient guarantee for their uptake by gays and lesbians in the two cities as barriers still existed to access the products. The respondents consider where the drop-in centres are located, the financial resources in the form of transport fees required to access the centres and the time it takes to reach them. The respondents indicated that at times, financial resources permitting, they are forced to buy from the nearest pharmacies than travelling to access the free ones at drop-in centres.

Access to free lubes was reported to be difficult in both Bulawayo and Pretoria's public health facilities such as government or council-operated clinics and hospitals. All the public health facilities at community level in the two cities did not have lubricants, as they were not among the products distributed by the public health delivery systems in both countries. One of the key government informants mentioned that *"the lack of appropriate lubricants is unacceptable. Promotion and distribution of safe, condom-compatible lubricants should go hand in hand with condom promotion and distribution programs," (Key informant, Pretoria).* The public hospitals can only stock commodities supplied by the Delivery Team Topping Up (DTTU) system that is managed by the countries' Ministries of Health. Lubricants are not supplied through this system in Zimbabwe due to the criminalization of homosexuality while in South Africa they are distributed only up to the Provincial health facilities. The lower-level public facilities rarely stock the lubes because of the presence of other products in the private facilities, pharmacies and civil society organizations managed drop-in centres. However, the lubricants that are distributed to the public health facilities in South Africa are the less preferred water-based ones, creating another barrier for consistent lubricants use.

Further, distance to the drop-in centres was reported as a barrier to access the lubes by about 17% of the respondents in Bulawayo and 23% in Pretoria. The distances averaged eight kilometres in

Bulawayo and six kilometres in Pretoria. The key informants mentioned that lubes facilitate the use of condoms and ensured that they do not slip or break during sexual intercourse and it was important to advocate for their availability and access to gays and lesbians within reasonable distances, at most two kilometres. According to one of the FGD participants in Bulawayo;

"Even in instances when silicone-based lubricants were available in selected pharmacies, marketed for the general population, gays and lesbians still shun buying them for fear of giving away their sexual identity and possible negative reactions and several of us get our lubricants from friends coming from neighbouring countries such as South Africa and Botswana," (FGD participant, Bulawayo).

In Bulawayo, key informants mentioned that the legislation that criminalizes homosexuality contributes to secrecy, marginalization and acts as a barrier to accessing lubricants. They mentioned that *"Secrecy aimed at avoiding not only legal persecution, but social stigmatization and discrimination contributes to increased risk of HIV infection, delays in diagnosis and reduced access to services. In some instances, agencies and health care workers serving gays and lesbians were subjected to accusations of aiding criminality," (Key Informant, Bulawayo).*

Due to the barrier at policy level of the banning and non-recognition of homosexuality in Zimbabwe, gays and lesbians are afraid of buying products such as lubricants publicly as they risk being identified in the process by security agents. Thus, lubricants are bought secretly and if the environment in the pharmacy is not conducive, gays and lesbians avoid or defer buying them. This forces the respondents to largely rely on the lubricants found at the drop-in centres as their cue to action, because the centres are supposed to be discreet and safe, a perceived benefit of using drop-in centres to access the SRH products.

One of the most important facilitators is the huge acceptability of the lubricants among both gays and lesbians as they mentioned that it reduces the likelihood of condom breakage, tissue damage and tearing on the genitals. In an FGD with gays in Pretoria, some of the participants reported that *"We always use lubricants for anal sex as it 'feels better' and prevents condom tears or lesions during the act. Most partners accept the use of lubricants because sex becomes more fluid and pleasant and through their health education sessions, prevents bruises that promote the spread of sexually transmitted infections."* Thus, gays and lesbians use lubricants with a full understanding of the health benefits associated with their use, explaining the high rates of use by the respondents of 99% in Bulawayo and 100% in Pretoria among gays and 90% in Bulawayo and 99% in Pretoria among lesbians. This is new empirical evidence about high lubricants use among both gays and lesbians as most of the previously available data was anecdotal with most service providers assuming that condom use was higher than lubricants use among gays.

The presence of a strong social support network is confirmed by some respondents who mentioned that they received lubricants from friends, sexual partners or buy from pharmacies, acting as facilitators to promote access. About 25% of those who used lubes at their last sexual encounter received them from their friends or the partner brought them. FGD participants in Bulawayo explained this further and acknowledged that the majority of the lubricants they use were from friends or partners coming from neighbouring South Africa or Botswana;

"The struggle to get lubricants here is a real one. When our friends are coming from South Africa or Botswana, we often ask them to bring for us to avoid sourcing them locally. We just hope in future something can be done to make the lubes available in convenient spaces where we avoid clashes with the security agents," (FGD Participant, Bulawayo).

Another participant mentioned that *"Most of us know the importance of using lubricants to make sex safer and enjoyable, but the fact that our preferred brands are not available locally because of the criminalization issues, we end up getting them our friends and relatives who travel between countries," (FGD Participant, Bulawayo).* The key informants and the focus group participants in Bulawayo concurred that several lubricants brands are coming from across the borders through friends or sexual partners. This contributes to the options that gays and lesbians have of accessing the lubricants in Bulawayo. The same situation was not reported in Pretoria as the respondents indicated that they could access both water, silicone-based or natural lubes, the difference being the costs charged and choice of individuals.

5.3.3 Facility Based Services: Barriers and Facilitators

The most commonly available services for gays and lesbians in Pretoria and Bulawayo were contraceptive services (100% among gays and 98% among lesbians), STI services (counselling, testing, treatment and prevention), available to 100% gays and 97% lesbians, HIV services (PrEP, PEP, testing and counselling, treatment and adherence counselling), mentioned by 96% gays and 97% lesbians and general counselling services (78% among gays and 69% among lesbians) as in Table 9 below:

Table 9: Range of services available by proportion of respondents

Available Services	Bulawayo (Zimbabwe)		Pretoria (South Africa)		Overall	
	Lesbian	Gay	Lesbian	Gay	Lesbian	Gay
N	87	107	86	107	173	214
Contraceptive services	98.5%	100%	97.2%	100%	97.8%	100%
STI services (counselling, testing, treatment & prevention)	97.6%	100%	96.4%	100%	97%	100%
HIV services (PreP, PEP, HTC, treatment, adherence counselling)	97.5%	96.4%	96.1%	94.5%	96.8%	95.5%
Counselling services	66.7%	81.3%	72%	75%	69.3%	78.3%
Information, Education and Communications (IEC Materials)	51.2%	31.3%	39.8%	37.5%	45.5%	34.2%
Mental health and Psychosocial support services	38.3%	29.2%	37.8%	25%	38%	27.2%
Life skills & literacy building	0%	0%	0%	0%	0%	0%

The four most common services are reported to be within walking distance (less than 2 kilometres) by only 18% (16% in Bulawayo and 20% in Pretoria) of the respondents. The combined battery of services were reported to be within walking distance by only 8% of the respondents (6% in Bulawayo and 10% in Pretoria) while 92% mentioned that they made at least one or two public transport trips to access the nearest service provider. An FGD participant in Bulawayo mentioned that;

"The challenge we face is that all these services are not available under one roof, except at the Drop-in centre. One needs to have money to travel to the centres, and sometimes we pool the money together because it is difficult to always go and collect what you need alone. I think more centres should be made available in every community as it helps us to access the services anytime without thinking of transport costs", (FGD participant, Bulawayo).

Services least available include access to information, education and communications (IEC) materials (34% among gays and 46% among lesbians), parenting services (27% among gays and 4% among lesbians), mental health and psychosocial support services (27% among gays and 38% among lesbians), non-health services (youth development services, domestic violence prevention), mentioned by 4% gays and 16% lesbians and life skills and literacy building (0%).

A key informant in Pretoria bemoaned the lack of life skills trainings and limited mental health and psychosocial support services (MHPSS) and indicated that *"There is need to scale up MHPSS because we receive several cases of depression, substance abuse, stress, exposure due to unprotected sex, sexual assault and intimate partner violence which require specialized counselling services. Some of the clients are also idle in life, and it is important to train them practical life skills so that they can earn a living", (Key informant, Pretoria).*

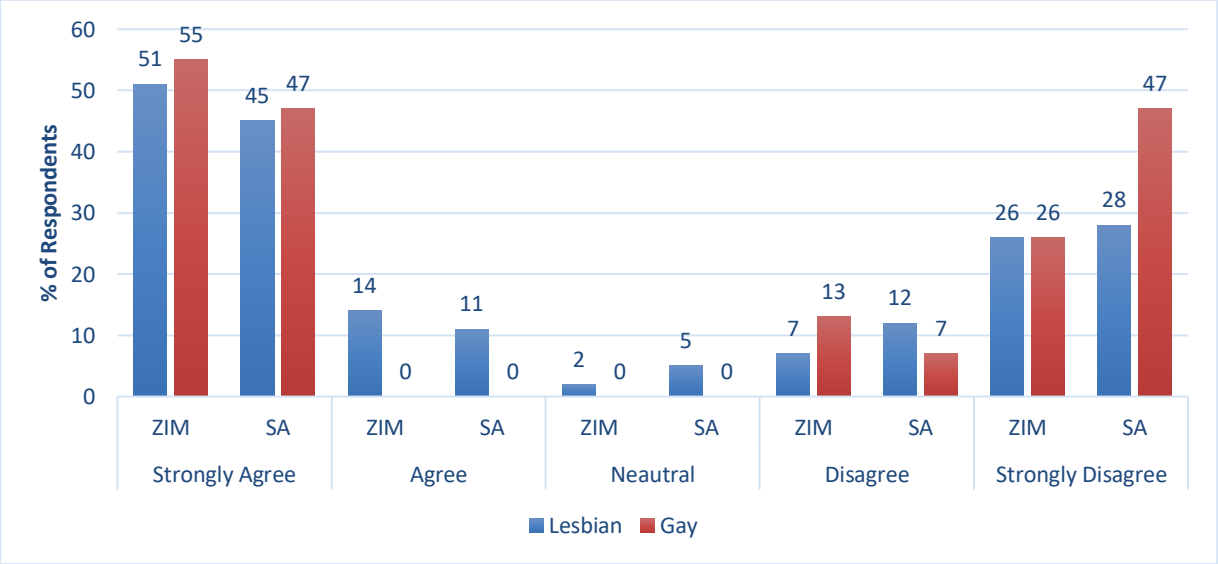
The quality of SRH services is key in determining the health seeking behaviours of gays and lesbians. The public health facilities in both countries do not meet the expectations and requirements of gays and lesbians. Only 31% of lesbians in Bulawayo and 38% in Pretoria indicated that the package of care accessed at the last health facility they visited fulfilled their needs at point of delivery or referral linkages. This means about 69% of lesbians in Bulawayo and 62% in Pretoria did not get the services they wanted when they visited the health facility. The participants in an FGD with lesbians in Bulawayo echoed that;

"Services are not available under one roof, and this makes access very difficult. Once centre may offer HIV and AIDS services only, and if you want to be screened for other STIs then you have to go elsewhere. Even screening, testing or treatment of infections such as syphilis and gonorrhoea or warts are not easily available. The package provided by most of the centres is surely not pleasing", (FGD participant, Bulawayo).

About 66% of the lesbians reported that there are limited treatment options at most of the facilities they last visited. The same scenario applies to 49% of the gay population who indicated that the services are limited in terms of their coverage and absence of treatment choices. This agreed with what was mentioned during the FGD with the lesbians in Bulawayo that the services are scattered, compromising access and quality of care.

About 51% and 60% of gays and lesbians respectively in Pretoria and Bulawayo, either agree or strongly agree that they do not go for SRH services because of the poor quality of the services. The level of agreement/ disagreement by percentage of gays and lesbians with regard to the statement: *Gays and lesbians in my community do not go for SRH services because the poor quality of services provided* is shown in Figure 4 below

Figure 4: Gays and lesbians in my community do not go for SRH services because of poor services



The situation for not going for services among gays and lesbians was worse off in Bulawayo than Pretoria. About 65% of lesbians and 55% of gays in Bulawayo compared to 56% of lesbians and 47% of gays in Pretoria either agreed or strongly agreed that poor quality was a deterrent for them to

access SRH services. One key informant from a non-governmental organization (NGO) that works with key populations in Bulawayo mentioned that;

"We try our best to do out-reaches during the night, called Moonlighting at places close to the clubs or venues visited by different groups of key populations such as sex workers, gays and lesbians. However, due to the scheduling, sometimes we come back after 3 months making the availability of the services irregular. The economic situation makes it difficult for them to keep coming to our workplace and that is why we provide some services through outreaches", (Key informant, Bulawayo).

Gays and lesbians confirmed the irregularity of the services provided by civil society organizations through outreaches. They indicated that most of the times, they complement outreach services by visiting the static sites when they have the financial resources to foot the transport bills. A combination of getting the services from outreaches and visiting static sites minimizes the gaps in the continuum of care for the various SRH services required by gays and lesbians in both Bulawayo and Pretoria. A report of the role of mobile outreach services by the Ministry of Health in Zimbabwe indicated that it is valued model that is preferred especially to service hard-to-reach communities such as sex workers, LGBTIQ, artisanal miners and farm workers (Zimbabwe Ministry of Health, 2019).

5.3.3.1 Stigma and Discrimination

Gays and lesbians experience various forms of stigma and discrimination within the society and from service providers. The proportions of gays and lesbians who experienced various forms of stigma and discrimination are shown in Table 10 below. The lesbian population in both cities experienced more discrimination than the gay population. A larger proportion of lesbian (88%) than gays (63%) were made to feel bad because of things people did or said to them aligned to

their sexual orientation. About 51% of lesbians compared to 24% of gay respondents in the two cities were excluded from social events because of their sexual orientation. More than half (56%) of the lesbian respondents and 31% of gay respondents experienced sexual assault. In Pretoria, a key informant mentioned that; *"we have had several cases, in fact 3 in this month alone, of corrective rape[1] on our lesbian clients. There is no doubt that so many may go unreported, but this is a big issue we are facing", (Key informant, NGO, Pretoria).*

Table 10: Proportions of Gays and Lesbians who experienced stigma

Criteria	Bulawayo (Zimbabwe)		Pretoria (South Africa)		Overall	
	Lesbian	Gay	Lesbian	Gay	Lesbian	Gay
N	87	107	86	107	173	214
Made to feel bad because of things people did or said to you because you are gay/lesbian?						
Yes	88.5%	63.6%	88.4%	61.7%	88.4%	62.6%
No	11.5%	36.4%	11.6%	38.3%	11.6%	37.4%
Experienced any of the following and you thought it was because you are gay/lesbian						
Excluded from social events	50.6%	20.6%	52.3%	28%	51.4%	24.3%
Abandoned by your spouse or partner	33.3%	19.6%	39.5%	23.4%	36.4%	21.5%
Abandoned by other family members	33.3%	4.7%	34.9%	5.6%	34.1%	5.1%
Sexually assaulted by anyone	54%	29%	57%	33.6%	55.5%	31.3%
Had property taken away	32.2%	0	31.4%	0	31.8%	0
When you used health services, did the following happen to you and you thought it was because you are gay/lesbian?						
Staff ignored you or avoided taking care of you	38.4%	20.8%	46.5%	24.8%	42.4%	22.7%
You were denied care that you should have received	36%	20.8%	45.3%	24.8%	40.7%	22.7%
You were treated with disrespect or abused	10.5%	37.5%	20.9%	33%	15.7%	35.3%

[1] Corrective rape is the term used to describe when men rape lesbians in what they see as an attempt to 'correct' their sexual behaviour.

Stigma and discrimination experienced in the community also permeates through to the health service providers. Regarding access to health services, 23% gays and 42% lesbians reported that they had been ignored by staff or they were ignored at the last health facility they visited. A similar proportion of gays (23%) and 41% lesbians indicated that they were denied care that they should have received because they were gays or lesbians. More gays (35%) than lesbians (16%) were treated with disrespect or abused when they visited a health facility. These acts of stigma and discrimination affected the perceptions that gays and lesbians had regarding the quality of the services and were barriers to them or their peers against health seeking behaviour. One FGD participant indicated that;

"There are massive issues regarding the society and health providers' perceptions about us. Here they see us as misfits and so many times when you go and indicate that you want to be examined or screened for anal STIs, they become very judgemental. Sometimes we just self-diagnose and go and get some medicines from the pharmacy", (Gay FGD participant, Bulawayo).

The stigma and discrimination experienced by gays and lesbians is a perceived barrier to accessing services as most of them reported that they ended up avoiding service providers with discriminatory tendencies. This caused them to either fail to access the SRH services with the frequency they require or travel longer distances to access services from preferred service providers. The findings confirm a 2011 study done in Mozambique where it was confirmed that approximately 5.2%, 8.0%, and 8.1% of MSM in Maputo, Beira, and Nampula, respectively, had experienced discrimination and violence in the 12 months preceding the survey (INS et al, 2017). The experience of discrimination was defined in the survey as when an MSM believes he was refused services because he was perceived to be an MSM. The services concerned are health care, employment, education, police services, legal assistance, accommodation and service in a

restaurant or bar. In a similar study in Malawi, Bandawe (2015) reported that because of fear of stigma and discrimination coupled with unfriendly laws, many LGBTIQ individuals operate underground, which makes it much harder to target them with sexual reproductive health (SRH) interventions. The respondents in both Pretoria and Bulawayo implored that the government and non-governmental organizations need to retrain the health care workers to provide services that are friendly to key populations.

5.3.3.2 Fear of cancer screening services

Most gays (64%) and lesbians (57%) had not been screened for any type of cancer before at the health facilities. About 79% of lesbians were routinely screened for cervical cancer and only about 55% gay respondents were routinely screened for prostate cancer as in Table 11 below. Most lesbians go for routine screening more frequently than gays and about 52% of lesbian respondents intended to go for routine screening in 30 days' time while about 60% of gays intended to go for the screening after 6 months.

Table 11: Cancer screening by proportion of respondents

Variable	Bulawayo (Zimbabwe)		Pretoria (South Africa)		Overall	
	Lesbian	Gay	Lesbian	Gay	Lesbian	Gay
N	87	107	86	107	173	214
Screened for cancer at the health facilities	43.7%	40.2%	43%	30.8%	43.4%	35.5%
Which type of cancer were you routinely screened for						
Cervical	76.3%	NA	81.1%	NA	78.7%	NA
Prostate	NA	60.5%	NA	48.5%	NA	55.3%
When do you intend to go for another routine screening?						
30 days	52.9%	2.8%	50%	0	51.5%	1.8%
3 months	26.5%	27.8%	31.3%	14.3%	28.8%	22.8%
6 months	8.8%	55.6%	12.5%	66.7%	10,6%	59.6%
Do not know	11.8%	13.9%	6.3%	19%	9.1%	15.8%

The reluctance to seek cancer screening was mentioned by some FGD participants in both Bulawayo and Pretoria. The main perceived barrier to cancer screening as a positive health behaviour was the fear of being diagnosed in the absence of treatment facilities as most of the respondents mentioned that they knew of relatives who never recovered once diagnosed with some cancers. The respondents mentioned that healthcare workers can help women and men move past cancer screening fears to promote early detection through sustained health education during outreach activities.

However, one participant during an FGD in Bulawayo had a positive message to encourage screening by mentioning that;

"I think HIV and AIDS is better than cancer, because most of the cancers cannot be cured and AIDS can be managed through ARVs. Everyone who was diagnosed with cancer that I heard died before or soon after completing chemotherapy. The chemo is also very expensive so it is better to be screened and diagnosed early. The only challenge is that very few facilities offer screening and that is a problem", (FGD participant, Bulawayo)

The limited service-providers for cancer screening services were mentioned by the key informant from the Zimbabwe Ministry of health who indicated that there were plans to expand the services to lower level health facilities in Zimbabwe and provide mobile screening services where applicable, for cervical, prostate and HPV-related anal cancers.

Further analysis, as shown in Table 12 below shows that there are significant differences between the two cities (p=0.046) and between gays and lesbians' (p=0.000) towards cancer screening. Comparatively, there are more gays and lesbians screened for cancer in Bulawayo (57%) than in Pretoria (44%). Differences at city level may be indicative of availability of facilities for cancer screening as well as the awareness among gays and lesbians of the importance of cancer screening,

which is linked to their self-efficacy to access these services. There are more lesbians (63%) than gays (42%) screened for cancer, and the difference is significant (p=0.000).

Table 12: Percent of Respondents screened for cancer by city and by KP group

Measurement Variable/ Determinant	%	p - value
% screened for cancer by city		
Bulawayo	56.6	.046
Pretoria	44.3	
% screened for cancer by KP group		
Lesbians	63.0	.000
Gays	41.8	

The age and educational levels of gays have a significant effect on cancer screening behaviours. A higher proportion of gays (79%) aged 18 years and compared to 11% of gays above 18 years were screened for at least one type of cancer (p=0.00). This is due to the higher prevalence of cancers among the older citizens and the respondents feared they would be in this category, thereby acting as a perceived barrier to access the service. The younger gays and lesbians have lower risk perceptions and susceptibility for cancers and are therefore less afraid to screen for cancers. As regards educational level, 63% of gays with primary/secondary level education were screened for cancer compared to 12% with tertiary/ university level education (p=0.000).

The level of education attained by lesbians is a significant determinant (p=0.003) for cancer screening behaviour as all lesbians with tertiary/university level education (100%) were screened for cancer while 85% with primary/ secondary level education were screened. This means that the more educated gays and lesbians have better preventive health seeking behaviour than the less educated due to greater exposure to health information, a perceived facilitator encouraging their access to the service. The fear of being screened was not only for cancer, but for HIV and all other sexually transmitted infections as gays and lesbians mentioned that sometimes living in denial was

better than knowing their status and not be able to access further services. This fear was a perceived barrier as it linked up with the low knowledge levels regarding the health benefits of accessing the screening services in the two cities.

5.3.3.3 Acceptability of Services

The acceptability of a service by the users can act as a barrier or a facilitator to promote or discourage access to the service. Even though over 80% of lesbians in the two cities acknowledge that the health facilities they last visited had a good reputation, few (18%) would recommend the facility to a friend. Only 12% and 24% of lesbian respondents in Bulawayo and Pretoria respectively would recommend the facility to a friend. Unlike lesbians, most gays would recommend facilities with good reputation to a friend. However, it is important to note that once a facility was rated as acceptable among gays, they would recommend it to their peers, unlike lesbians who rated facilities as acceptable but would still not recommend it. In Bulawayo, 80% agreed that the facility they last visited had a good reputation but only 12% would recommend it to a friend, 85% and 24% for Pretoria as well as in Table 13 below.

Table 13: Acceptability of SRH services by proportion of respondents

Variable	Bulawayo (Zimbabwe)		Pretoria (South Africa)		Overall	
	Lesbian	Gay	Lesbian	Gay	Lesbian	Gay
N	87	107	86	107	173	214
Client would recommend the facility to friend	12.2%	68.8%	24.1%	62.5%	18.2%	65.8%
Facility has good reputation	80%	69.8%	85%	63.6%	82.5%	66.8%

In FGDs with lesbians in both countries, it was gathered that "*Usually the facilities had good reputation because of facilitators such as their location, availability of most of the required services, treatment options and good referral systems but the only barrier was the health care workers, who*

had issues when it comes to serving the key populations," (FGD participant, Pretoria). Accessing the SRH services would give them a different opinion and would not recommend to their friends, thereafter, including the absence of user-friendly ablution facilities at three of the health facilities.

Further analysis reveals that there is no significant difference between the two cities regarding the reputation of facilities (p=0.652) as shown in Table 14. This means that facilities in both Bulawayo and Pretoria are regarded as having the same quality of health facilities and challenges. A significant difference exists between lesbians and gays (p=0.009) on this perception. About 81% of lesbians pointed out that the facilities had good reputation compared to 70% of gays, with the issue being failure to recommend the facilities to their peers.

Table 14: Percent of respondents indicating good reputation of facilities by city and by KP group

Measurement Variable/ Determinant	%	p - value
% of lesbians and gays indicating facility has good reputation by city		
Bulawayo	73.8	.652
Pretoria	75.8	
% of gays and lesbians who indicate facility has good reputation		
Lesbians	81.3	.009
Gays	69.5	

Age is a significant factor for lesbians (p=0.000) but not for gays (p=0.062). About 94% of lesbians aged above 18 years indicated the facilities were of good reputation compared to 63% of lesbians aged 18 years and below. This indicates that the services were not uniformly rated, and they appealed more to the older than the younger lesbians. This is consistent with the findings in studies done by UNFPA (2017) which indicated that there were significant gaps in provision of SRH services for adolescents, hence advocating for the establishment of adolescent friendly SRH centres, including adolescent key populations.

There is no significant difference between the two cities (p=0.710) regarding recommending the last health facility they visited while the difference between gays and lesbians is significant (p=0.000) as shown in Table 15 below. More gays (66%) would recommend health facilities to friends than lesbians (19%) and this indicates the prevalence of self-centredness among lesbians on one hand or that the service they received was not to their expectation. These are barriers to behaviour change that public health authorities would have to contend with to promote the access of SRH services by gays and lesbians, as the HBM posits.

Table 15: Percent who recommend health facility by country and KP group

Measurement Variable/ Determinant	%	p - value
% of gays and lesbians who would recommend facility to a friend by city		
Bulawayo	42.6	.710
Pretoria	44.6	
% of gays and lesbians who would recommend facility to a friend		
Lesbians	19.3	.000
Gays	65.8	

However, more younger gays and lesbians (18 years and below) than the older ones tend to recommend good health facilities to friends. The study shows that 27% of lesbians aged 18 years and below recommended reputable health facilities to friends compared to 14% of lesbians above 18 years (p=0.037). On the other hand, 76% of gays aged 18 years and below recommended good health facilities to friends compared to 60% of gays older than 18 years (p=0.027), showing that the younger gays and lesbians were more open to share information with their peers hence acting as a facilitator to access of SRH services.

One's level of education is also significant in determining whether one was likely to recommend a reputable health facility to a friend or not. Advancement in education militated against sharing information regarding good health facilities among gays and lesbians as in Table 16 below. About

31% of lesbians and 74% of gays with primary/ secondary level of education recommended facility to friends compared to only 4% lesbians and 48% of gays with tertiary/ university level education.

Table 16: Percent of Gays and Lesbians who recommend facility to friend by educational level

Measurement Variable/ Determinant	Primary/ Secondary	Tertiary/ University	p - value
Lesbian	30.9	4.1	.000
Gay	74.2	47.5	.000

During an FGD in Bulawayo, it was mentioned that *"the upper-class gays and lesbians have access to a lot of information and services on the internet, which is sometimes problematic for the lower classes to access due to costs of data and internet coverage", (FGD participant, Bulawayo).* The issue of access to information results in the less educated respondents recommending the facilities to their friends because of limited exposure to better facilities elsewhere. The more educated and well-resourced gays and lesbians indicated that the facilities they encounter in the two cities are not the best if compared to what is available in other countries and therefore their expectations are higher for better quality SRH services.

5.3.3.4 Convenient working hours

Access to SRH services is further affected by the convenience or inconvenience of working hours. Service provider working hours are quite convenient for all gays (100%) and almost all lesbians (98%) in the two cities as shown in Table 17 below.

Table 17: Accessibility of SRH services by proportion of respondents

Variable	Bulawayo (Zimbabwe)		Pretoria (South Africa)		Overall	
	Lesbian	Gay	Lesbian	Gay	Lesbian	Gay
N	87	107	86	107	173	214
Convenient working hours	98.8%	100%	97.6%	100%	98.2%	100%
Gay/ Lesbian only hours	29.6%	69.8%	29.3%	69.3%	29.4%	69.6%

However, services with reserved times for gays and lesbians are quite few in both cities with lesbians being the most affected. Only 29% of lesbian respondents indicated availability of services with lesbian only hours. This means that the services are availed to both the general and the key populations at the same opening and closing times, thus acting as a barrier to almost 30% gays and 70% lesbians who would have preferred specific hours for them to access services without fear of mixing with members of the general population.

Availability of these key populations (KP) - only hours (hours reserved for all key population groups such as sex workers, gays, lesbians, bisexual, transgender, intersex, queer and others) is not significantly different between the two cities (p=0.915). However, there is a significant difference in the availability of KP- only hours between lesbians and gays. About 71% of gays compared to 28% of lesbians indicated availability of KP - only hours (p=0.000). Hence, lesbians have limited access to health facilities with lesbian-only hours, acting as a perceived barrier to their access of SRH services. Facilities such as New Start centres in Bulawayo's City Centre, Nkulumane, Matabeleland AIDS Council (MAC) and outreaches to different moonlighting areas around the Bulawayo city have KP-only hours. In Pretoria, SFH facilities in Hatfield, Tembisa, Lotus Gardens and Stanza 2 Bopape have KP-only hours. This facilitates more comfortable access of services by these key population groups in an environment that is user-friendly to them.

The ages and levels of education for lesbians and gays are significant determinants in accessing health facilities with KP Only hours. This means there are areas accessible to some specific age groups but not the other ages, while others are accessible to gays and lesbians with specific levels of education. Further probing revealed that there are health facilities *"where you can book for an appointment in advance and come at a specific time and see a specific health care worker. The choice of time is as per the flexibility of the client and nurses' or doctors' availability. This was for*

specialized services such as PreP initiation and others," (Key informant, heath service provider, Pretoria). The respondents indicated that these facilities are preferable to them as they will not waste their time with waiting in the queues. A further advantage mentioned by the respondents in Pretoria was that prior bookings guarantee the availability of a preferred health care worker with history of the health issues faced by the patient.

More lesbians (41%) and gays (81%) aged 18 years or below indicated availability of KP-only hours compared to those above 18 years (65% gays and 19% lesbians) as shown in Table 18 below. Thus, there were health facilities with KP- only hours that were accessible to more gays and lesbians aged 18 years and below than those aged above 18 years.

Table 18: Percent of KPs indicating availability of KP Only Hours by Age

Measurement Variable/ Determinant	18 years or below	Above 18 years	p - value
Lesbian	40.8	19.4	.002
Gay	81.4	64.8	.014

The same situation applied to the level of education in relation to accessing health facilities for SRH in Bulawayo and Pretoria. More lesbians and gays (51% and 81% respectively) with primary/secondary level education indicated availability of KP - only hours while comparatively fewer gays and lesbians (48% and 40% respectively) with tertiary/ university level education indicated the same.

5.3.3.5 Limited treatment options

The difference between Bulawayo (42%) and Pretoria (43%) in terms of choice of treatment options for HIV, STIs and other health conditions is not significant (p=0.816). However, the availability of choice of treatment by gays (50%) and lesbians (34%) respondents is significant (p=0.002) in the two cities as shown in Table 19 below.

Table 19: Percent indicating availability of choice of treatment options by city and KP group

Measurement Variable/ Determinant	%	p - value
% of gays and lesbians indicating availability of choice of treatment options by city		
Bulawayo	42.1	.816
Pretoria	43.1	
% of gays and lesbians indicating availability of choice of treatment options by group		
Lesbians	33.7	.002
Gays	50.3	

Age and educational levels of lesbians and gays are also significant determinants in the availability of choice for treatment options. The younger gays and lesbians (74% and 54%), aged 18 years and below had more choice of treatment options compared to their older counterparts (37% gays and 19% lesbians), aged 18 and above (p=0.000) as in Table 20 below.

Table 20: Percent of gays and lesbians indicating availability of choice of treatment options by age

Measurement Variable/ Determinant	18 years or below	Above 18 years	p - value
Lesbian	53.5	19.4	.000
Gay	74.3	36.8	.000

The choice of treatment options for both lesbians and gays was also largely available to gays and lesbians (72% gays and 60% lesbians) with primary/secondary level education than those with tertiary/ university level education (0%) as shown in Table 21 below. All lesbians and gays (100% for both) with tertiary/university level education mentioned that there was no choice of treatment options, a barrier that affected access to all the SRH services that gays and lesbians required in the two cities.

Table 21: Percent of KPs indicating availability of choice of treatment options by educational level

Measurement Variable/ Determinant	Primary/ Secondary	Tertiary/ University	p - value
Lesbian	60.0	0.0	.000
Gay	72.1	0.0	.000

A key informant mentioned that *"it is disheartening to fail to provide services required by your clients. We rely on referrals and linkages with other service provider to ensure that the complete package of services is provided to our key populations. It is not easy, but we have since invested into expanding the referral network,"(Key informant, Bulawayo).*

The limited treatment options are a perceived barrier, according to the postulations of the HBM, to accessing services for those facilities that were last visited by gays and lesbians. As indicated by the key informant, the absence of services required by gays and lesbians presents a challenge to the service providers, and they end up referring the clients to facilities that are far away from the comfort of the respondents. The referral linkages are not fully functional in Bulawayo as most of the facilities face the same challenges and delivered a similar package of care services, while in Pretoria, the respondents are able to access the required services from the referred institutions.

5.3.3.6 Administrative Procedures

More gay respondents (78%) than lesbians (66%) in the two cities are comfortable with the waiting time before receiving services, as shown below in Table 22.

Table 22: Appropriateness of Administrative Procedures by Proportion of Respondents

Variable	Bulawayo (Zimbabwe)		Pretoria (South Africa)		Overall	
	Lesbian	Gay	Lesbian	Gay	Lesbian	Gay
N	87	107	86	107	173	214
Waiting time is okay	66.3%	81.3%	65%	75%	65.6%	78.3%
Choice to be seen by the same clinician during next visit	5%	46.9%	13.8%	48.9%	9.4%	47.8%

However, most gays and lesbians do not have the choice to be seen by the same clinician during their next visit. This choice is not available for 91% of the lesbians, compared to 52% of gays in the

two cities who could not make a choice to be seen by the same clinician during their next visit. This is a huge barrier as most gays and lesbians who participated in the FGDs revealed that;

"We prefer to go to the same service provider and be attended to by the same nurse or doctor than to change every time you visit a clinic. It is not always easy to narrate your story to a new person every time. A few clinics are making that possible, especially when you book in advance, but the majority are not. So, it is a new face every time and it really is embarrassing at times,"

(FGD participant, Pretoria)

There is a significant relationship between level of education and how gays and lesbians feel about waiting times at health facilities. More lesbians and gays with primary/secondary level education (84%) were comfortable with the waiting times at health facilities than those with tertiary/university level education (43%) as shown in Table 23 below.

Table 23: Comfortable with waiting time and availability of choice by level of education

Measurement Variable/ Determinant	Primary/ Secondary	Tertiary/ University	p - value
% comfortable with waiting time at health facility by level of education			
Lesbians	83.7	43.2	.000
Gays	79.3	49.2	.000
% indicating availability of choice to be seen by the same clinician			
Lesbians	18.5	4.1	.005
Gays	43.8	47.5	.636

Regarding the choice to be seen by the same clinician, there was a significant relationship for lesbians but not for gays. Only 19% with primary/secondary level education indicated availability of choice compared to 4% of tertiary/university level lesbians (p=0.005). This reinforces the finding that choice of service provider is a huge barrier for accessing SRH services, more for lesbians and less of a problem for gays in the two cities.

One's age is a factor in accessing health services and facilities and Table 24 shows that age is significant for gays but not for lesbians as regards waiting time at health facility. There are more gays aged 18 years and below (84%) who are more comfortable with waiting times at health facility than those above 18 years (63%) (p=0.001), showing that the older are less patient than the younger key populations as indicated in Table 28 below.

Table 24: Comfortable with waiting time and availability of choice by age of KP

Measurement Variable/ Determinant	18 years & below	Above 18 Years	p - value
% comfortable with waiting time at health facility by age			
Lesbian	63.2	63.7	.583
Gay	84.2	62.5	.001
% indicating availability of choice to be seen by the same clinician			
Lesbian	27.9	1.0	.000
Gay	67.1	30.8	.000

Age is significant for both gays and lesbians as regards availability of choice to be seen by the same clinician. Comparatively, there are more lesbians and gays aged 18 years and below (67% gays and 28% lesbians, p=0.000) who indicated the availability of choice to be seen by the same clinician than those above 18 years of age (31% gays and 1% lesbians, p=0.000).

5.3.4 Barriers and Facilitators to Accessing Institution-based Services

5.3.4.1 Convenient Opening Hours

There are differences between the two cities and the perceptions of lesbians and gays regarding the convenience of health facility opening hours. Almost all the respondents (97%) in Bulawayo and 91% of respondents in Pretoria are happy with the opening hours of the health facilities they last visited within the past six months. Despite high percentages of respondents who are happy with opening hours in the two cities, there is still scope for public authorities in both cities to draw lessons from their differences to further enhance convenience in health facility opening hours for

the benefit of key populations in the two cities. By KP group, 98% of lesbians compared to 92% of gays interviewed regard the health facility opening hours as convenient as in Table 25 below.

Table 25: Percent of Respondents happy with opening hours by city and KP

Measurement Variable/ Determinant	%	p – value
% who regard Health Facility Opening Hours as Convenient by City		
Bulawayo	97.3	.046
Pretoria	91.4	
% who regard Opening Hours as Convenient by KP group		
Lesbians	97.6	.034
Gays	91.6	

Similarly, to enhance equity between the two groups, public health authorities would need to address any differences in opening hours whilst catering for the specific needs of each group. This means that opening hours are a barrier to 2% of the lesbians and 8% of gays.

However, convenient opening hours is one key facilitator which authorities can leverage on to promote positive health seeking behaviours among gays and lesbians. While the survey shows that ages of both lesbians and gays are not significant in the acceptability of convenient opening hours, the level of education, particularly for gays, is an important consideration. All (100%) tertiary/university level gays were happy with opening hours compared to 88% of gays who had attained primary/ secondary level education (p=0.022). This may be linked to the occupations of gays with the more educated ones being available at certain hours that may not be convenient in comparison to their less educated counterparts. SANAC (2017) observed the same results in a study in South Africa where they encouraged services to be available 24 hours to cater for the different times that members are available and 'leave no-one behind'.

5.3.4.2 Social Support

The level of support or lack of it from peers, partners and family members is crucial in understanding health seeking behaviour of key populations and can act as a facilitator and barrier to accessing SRH services. Gays and lesbians view the support they get from their friends, partners and parents differently as shown in Table 26 below.

Table 26: Perception on Level of Social Support by Proportion of Respondents

Criteria	Bulawayo (Zimbabwe)		Pretoria (South Africa)		Overall	
	Lesbian	Gay	Lesbian	Gay	Lesbian	Gay
N	87	107	86	107	173	214
My friends encourage me to go for SRH services						
Strongly Agree	64.4%	84.1%	61.6%	76.6%	63%	80.4%
Agree	2.3%	13.1%	5.8%	21.5%	4%	17.2%
Neither agree nor disagree	1.1%	1.9%	0	0	0.6%	0.9%
Disagree	25.3%	0.9%	29.1%	1.9%	27.2%	1.4%
Strongly disagree	6.9%	0	3.5%	0	5.2%	0
My partner/spouse encourages me to go for SRH services						
Strongly Agree	77%	96%	81.4%	89.7%	79.2%	92.9%
Agree	19.5%	2%	17.4%	7.2%	18.5%	4.6%
Neither agree nor disagree	2.3%	2%	1.2%	3.1%	1.7%	2.5%
Disagree/Strongly disagree	1.1%	0	0	0	0.6%	0
My parents encourage me to go for SRH services						
Strongly Agree	35.6%	41.1%	37.2%	37.4%	36.4%	39.3%
Agree	12.6%	0.9%	14%	1.9%	13.3%	1.4%
Neither agree nor disagree	3.4%	8.4%	9.3%	15.9%	6.4%	12.1%
Disagree/Strongly disagree	48.3%	49.5%	39.5%	44.9%	43.9%	47.2%

Most lesbian and gay respondents strongly agree that their partners/spouses and friends encourage them to go for SRH services. It is important to note that about a third (32%) of lesbian respondents disagree or strongly disagree that their friends encourage them to go for SRH services. This contributes to influencing their health seeking behaviour and acts as a perceived barrier to

accessing SRH services among them. The proportion of gays and lesbians receiving parental encouragement to go for SRH services was also low in both cities and between the two groups (41% among gays and 50% among lesbians). This is due to the fact that fewer gays and lesbians discussed the issues of SRH services with their parents.

However, for those who freely and often discuss SRH issues with their parents, parental encouragement was often provided. About 49% of lesbian and 40% of gay respondents in both countries agree or strongly agree that their parents encourage them to go for SRH services. A response from an FGD participant supported this finding that;

"When we are discussing with our parents, most of them do not know that we have our preferred orientation and the services we discuss are those that are also accessed by non-key populations. But it is not easy to tell them that sometimes you want specialized services, that you can access from Drop-in centres or other non-conventional health facilities," (FGD participant, Bulawayo)

The difficulties associated with opening to social support systems about sexual orientation and the specialized services required often acts as a barrier for the respondents' access to SRH services. This was mentioned mainly by the younger gays and lesbians who still rely on parental financial support to access health services.

Besides social support, self-efficacy, belief and esteem are crucial intrinsic determinants in an individual's health seeking behaviour. The level of self-efficacy in seeking health services by gays and lesbians shows that over 80% of lesbians and 100% of gay respondents in the two cities strongly agree that they know where to go and what to do if they want to access SRH services. The high levels of self-efficacy are crucial facilitators to ensure SRH services were accessed by both groups.

About 60% of lesbians and 70% of gays in Bulawayo strongly agreed that they knew where to go and what to do to access SRH services, a facilitator that encourages access of services. Pretoria had relatively lower proportions of gays and lesbians than Bulawayo who know where to go and what to do as 52% of lesbians and 60% of gays strongly agreed with the statement. Despite the high proportions of gays and lesbians with knowledge about where to go and what to do to access SRH services, fewer had the confidence that they could go and access the services they wanted. Lesbians (56%) are less confident than gays (65%) about going on their own to access SRH services as shown below in Table 27 below.

Table 27: Self efficacy by proportion of respondents

Criteria	Bulawayo (Zimbabwe)		Pretoria (South Africa)		Overall	
	Lesbian	Gay	Lesbian	Gay	Lesbian	Gay
N	87	107	86	107	173	214
I know where to go and what to do if I want to access SRH services						
Strongly Agree	86.2%	100%	90.7%	100%	88.4%	100%
Agree	13.8%	0	9.3%	0	11.6%	0
Neither agree nor disagree, Disagree/Strongly disagree	0	0	0	0	0	0
I am confident that I can go and access any SRH services I want						
Strongly Agree	59.8%	70.1%	52.3%	59.8%	56.1%	65%
Agree	2.3%	0	8.1%	0	5.2%	0
Neither agree nor disagree	13.8%	7.5%	19.8%	15%	16.8%	11.2%
Disagree	2.3%	14%	2.3%	10.3%	2.3%	12.1%
Strongly disagree	21.8%	8.4%	17.4%	15%	19.7%	11.7%

Confidence to access SRH services is a barrier to 23% gays and 23% lesbians across the two countries, with highest proportions among lesbians (24%) in Bulawayo and gays (25%) in Pretoria who indicated that they disagree or strongly disagree that they are confident that they could access the SRH services.

5.3.4.3 Equitability of services

All gay respondents (100%) in both countries felt welcomed at receptions of SRH service providers regardless of their age, gender, race or sexual orientation as in Table 28 below while a lesser proportion (only 64%) of the lesbians felt welcomed.

Table 28: Equitability of services by proportion of respondents

Criteria	Bulawayo (Zimbabwe)		Pretoria (South Africa)		Overall	
	Lesbian	Gay	Lesbian	Gay	Lesbian	Gay
N	87	107	86	107	173	214
Felt welcomed at the reception	64.2%	100%	64.6%	100%	64.4%	100%
Open to persons of all sexual orientations	64.2%	100%	65.4%	100%	64.8%	100%

The service providers welcomed gays as indicated by 100% of respondents at their receptions. However, the situation was different with lesbian respondents as about 36% of them did not feel welcomed at the SRH service providers. This shows that some service providers are less friendly to the lesbians compared to treatment they provide to gays, and this is a huge barrier to accessing SRH services. This pattern is worse for those who presented as couples at the health facilities. Beyond the reception, acceptability depends on who is serving them, and the nature of the health issues presented, as discussed under stigma and discrimination.

Further analysis shows that there are no significant differences at city level in the way gays and lesbians are received at receptions of health facilities as in Table 29 below. However, there are more gays (100%) than lesbians (65%) who felt welcomed at health facilities regardless of age, gender or sexual orientation (p=0.000).

Table 29: Percent of respondents welcome at health facility by city and KP group

Measurement Variable/ Determinant	%	p - value
% who indicate they felt welcomed at health facility regardless of age, gender or sexual orientation by city		
Bulawayo	82.9	.822
Pretoria	82.6	
% who indicate they felt welcomed at health facility regardless of age, gender or sexual orientation by group		
Lesbians	65.1	.000
Gays	100.0	

This means public authorities in both countries need to do more work specifically targeting the lesbian population if equitable access to health facilities was to be achieved. Inequitable services are therefore a barrier that needs to be addressed in both cities.

The age of an individual influences how one is treated by health officials. There are significantly fewer younger lesbians than those above 18 years (52% younger and 83% older) who felt welcomed at reception centres of health facilities. The same was true for gays, as all those older than 18 years (100%) felt more welcomed than the younger ones (96%). This adds to the earlier finding that the young gays and lesbians are less comfortable accessing SRH services regardless of where they are located as shown in Table 30 below.

Table 30: Percent of KPs welcome at health facility regardless of age, gender or sexual orientation

Measurement Variable/ Determinant	18 years or below	Above 18 years	p - value
% gays and lesbians who indicate they felt welcomed at health facility regardless of age, gender or sexual orientation by Age Category			
Lesbian	52.0	83.0	.000
Gay	95.7	100.0	.024
% gays and lesbians who indicate Health Facility is open to persons of all sexual orientation			
Lesbian	87.7	51.0	.000
Gay	95.7	100.0	.024

The difference between perceptions of gays and lesbians indicates that the older lesbians and the younger gays had the same experiences that made them conclude that health facilities are not

entirely open to persons of different sexual orientations. This shows that SRH services were not equitably provided to gays and lesbians in the two cities, as there are disparities within each KP group.

5.3.4.4 Staff Characteristics and Competence

Significant proportions of the gay respondents across the two cities (20% in Bulawayo and 22% in Pretoria) reported that the SRH service providers are not friendly, only 67% said they are non-judgemental and 9% indicated that they are not respectful as shown below in Table 31.

Table 31: Staff characteristics by proportion of respondents

Variable	Bulawayo (Zimbabwe)		Pretoria (South Africa)		Overall	
	Lesbian	Gay	Lesbian	Gay	Lesbian	Gay
N	87	107	86	107	173	214
Non-judgmental	68.7%	68.1%	66.1%	66.6%	67.4%	67.3%
Friendly	64.6%	80.0%	66.3%	78.0%	65.5%	75.0%
Respectful	63.4%	82.0%	63.9%	80.0%	63.6%	91.0%
Provider uses language that is understandable to clients	98.8%	100.0%	98.8%	100.0%	98.8%	100.0 %

Similarly, about two thirds of all lesbian respondents in the two countries (69% in Bulawayo and 66% in Pretoria) indicated that the staff were not judgemental and used appropriate language that was understandable to them. However, almost a third of the lesbian respondents in both countries felt that staff members are not friendly or respectful (25% and 36% respectively). This is a huge potential barrier to accessing SRH services as the absence of respect may result in some clients shunning the services and should be addressed by the responsible authorities. The WHO (2017) confirmed that many countries globally have healthcare workers who require further support to improve their skills and change their attitude to effectively provide user-friendly services to the LGBTIQ community.

5.3.4.5 Confidentiality and Privacy of services

Almost all gays and lesbians interviewed conceded that client consultations are held in privacy in both countries as shown below in Table 32. Almost all (97%) of lesbian and 79% of gay respondents indicated that the staff explained the confidentiality of the services. The presence of a private and confidential set up at the health facilities is a facilitator that promoted access to the services.

Table 32: Confidentiality and Privacy of Services by Proportion of Respondents

Variable	Bulawayo (Zimbabwe)		Pretoria (South Africa)		Overall	
	Lesbian	Gay	Lesbian	Gay	Lesbian	Gay
N	87	107	86	107	173	214
Confidentiality and privacy are respected	64.6%	82.3%	59%	76.1%	61.8%	79.3%
Client consultation cannot be heard or seen by other clients or staff	100%	100%	100%	100%	100%	100%
Staff explains services are confidential	97.6%	82.3%	96.4%	76.1%	97%	79.3%

While the environment was conducive for confidentiality and privacy, the perception of the key population groups on the practice of staff members is quite varied. Analysis was done to show the proportion of lesbian and gay respondents in both cities who agree or disagree with the statement that '*staff members are very careful not to reveal private patient information*'. Just about two thirds of lesbian respondents (67% in Pretoria and 62% in Pretoria) in both countries strongly agreed while a quarter of the respondents were neutral (26% in Bulawayo and 24% in Pretoria). However, almost half (43% in Bulawayo and 41% in Pretoria) of gays strongly disagreed that the staff members were very careful not to reveal private information, compared to 5% and 12% in Bulawayo and Pretoria among the lesbians respectively.

The strong negative perception acts as a barrier among the gay respondents in both cities on the behaviour of staff members as 43% and 41% of gay respondents in Bulawayo and Pretoria respectively strongly disagreed regarding the statement. There is a general feeling among 42% of gays in Bulawayo and Pretoria that their health test results and records are not kept confidentially. Only 8% of lesbian respondents in both countries disagree or strongly disagree with the statement which shows that confidentiality issues are perceived to be well observed among health care workers who attend to the lesbian population compared to the staff members providing services to the gay population, acting as a barrier to both key population groups.

A friendly and respectful environment facilitates positive health seeking behaviours among gays and populations. The difference in the way staff were friendly and respectful between gays (99%) and lesbians (66%) is significant (p=0.000) and in both instances there were more gays than lesbians who indicated that the staff were friendly and respectful as shown in Table 33 below.

Table 23: Staff friendliness and respectfulness by KP group

Measurement Variable/ Determinant	%	p - value
% indicating staff is friendly to them		
Lesbians	65.7	.000
Gays	99.0	
% indicating staff is respectful to them		
Lesbians	64.5	.000
Gays	97.5	

This means that there is need for public health authorities to ensure health staff become more sensitive to the specific needs of lesbians if more lesbians are to visit health facilities and access SRH services. Gays feel universally more respected than their lesbian counterparts and this is in line with the issues mentioned earlier that they felt welcomed at receptions of health facilities they last visited in both cities.

Age of gays and lesbians is a significant factor in determining the behaviour of health staff. The study shows that there are less lesbians aged 18 years and below (51%) who regard health personnel as friendly than those above 18 years (86%), (p=0.000) as shown below in Table 34.

Table 34: Percent of KPs indicating friendliness and respectfulness of health personnel by age

Measurement Variable/ Determinant	18 years or below	Above 18 years	p - value
% indicating health personnel is friendly by age			
Lesbian	51.0	86.1	.000
Gay	97.2	100.0	.059
% indicating health personnel are respectful by age			
Lesbian	51.0	83.3	.000
Gay	93.7	100.0	.005

As regards respect by health personnel, one's age is a significant determinant for both lesbians (15% for 18 years and below, 83% those 18 years and above, p=0.000) and gays (94% for 18 years and below, 100% those 18 years and above, p=0.005) in both cities. Proportionally, there were fewer younger lesbians than older ones being treated with respect by health personnel, presenting another potential barrier to accessing services. On the other hand, all gays above 18 years indicated that health personnel were respectful compared to 94% of gays aged 18 years and below. The findings are consistent with earlier findings that younger gays and lesbians do not find the current health service providers and health care workers conducive for them to access SRH services as they felt that the service providers have shaped an opinion against them compared to their older counterparts.

5.3.4.6 Environment at service delivery points

The environment at the service delivery points (clinic, hospital, drop-in centres, outreach points) is reported as comfortable and clean by 98% of lesbian and 79% of gay respondents in both cities as

shown in Table 35. Clean water is ubiquitously available for both groups in both cities and this environment was a facilitator to access more SRH services.

Table 35: Appropriateness of Environment by Proportion of Respondents

Variable	Bulawayo (Zimbabwe)		Pretoria (South Africa)		Overall	
	Lesbian	Gay	Lesbian	Gay	Lesbian	Gay
N	87	107	86	107	173	214
Comfortable and clean	98.8%	82.3%	97.6%	76.1%	98.2%	79.3%
KP-only space	11%	51%	15.7%	38.6%	13.3%	45.1%
Toilet facility is of good quality	44.4%	52.1%	50%	39.8%	47.2%	46.2%
Clean water	97.6%	100%	96.4%	100%	97%	100%

However, there is very limited availability of key populations (KP) - only spaces with the lesbian group most affected. Only 13% of lesbian and 45% of gay respondents in both cities indicated the availability of KP-only spaces such as waiting area, toilets, screening rooms, pharmacy sections and observation rooms. The toilet facilities for clients and patients who visit the public health institutions providing SRH services for gays and lesbians, including drop-in centres, are reportedly of poor quality and not gender neutral, with only 47% of lesbian and 46% of gay respondents regarding the facilities as being of good quality. The environmental issues at the service delivery points are perceived barriers to access of the services. However, this affected mostly the facilities in Bulawayo than in Pretoria, highlighting the disparities in quality observed earlier.

The differences between lesbians and gays with reference to comfortable and clean environment as well as availability of KP-only space are significant. About 98% of lesbians indicated availability of a comfortable and clean environment compared to 78% of the gay respondents while KP - only spaces are more available to gays than lesbians (44% and 15% respectively) as shown in Table 36 below.

Table 36: KPs indicating availability of comfortable, clean environment and KP Only Space

Measurement Variable/ Determinant	%	p - value
% who indicate environment is comfortable and clean by KPs		
Lesbian	98.2	.000
Gay	78.3	
% who indicate availability of KP - Only spaces		
Lesbian	15.4	.000
Gay	43.5	

The issues regarding the availability of KP - only spaces is critical for those facilities that provide SRH services to both general and key populations in the two cities. The respondents mentioned that; *"it is very difficult to wait for assistance in the same waiting area as members of the public who will be looking at you with suspicion. This is really difficult for some of us who have not come out as they will recognize us outside and it is not safe", (FGD participant, Bulawayo).* This means that the lack of a free environment for gays and lesbians to freely express themselves creates a complex and acts as a barrier to accessing SRH services in Bulawayo and Pretoria.

5.4 Conclusion

The arguments discussed and data analysed in this chapter are theoretically grounded in and framed by the Health Belief Model developed by Hochbaum (1958) and modified by Rosenstock (1974) and Siddiqui (2016) to answer two key questions about the extent to which gays and lesbians access quality SRH services and the facilitators and barriers for accessing the same in Bulawayo and Pretoria. The model uses six constructs (risk susceptibility, risk severity, perceived benefits and barriers, self-efficacy and cue to action) to understand health seeking behaviour and each of them can act as barriers or facilitators to accessing health services.

From the analysis above, despite availability of health products, services and concomitant programmes to enhance access to health services by gays and lesbians, utilisation of condoms and preferred lubricants among the two groups in both cities is very low, partly due to their low-risk perceptions. Several barriers are cited which include the unavailability of preferred affordable condoms and lubricants for gays and user-friendly types of condoms such as dental dams and latex gloves for lesbians. Distance to drop-in centres, which provide services in an environment that is comfortable to gays and lesbians, is another barrier mentioned. Gays and lesbians access lubricants from health facilities, drop-in centres, pharmacies, and vendors. Vendors as sources of lubricants are mostly used by lesbians in Pretoria (11%) compared to Bulawayo (3%). Pharmacies are the main sources of lubricants for gays in Bulawayo (56%) and Pretoria (46%), with several strategies being used as cue to action to avoid being noticed by security agents as they purchased the lubricants from pharmacies.

There is a high level use of water-based lubricant amongst gays and lesbians in the two cities was very high when available as there is high risk susceptibility to developing bruises if lubricants are not used. However, it was noted that the most commonly available water-based lubricants are the least preferred, resulting in lower rates of lubricants use and their cue to action was to rely on friends and sexual partners to bring them the silicone-based lubricants. The positive attitude towards lubricants and condom use among gays and lesbians is a perceived facilitator that contributes to the utilization rates. The public health system in both cities does not supply lubricants to the community level where they are required, a barrier that needs to be looked at focusing on improving the supply chain to the last mile.

Although there is a barrier of limited gays and lesbians - only hours and unique spaces at some of the facilities, service provider working hours are regarded as convenient by gays and lesbians in the

two cities and this acts as a facilitator to accessing services. In addition, the services are affordable or free of charge and the only costs incurred were transport-related to and from the facilities, a barrier reported mainly in Bulawayo where some of the facilities are between 16 and 25 kilometres away. While the actual services are free and this enhances their affordability, the issue of transport costs is a barrier to the access of SRH services by gays and lesbians.

Regarding coverage of SRH services, commonly known and available services by most gays and lesbians in Pretoria and Bulawayo are contraceptive services, STI services (counselling, testing, treatment and prevention), HIV services (PreP, PEP, HTC, treatment, adherence counselling) and general counselling services. Cancer screening services are not as widely available as the other SRH services in Pretoria, while in Bulawayo there are slightly more service providers. However, the major barrier to accessing cancer screening services is fear among the respondents, due to the perceived severity of the disease once diagnosed. This requires adequate health education that early screening should be part of basic healthcare to encourage preventive health seeking behaviour.

In terms of quality of services, health facilities do not largely meet the expectations and requirements of gays and lesbians, a barrier that was mentioned in both cities. Only 31% of lesbian respondents in Bulawayo and 38% of lesbians in Pretoria indicated that the package of care fulfils their needs at point of delivery or referral linkages, further discouraging the utilization of the facilities. The results also show that there are disparities between and within the KP groups in terms of perceptions of preferred services. For example, supplies for medical testing and treatment were available for most (95%) gay respondents, but only available to 54% of lesbian respondents at public health facilities they last visited. This is a barrier to lesbians while at the same time it is a benefit to gays in the two cities.

Regarding perceptions of service provider competency, less than half of the lesbian respondents felt the service providers were medically competent while slightly above half of the gay respondents felt the same, a barrier that always forced the respondents to be always hoping for better quality services. However, most gays and lesbians do not have the choice to be seen by the same clinician during their next visit as they would have preferred. This choice is very low among lesbians compared to gays in the two cities and acting as a barrier to accessing the required SRH services. The quality of the services was a facilitator for most of gays as they recommended their peers while it was a barrier to lesbians as fewer recommended the services to their peers.

Stigma, discrimination and abuse against gays and lesbians present huge barriers to the access to services in the two cities with 88% of lesbian and 63% of gay respondents feeling bad because of things people did or said to them because of their sexual orientation, forcing them to be private about their life and avoid public places. Almost half of lesbian respondents in the two cities are excluded from social events because of their sexual orientation while 56% of the lesbian respondents and 31% of gay respondents experienced sexual assault, further limiting their public appearances, including visits to public health facilities. The major recommendation from the respondents is to ensure that healthcare workers are trained on responding to the needs of key populations according to the WHO guidelines which encourages sensitivity and non-judgemental approaches.

Furthermore, the barriers and facilitators for accessing quality health services and key areas of focus include acceptability of services, social support, self-efficacy, equitability, effectiveness, confidentiality and privacy. Regarding social support, the highest frequency of discussing SRH services was with partners, followed by friends and lastly parents. Discussion with parents is quite rare or non-existent for gays and lesbians in both Bulawayo and Pretoria, hence, there is limited

parental social support for them to access SRH services, especially the younger respondents aged 18 years and below. Discussions act as a facilitator to improve the self-efficacy of accessing SRH services as new information and encouragements were obtained by the respondents from their support network.

There are barriers and facilitators to access of SRH services and products for gays and lesbians. Gays and lesbians have different levels of risk susceptibility and severity regarding their limited access and utilization of condoms, lubricants, dental dams, latex gloves, HIV testing and prevention and other services. However, most of them show high levels of self-efficacy regarding use of SRH services and products and have various cues to action if the services or products are not available. Several gaps across the six constructs were identified to be discussed in the next chapters to provide pathways that can be utilized to overcome the limitations of the current public health systems. This will ensure that the key populations have comprehensive and quality SRH services in Bulawayo and Pretoria.

Chapter Six

Public Health Systems Limitations: Pathways for Adjustment

6.1 Introduction

This chapter answers the third question of the study which was to explore how the current health systems in Pretoria and Bulawayo can be improved to cater for gays and lesbians' sexual and reproductive health (SRH) needs. Through a comparative appraisal of the extent to which gays and lesbians access quality sexual and reproductive health services in Pretoria and Bulawayo within the context of different public health systems, the study explored the public health, personal, socio-economic, legal and political barriers that gays and lesbians encounter as they seek to access sexual and reproductive health services. This chapter explains the gaps identified and the possible interventions that different stakeholders can implement to improve health systems to effectively provide quality SRH services to gays and lesbians in Pretoria and Bulawayo.

The analysis was guided by the Health Belief Model (HBM) as postulated by Hochbaum (1958) and modified by Rosenstock (1974) and Siddiqui (2016) to understand the barriers, facilitators and the limitations affecting access to quality SRH services by gays and lesbians in the two cities. The model argues that a person's belief in a personal threat of an illness or disease together with a person's belief in the effectiveness of the recommended health behaviour or action will predict the likelihood that the person will adopt the behaviour. There are six constructs that predict health behaviour according to the model: risk susceptibility, risk severity, benefits to action, barriers to action, self-efficacy and cues to action. The limitations identified under the six constructs are explored to ensure that gays and lesbians adopt early health seeking behaviour and access quality SRH services in Bulawayo and Pretoria.

The high cost of branded private sector condoms in Bulawayo and Pretoria such as Carex, Durex, Choice, Clicks, Contempo, Dr. Long's, LifeStyles and Skyn is the first perceived barrier identified by the study, which results in low condom use as gays and lesbians do not prefer the unscented, unflavoured, and unbranded public sector condoms, exposing them to STIs including HIV. Linked to this gap is the unavailability of dental dams and latex gloves, critical products that lesbians require to enjoy risk-free sexual activities. Their risk susceptibility therefore increases because of the absence of the preventive products, with the majority mentioning the severity of being exposed to STIs and HIV as grave. The unavailability and high cost of silicone-based lubricants were mentioned by both gays and lesbians in the two cities as barriers, and they resort to using the less preferred water-based lubricants or not using any at all as their cues to action. The public health products delivery system by the Zimbabwe government does not supply any type of lubricants due to policy issues, while in Pretoria, lubricants are only distributed up to Provincial level, gaps that must be addressed to ensure the right lubricants are accessed by all gays and lesbians.

The gap between policy and implementation is evident in both cities. In Zimbabwe, the criminalization of homosexuality forces gays and lesbians to use underground methods to acquire some of the products and services they require as their cues to action. Purchase of lubricants in pharmacies, for example, is not done freely as there are always suspicions that security agents may follow gays and the lesbians after purchase. The preference of seeking services only at the few drop-in centres instead of public health facilities in the two cities is also linked to the fear of victimisation by the security agents and risks of being judged by health care workers and this is a perceived barrier to utilizing public health facilities. In Pretoria, despite the non-criminalization of homosexuality by the government, a total of 211 cases of overzealous security agents harassing gays, lesbians and sex workers including invasion of private functions were recorded by the

organization OUT Well Being since 2017. This inconsistency must be addressed to promote access of SRH services by gays and lesbians in the two cities.

The quality of the SRH services, coupled with the poor state of public health facilities and the absence of comprehensive services is a limitation that was identified in both cities, but is more prominent in Bulawayo than in Pretoria. About 69% of lesbians in Bulawayo and 62% of lesbians in Pretoria indicated that the package of health care services accessed at the last health facility they visited did not meet their needs at point of delivery or referred points, acting as a barrier to future visits to these facilities. Gays and lesbians confirmed the irregularity of the services provided by civil society organizations through outreaches, which are less frequent as required and do not cover the comprehensive services they require.

The stigma and discrimination experienced by gays and lesbians is a barrier towards ensuring access to services as they end up avoiding service providers with discriminatory tendencies as their cues to action. This forces them to either fail to access the SRH services with the frequency they require or travel longer distances to access services from preferred service providers. Low knowledge levels, negative attitudes and practices by healthcare workers and community members are the main drivers of the stigma and discrimination against gays and lesbians. In Bulawayo, such stigma forces gays and lesbians to avoid seeking SRH services and are prepared to travel longer distances to health facilities with staff deemed less stigmatizing and discriminating.

The distance to the drop-in centres is a barrier to access lubricants to about 17% of the respondents in Bulawayo and 23% in Pretoria. The distances averaged eight kilometres in Bulawayo and six kilometres in Pretoria, costing between USD 2 to USD 5 for a return trip, an amount that the respondents from both cities regard as very expensive.

6.2 Health Systems Limitations in Bulawayo and Pretoria

The study found that there are bottlenecks and perceived barriers affecting access to SRH services and products by gays and lesbians in Pretoria and Bulawayo. The first gap identified related to the high price of private sector condoms which, according to one FGD participant in Bulawayo *"acts as a barrier to us as we prefer the better quality and flavoured, textured or scented condoms to the basic unbranded free condoms, which have a very strong after-sex smell. We think that these should be affordable for us all, to prices below one dollar," (FGD participant, Bulawayo).*

The better condom brands with additional features costed more (R53 in Pretoria, USD 5 in Bulawayo) than the inferior quality brands (less than R20 and USD 2), therefore discouraging their use because they are perceived to be expensive. The unavailability of these preferred private sector brands is partially responsible for the lower rates of condom use among both gays and lesbians, which contributes to the perceived risk susceptibility and severity of contracting STIs including HIV, according to the HBM tenets. The model explains that the individuals' perceptions of risk and its consequences depend on the medical and social consequences and despite the presence of these risks, the high costs of condoms contribute to the low utilization rates. This is a gap that needs to be addressed to ensure that gays and lesbians access quality condoms.

The second limitation is that despite the availability and universal distribution of free male and female condoms, some gays and lesbians do not consistently use condoms every time they had sex due to factors other than their availability. This is contrary to what the HBM suggests that the perceived risks and their severity must be high to promote the adoption of preventive behaviours. In this case, the findings show that gays and lesbians can forego the risks of contracting STIs including HIV. There is very low self-efficacy for condom use, with mainly lesbians encountering challenges, especially coupled with the absence of dental dams and latex gloves. Condom use is

very low among lesbians (11% and 16% in Bulawayo and Pretoria respectively), which exposes them to STIs while a slightly higher proportion of gays in Bulawayo (49%) use condoms than in Pretoria (33%), every time they had sex. The low self-efficacy is a result of the low knowledge levels regarding how to effectively use female condoms, lubricants and the effect of alcohol consumption.

The other factor which contributes to the non-use of condoms is that the respondents mentioned that they are not able to use condoms every time they were drunk or high. Alcohol and drugs are cited as barriers to both condom access and use because they influence sexual behaviour as being high on alcohol or drugs reportedly increased sexual urge, made it difficult to maintain self-control and think about condoms when having sex. One of the FGD participants in Pretoria mentioned that *"you will only realize after, either the following morning or when you are sober, that you had sex and did not use a condom, and this is very common," (FGD participant, Pretoria).*

The second factor is that some of the respondents had unprotected sex when drunk or high because they were not sufficiently empowered to negotiate for safe sex with their partners. This confirmed that the low self-efficacy for condom use, according to the HBM (Hochbaum 1958, Rosenstock 1974, Siddiqui 2016), acts as a perceived barrier among both gays and lesbians, as it compromises their risk perception to infections and diseases, a gap that requires attention. Among lesbians in both countries, they did not regularly use condoms because they thought it was not necessary, the smell of the condoms (88% of respondents in Bulawayo and 81% of respondents in Pretoria) and that it takes long for the smell to disappear, hence the dislike for the unscented public sector condom brands.

The third gap identified is in the costing and the availability of lubricants, especially silicone-based ones, in both Bulawayo and Pretoria. Water based lubricants are availed mainly for free or very low cost (less than R 10) from drop-in centres, while silicone-based lubricants are sold from pharmacies

at around R 96 per 50 millilitres bottle. Affordability is a major perceived barrier to accessing the silicone-based lubricants across the two cities for both gays and lesbians, despite being the preferred lubricant, resulting in them using the less preferred brands or not using lubricants altogether as their cues to action. This predisposes them to STIs including HIV as dry sex contributes to lacerations and bruises, thereby elevating the risk and severity of infections.

Regarding lubricants, another bottleneck identified is that some gays and lesbians reportedly choose to access the free products from centres outside their community to avoid being recognized due to the high levels of stigma from service providers, as some of them live in the same localities. This has transport cost implications, which vary depending on distance to the targeted drop-in centre, showing a complex relationship between access, geographic location, financial and time considerations to determine use of lubricants among gays and lesbians in the two cities. Thus, the respondents consider where the drop-in centres are located, the personnel manning those centres, the financial resources in the form of transport fees required to access the centres and the time it would take to reach them. Provided that the facilities have good services and manned by non-judgemental staff, gays and lesbians are prepared to travel the distances, therefore distance is not a significant perceived barrier if treated in isolation.

A fifth limitation that was identified is that the public health clinics and hospitals can only stock commodities supplied by the Delivery Team Topping Up (DTTU) system managed by NatPharm in Zimbabwe and Department of Health (COMED) under the countries' Ministries of Health. Lubricants are not supplied through the DTTU system in Zimbabwe due to policy issues that criminalize homosexuality while in Pretoria they are distributed only up to the Provincial health facilities. The lower-level public facilities in Pretoria rarely stock the lubes because of the presence of other products in the private facilities, pharmacies and CSO - managed drop-in centres. However,

the study found that the lubricants that are distributed to the public health facilities in Pretoria are the less preferred water-based ones such as Astroglide, K-Y jelly and Sliquid Sassy and not the preferred silicone-based lubricants such as Swiss Navy, Intimate Lube and Assegai. Other pharmacies in Pretoria stock silicone-based products such as Replens and Wet Platinum and natural lubricants such as Aloe cadabra and Blossom organics which cost more than the preferred silicone-based brands. The failure by the public health distribution systems to provide the preferred lubricants is a perceived barrier to the utilization of lubricants in preventing infections and enjoyment of sexual activities. It is critical to note that oil-based lubricants can be used to enhance sexual pleasure and reduce abrasions but the use of appropriate non-oil-based lubricants such as silicone or water-based in conjunction with condoms is one of the best HIV preventive strategies among gays.

The distance to the drop-in centres is reported as a barrier to access the lubes by about 17% of the respondents in Bulawayo and 23% in Pretoria, making it the sixth limitation identified in preventing access to quality SRH services by gays and lesbians. The distances averaged eight kilometres in Bulawayo and six kilometres in Pretoria, costing between USD 2 to USD 5 for a return trip. One FGD participant was from Cowdray Park, 16 kilometres from Bulawayo City Centre who mentioned that;

"It takes about 30 to 45 minutes to get into town and another 20 minutes to Hillside where the Drop in centre is located, and at USD 1 per trip, I will need about 4 dollars just for transport. In addition, I need money for food, to buy the condoms, lubricants and if I have some health issues it means I must be prepared to pay for consultation and medication. This is very expensive for us as we are not meaningfully employed."

This was echoed by another participant in Pretoria who indicated that *"transport from West to Hatfield costs about R 40, and if I include money for products, consultation and medication, it means*

that I need to have a minimum of R 300 per trip to the drop-in centre and this is a lot of money," (FGD participant, Pretoria)

The participants made it clear that there is need to come up with better systems that address these barriers that include high transport costs which prevents them from accessing lubricants from the drop-in centres. One key informant in Pretoria mentioned that *"lubes facilitate the use of condoms and ensure that they do not slip or break during sexual intercourse, and it is important to advocate for their availability and access to gays and lesbians within reasonable distances, at most two kilometres," (Key informant, Pretoria).*

The difficulties of accessing water-based lubricants because of transport costs meant that some of gays and lesbians resorted to using the least affordable silicone-based lubricants purchased from pharmacies and they reported that this raised the cost of safer sex.

The criminalization and non-recognition of homosexuality in Zimbabwe results in fear by some of gays and lesbians to buy products such as lubricants publicly as they risk being identified in the process by security agents. There were three such cases that were recorded in the Bulawayo Central Business District in 2018 involving both gays and lesbians which heightened their risk susceptibility to arrests, torture or imprisonment. Thus, their cue to action was to buy lubricants secretly and if the environment in the pharmacy was not conducive, gays and lesbians would avoid or defer buying them. This forces the respondents to largely rely on the less preferred water-based lubricants found at the drop-in centres as the facilities are discreet, safe and free from surveillance by security agents.

The public health facilities have limited services required by gays and lesbians in both cities, and this is another limitation identified. There are no comprehensive SRH services with access to

information, education and communications (IEC) materials (34% among gays and 46% among lesbians), Parenting services (27% gays and 4% lesbians), mental health and psychosocial support services (27% gays and 38% lesbians), non-health services (youth development services, domestic violence prevention), mentioned by 4% gays and 16% lesbians and life skills and literacy building (0%) being mentioned as the least available. In agreement during an FGD in Pretoria, one participant mentioned that;

"There are so many things we want, but they are not available at the Drop in centres or the health facilities, for us to enjoy a complete life. We appeal to the government or the civil society partners to provide comprehensive services so that we do not have to move from one centre to another. Some countries have these facilities, from the workshops we have attended, "(FGD participant, Pretoria).

The quality of the facilities and SRH services are key in determining the health seeking behaviours of gays and lesbians. An eighth gap that the study revealed is that the public health facilities in both countries do not meet the expectations and requirements of gays and lesbians. Only 31% of lesbians in Bulawayo and 38% of lesbians in Pretoria indicated that the package of care accessed at the last health facility they visited fulfilled their needs at point of delivery or referral linkages. Gays and lesbians confirmed the irregularity and inadequacy of the services provided by CSOs through outreaches in both cities.

Gays and lesbians indicated that most of the times, they complement outreach services by visiting the static sites when financial resources permitted them to access the rest of the services not provided during the outreaches. A combination of accessing the services from outreaches and visiting static sites minimizes, but does not eliminate, the gaps in the continuum of care for the various SRH services required by gays and lesbians in both Pretoria and Bulawayo. Services such as

cancer screening, treatments of some STIs, circumcision and initiation of ART were not provided during the outreaches.

The study identified the ninth bottleneck that different forms of stigma and discrimination are experienced within the society and from health care service providers, a significant barrier to both disclosure of sexual orientation and accessing SRH services. Both gays and lesbians who had disclosed their sexual orientation experience various forms of stigma and discrimination, with the lesbian population being more affected than gays in both cities. These range from being made to feel bad because of things people did or said to them aligned to their sexual orientation (88% lesbians and 63% gays), exclusion from social events (51% of lesbians and 24% of gays) by being told by family members that they are not welcome to functions such as weddings or cultural ceremonies and sexual assault (56% lesbians and 31% gays). The gap exists both in the communities and among healthcare workers and must be addressed to remove the perceived barriers.

Low knowledge, negative attitudes and practices by societies and health care service providers towards gays and lesbians' sexual orientation and health needs were identified by the study as the tenth limitation. Regarding access to health services, 23% gays and 42% lesbians reported that they were ignored by health staff when they visited the public health facilities, who only attended to them after completing procedures with other general population clients. A similar proportion of gays (23%) and 41% of lesbians indicated that they were denied care that they should have received because they were gays or lesbians.

In Bulawayo, those who were denied care were told that the facilities do not have the healthcare workers specially trained to handle medical conditions of gays and lesbians such as anal STIs, in-vitro fertilization (IVF) and hormone therapy. In Pretoria, some of the reasons for denial of care were personal and religious beliefs of the health care workers who denied the clients services or

referral letters for sterilization procedures, hormone therapy treatment, sex change and in-vitro fertilization. There were more gays (35%) than lesbians (16%) who were treated with disrespect or abused when they visited a health facility. These acts of stigma and discrimination affect the perceptions that gays and lesbians have regarding the quality of the services and compromises their willingness to visit the public health facilities for assistance in future.

The stigma and discrimination experienced by gays and lesbians is a barrier towards ensuring access to services as they end up avoiding service providers with discriminatory tendencies. This causes them to either fail to access the SRH services with the frequency they require or travel longer distances to access services from preferred service providers. During an FGD in Bulawayo, one participant indicated that;

"The government and non-governmental organizations need to retrain the health care workers to provide key populations friendly services in a non-judgemental environment. Most of them have negative attitudes and it becomes very difficult to explain all your problems to someone who stigmatizes you or is judgemental when you do so,"(FGD participant, Bulawayo).

The final gap that the study identified is the compromised quality and reputation of the health facilities that gays and lesbians last visited. Even though over 80% of lesbians in the two countries acknowledged that the health facilities they last visited had a good reputation, few (18%) recommended the facility to a friend. Only 12% and 24% of lesbian respondents in Bulawayo and Pretoria respectively would recommend the facility to a friend. The main perceived barrier contributing to this is the attitude of the healthcare workers and the clients would not want their peers to experience the same. This is an issue that needs to be addressed, to remove the barriers and encourage other peers to access SRH services. Linked to this is the fact that only a few facilities had reserved times for gays and lesbians in both cities with 70% of gays and 29% of the lesbians

confirming this and the rest of the facilities availed services to everyone at the same opening and closing times, thus acting as a barrier to 30% gays and 71% lesbians. Gays and lesbians mentioned during an FGD that;

"It is really difficult to tell someone to visit a facility where you were not treated well. Some facilities have good names and a reputation when serving the general population, but when we go and they realize that you want specialized services because you are gay or lesbian, then their attitude changes and they even frown sometimes. This is why we are advocating for gays/lesbians only hours with specially trained staff, or standalone facilities, like in other countries,"(FGD participant, Bulawayo).

Lastly, the limited choices of treatment options were a bottleneck identified which affects access to quality SRH services such as PrEP, PEP and MHPSS for both gays and lesbian as the respondents believe that post-test support and treatment services were limited. As indicated by a key informant in Pretoria that *"the absence of services required by gays and lesbians presents a challenge to the service providers, and they end up referring the clients to facilities that are far away from the comfort of the clients,"(Key informant, Pretoria).* The referral pathways are clearly documented in both cities, but most of the referral facilities are located far away from where gays and lesbians live. Few cases were reported in Bulawayo where gays and lesbians were referred to Mpilo and United Bulawayo Hospitals (UBH) that did not have in-vitro fertilization and hormone-therapy treatment services and were further referred to South Africa and Botswana.

6.3 Pathways for Addressing Public Health Systems Limitations

Firstly, the quality of the SRH services should be at their best so that gays and lesbians can access these services in the two cities without fear or discrimination and this positive health seeking behaviour will contribute to the decline in the incidence and prevalence of HIV and STIs, cancers

and other conditions such as substance abuse. To address this, the starting point is raising awareness among public health and security officials in Bulawayo and Pretoria on the constitutional and policy rights of gays and lesbians and ensure enforcement of the same. High knowledge levels among these stakeholders will contribute to normalization of treatment that they receive within the society and at health facilities, a barrier that was mentioned by several gays and lesbians. One of the key informants in Bulawayo mentioned that *"healthcare workers and security agents will need further training on how to provide comprehensive user-friendly services for the homosexuals in the two countries according to the WHO guidelines, and respect the enshrined rights and policies," (Key informant, Bulawayo).*

The trainings and mentoring will help reduce their own prejudices and provide services from a public health perspective in non-judgemental, confidential and private spaces. This will also reduce the victimization of gays and lesbians by the security agents and enhance access for services in a free environment. According to the HBM (Hochbaum, 1958, Rosenstock 1974, Siddiqui 2016), the perceived benefits of health seeking behaviour can only be realized if the barriers are removed so that users can freely adopt the behaviour, in this case accessing SRH services to contribute to the decline in the prevalence and incidence of HIV, STIs, cancers and other vices.

Secondly, the study found that there is need for public health authorities in Pretoria and Bulawayo to build upon the identified factors which facilitated the access to SRH services and use of products such as condoms and lubricants. These include the good reputation of some public health facilities as one stop service delivery points. However, from previous discussions in this chapter, the study noted that despite having good reputation while serving general population members, some staff at the facilities were judgemental towards gays and lesbians, a perceived barrier that resulted in non-recommendation of the facilities. While further retraining the staff on the WHO guidelines

(Consolidated Guidelines on HIV prevention, Diagnosis, Treatment and Care for Key Populations and secondly Guidelines on Implementing Comprehensive HIV and STI programmes with men who have sex with men: Practical guidance for collaborative interventions) is one option, another is to ensure that gays and lesbians have choice on who can attend to them when they visit the facilities.

Most of the facilities are reported to have comfortable and clean environments thus creating conducive spaces for confidentiality and individual privacy for gays and lesbians accessing SRH services in the two cities. Many of the respondents felt welcomed at some of the facilities and could freely utilize the ablution facilities and the water dispensers installed at the facilities. The positive reviews about these facilities should be used to encourage other gays and lesbians to disclose their sexual orientation and access the SRH services provided. The positive health seeking behaviours among gays and lesbians needs to be fully exploited to ensure that they overcome the barriers and take the cue to action, in this case seeking SRH services, according to the HBM (Hochbaum, 1958, Rosenstock 1974, Siddiqui 2016), that guided the analysis.

Resultantly, platforms for discussion of SRH issues among gays, lesbians and their social networks of partners and friends should be strengthened, and community support systems should be put in place to overcome the barriers and motivate them to seek SRH services. Their high levels of knowledge regarding where to go and what to do to access SRH services and products is a perceived benefit that facilitates their access to services, and this requires continued social communication. These factors can be operationalized through establishment or strengthening of community-based organizations or networks that work directly with gays and lesbians in both Bulawayo and Pretoria.

The study showed the importance of the interconnectedness of static and outreach activities that are conducted by civil society organizations such as PSI, PSZ, SFH, GALZ, Health4Men and OUT Well Being in the two cities. There is need for more regular outreaches with comprehensive services and

a strong referral and follow up mechanism to ensure that there is continuum of care from point of entry to exit of all clients. The outreaches in both Bulawayo and Pretoria are conducted at least once a quarter at sites mapped and designated by gays and lesbians as convenient, and the recommendation is to increase the frequency of the outreaches so that there are no stockouts in products such as condoms and lubricants. These efforts are meant to overcome perceived barriers associated with transport costs incurred when gays and lesbians travel to access services outside their usual places of residence.

There is need for the central government to support and strengthen the referral system and ensure all the critical services referred at the public health facilities are available and functional for gays and lesbians in the two cities. Services such as in-vitro fertilization, sex change and hormone-therapy treatment are not available in Bulawayo and clients were being referred to South Africa or Botswana. The CSOs need to ensure that they have an outreach plan that returns to the communities for follow up more regularly or links gays and lesbians to community-based support networks to access quality SRH services and products. The need to work closely with the community-based networks was emphasized in Bulawayo by one of the key informants who mentioned that *"these gays and lesbians need to organize functional community-based networks and organizations that can lead advocacy for more services and Drop-in centres at community levels. Some countries such as Kenya and Ghana have good systems on this and our own KP community can learn from them," (Key informant, Bulawayo).*

The study found a combination of positive facilitators and behaviours by gays and lesbians in Bulawayo and Pretoria that need to be supported to further strengthen and promote the effective utilisation of SRH services namely peer recommendation of SRH services by gays and lesbians. Firstly, in some facilities, there is largely equitable treatment by SRH service providers regardless of

gender and sexual orientation in both Bulawayo and Pretoria. This encouraged some of gays and lesbians to access services at local public health clinics and outreach points provided by CSOs without fear of stigmatization or discrimination. The problems cited at these sites are the unavailability of comprehensive services and the irregular nature of the outreach activities which affects the continuity of care and products supply, and not stigma or discrimination. However, it is important to note that this was only the case at few facilities in Bulawayo, as most of the clients were referred to static sites in Bulawayo City centre or Mpilo and United Bulawayo Hospitals to overcome the barriers of incomprehensive services.

The availability of medical testing and treatment facilities for both gays and lesbians and positive perceptions that SRH test results and records were kept confidentially and in privacy by health officials are positive cues to action, encouraging access to services. If utilized strategically, this positive factor will promote positive health seeking behaviour and access of SRH services by gays and lesbians because they valued privacy of their medical and personal records. This can be achieved through tailored and specific behaviour change messaging that utilizes preferred channels of communications such as using public service announcements (PSA) on social media platforms (Twitter, Facebook Groups, WhatsApp, Telegram) or direct text messages to reach the targeted gays and lesbians, highlighting the merits of those facilities.

Positive messages should be shared with gays and lesbians to encourage their peers to access SRH services. The central government in Pretoria through the Ministry of Health needs to include SRH products such as lubricants, dental dams and latex gloves in their distribution system and reach all public health facilities, beyond the Provincial health care centres. In Zimbabwe, there is need to adjust the policy at national level to ensure inclusion of such products and facilitate their distribution through the DTTU system. Currently, in Zimbabwe, the products are not being

distributed because of the legislative framework that criminalizes and does not recognize homosexuality, a key barrier that needs to be addressed even though the ZNASP (2015-2020) recognizes gays and lesbians as key populations.

The healthcare workers need further training and information on WHO guidelines regarding provision of comprehensive health services to key populations to ensure that they discharge their duties without prejudices in a stigma free environment. This will encourage gays and lesbians to seek the services without fear of stigma, discrimination or abuse. The SRH services and products offered either at public health facilities or CSO-operated facilities need to be improved to ensure access to comprehensive services including PrEP, PEP, ART initiation, mental health and psychosocial support services (MHPSS), lubricants, dental dams and latex gloves to ensure that there is a supermarket approach when gays and lesbians are accessing services. The health facilities, medical equipment and ablution facilities need to be continuously upgraded and maintained to ensure that the standards are not deteriorating and act as barriers to gays and lesbians intending to utilize them.

Critical SRH services that were not readily available to most of gays and lesbians in Bulawayo included mental health and psychosocial services (MHPSS). However, in Pretoria, these services were available including free psychosocial support services by trained counsellors who offered face-to-face counselling sessions by appointment, online counselling provided by virtual doctors and counsellors, telephonic counselling provided via a helpline. The study explored options for the CSOs in Bulawayo to adopt this model of providing MHPSS to gays and lesbians to ensure that there are no gaps in counseling and mental health support, services already being provided at some clinics to the general populations. The challenges of internet connectivity, electricity cuts and absence of a coordinated platform to provide tele-counselling were mentioned by the key

informants in Bulawayo. This approach can be adopted gradually, starting with a few pilot clinics offering these services digitally, and roll out once there is satisfaction among the providers and gays and lesbians and overcome the barrier of transport costs.

There was inadequate tailored information, educational and communications (IEC) materials and most of gays and lesbians expressed their dissatisfaction with the few materials that were available at Drop-in centres, especially in Bulawayo. A government key informant in Bulawayo also indicated that *"most of the IEC materials have messages that target the general population and do not communicate unique information about homosexuality issues, making the materials and messages less relevant to gays and lesbians," (Key informant, Bulawayo).*

This was a greater challenge in Bulawayo than in Pretoria, as the digital footprint of gays and lesbians' platforms and networks was less visible than in Pretoria. The study suggests that there is need to strengthen gays and lesbians' networks and platforms that disseminate tailored messages to address the SRH issues of the key populations. Regarding general health behaviour change communications, the central and local health departments need to raise awareness about the constitutional rights of gays and lesbians from a public health perspective, to help reduce stigma, discrimination, hate crimes and homophobia.

The study notes that there was a total of 22 drop-in centres in Pretoria while there were only three in Bulawayo. All the drop-in centres were managed by a mix of clinicians who provided professional, free, safe, confidential, non-judgmental and inclusive services. In Bulawayo, the drop-in centers have less services compared to those in Pretoria, due to inadequate private and public sector funding under a challenging economic environment, and the study proposes that the CSOs and public health facilities adopt the model of drop-in centers in Pretoria which provide a one stop center for all SRH services and products.

6.4 Conclusion

This chapter answered the study's third question which was to explore ways that the current health systems in Pretoria and Bulawayo could be improved to meet the SRH needs of gays and lesbians. The study explored the public health, socio-economic, legal and policy barriers that gays and lesbians encounter as they seek to access sexual and reproductive health services, summarized the different limitations and the possible strategies that different stakeholders can implement to improve health systems to effectively provide quality SRH services to gays and lesbians in Pretoria and Bulawayo. The analysis was guided by the Health Belief Model (HBM) as postulated by Hochbaum (1958) and modified by Rosenstock (1974) and Siddiqui (2016) to understand the barriers, facilitators and the limitations affecting access to SRH services.

The high cost of branded private sector condoms in Bulawayo and Pretoria is the first perceived barrier identified by the study, which results in low condom use as gays and lesbians do not prefer the unscented, unflavoured and unbranded public sector condoms exposing them to illnesses and infections, including HIV. The study notes a total unavailability of dental dams and latex gloves, resulting in increased risk susceptibility, with most lesbians mentioning that their exposure to STIs is severe. Linked to this barrier is the unavailability and high cost of silicone-based lubricants in the two cities which results in the use of the less preferred water-based lubricants as a cue to action. The DTTU system by the Zimbabwe government does not supply any type of lubricants due to policy issues, while in Pretoria, lubricants are only distributed up to Provincial level, gaps that must be addressed to ensure the right lubricants are accessed by all gays and lesbians. This is a limitation that require policy shifts in the two countries to overcome the barriers and ensure both water and silicone-based lubricants are available.

The study finds that there is a gap between policy and implementation in both cities. In Zimbabwe, the criminalization of homosexuality forces gays and lesbians to use underground methods to acquire some of the products such as lubricants from pharmacies and services they require as their cues to action. The preference of seeking services only at the few drop-in centres instead of public health facilities in the two cities is also linked to the fear of victimisation by the security agents and risks of being judged by health care workers and this is a perceived barrier to utilizing public health facilities. In Pretoria, despite the legalization of homosexuality by the government there are several reports of gays, lesbians and sex workers who were harassed. This inconsistency must be addressed to promote access of SRH services by gays and lesbians in the two cities.

The quality of the SRH services, the poor state of public health facilities and the absence of comprehensive services are limitations that were identified in both cities but are more prominent in Bulawayo than in Pretoria. Gays and lesbians confirmed the irregular, less frequent and incomprehensive services provided by civil society organizations through outreaches which attempt to overcome the barrier of high transport costs associated with traveling to static or referral health facilities.

The stigma and discrimination experienced by gays and lesbians is a barrier against ensuring access to services as they end up avoiding service providers with discriminatory tendencies. This causes them to either fail to access the SRH services with the frequency they require or travel longer distances to access services from preferred service providers. Low knowledge levels, negative attitudes and practices by healthcare workers and community members are the main causes of the stigma and discrimination. In Bulawayo, such stigma forces gays and lesbians to avoid seeking SRH services and prefer to travel longer distances to health facilities with staff deemed less stigmatizing and discriminating. However, the distance to the drop-in centres is also another barrier to access

lubricants by about 17% of the respondents in Bulawayo and 23% in Pretoria. The distances averaged eight kilometres in Bulawayo and six kilometres in Pretoria, costing between USD 2 to USD 5 for a return trip, an amount that the respondents from both cities regarded as very expensive.

The use of the HBM revealed that five of the six constructs are applicable to the findings of the study. These are risk susceptibility, perceived barriers, perceived benefits, self-efficacy and cues to action which were used to explain the limitations and the facilitators of the public health systems in Bulawayo and Pretoria. The final construct, perceived severity, is largely less applicable as most of the respondents do not regard the seriousness and dire consequences of contracting illnesses such as STIs and HIV. This is because gays and lesbians regard STIs including HIV as curable or manageable and therefore explains the low condom, dental dams and latex gloves use during sexual activities.

The study identified several barriers and facilitators to access of both the SRH products such as condoms, lubricants, dental dams, latex gloves and services such as STIs screening, treatment, HIV testing, prevention and treatment, use of PEP, PreP, MHPSS services, in-vitro fertilization and cervical, breast and prostate cancer screening to satisfy the first two constructs of the HBM. The respondents mentioned several actions they take (cues to action) to circumvent the barriers to access of SRH products and services. Most gays and lesbians perceive their high-risk susceptibility to various STIs including HIV due to the nature of the sexual activities they engage in, but they felt the risks are not severe. The study recommended various pathways that could be used to increase the risk perception and severity, reinforce the benefits and minimize the barriers of accessing SRH services and increase cues to action and self-efficacy towards accessing and utilizing SRH products.

Chapter Seven

Conclusions and Recommendations

7.1 Introduction

This chapter summarizes and reflects on the study findings. Firstly, two interlinked questions were answered by the study namely (i) to what extent do gays and lesbians access quality sexual and reproductive health services in Pretoria and Bulawayo and (ii) what are the facilitators and barriers for accessing sexual and reproductive health services by gays and lesbians in Pretoria and Bulawayo? The study utilized the Health Belief Model (HBM) by Hochbaum (1958), modified by Rosenstock (1974) and Siddiqui (2016) to understand the barriers, facilitators and the limitations affecting access to SRH services by gays and lesbians. The model identifies six dimensions that predict health behaviour namely risk susceptibility, risk severity, benefits to action, barriers to action, self-efficacy and cues to action. Under each dimension, gaps were identified that informed the recommendations of possible pathways that various stakeholders can adopt to ensure that gays and lesbians access quality SRH services in Bulawayo and Pretoria.

In answering the first and second research questions, the study showed that respondents knew where to get condoms and health centres, clinics, drop-in centres and shops were the main sources for condoms in the two cities The types of condoms accessed included the free government-supplied public sector condoms, the socially marketed condoms distributed by the Population Services International (PSI) in Zimbabwe, Society for family Health (SFH) in South Africa and other partners and private sector condoms supplied by various companies such as Carex, Skyn, Choice and Durex.

There was high self-efficacy to use lubricants in the two cities with almost all gays and lesbian respondents having used lubricants the last time they had sex. The study also found that the most commonly available sexual and reproductive health (SRH) services were contraceptive services, sexually transmitted infections (STI) services (counselling, testing, treatment and prevention) and Human immunodeficiency syndrome (HIV) services (Pre exposure Prophylaxis, Pre exposure treatment, HIV testing and counselling, treatment, adherence counselling).

The third and final research question explored how the current health systems in Pretoria and Bulawayo can be improved to cater for gays and lesbians' sexual and reproductive health needs. This question was answered through exploring the gaps identified across the six constructs of the HBM affecting the individual respondents and the health systems.

The high cost of branded private sector condoms was identified as a barrier which contributed to low condom use as gays and lesbians did not prefer the unscented, unflavoured and unbranded public sector condoms. Dental dams and latex gloves, critical products that lesbians required for safe sex, were not available at all in Bulawayo and available only in very few pharmacies in Pretoria at exorbitant prices. To overcome these barriers, stakeholders should partner to provide cost effective alternatives to the unbranded condoms to increase condom use and the incidence of safe sex. The availability of dental dams must be improved in Pretoria and a new supply chain must be established to ensure their availability in Bulawayo. The same approach is required for latex gloves to increase their presence in drop-in centres and public health facilities and promote their uptake by gays and lesbians.

The unavailability and high cost of silicone-based lubricants were mentioned by both gays and lesbians in the two cities, and they resorted to using the less preferred water-based lubricants or not using any at all. The health products procurement and distribution systems in the two countries

should secure more funding, both public and private, and supply both water- and silicone-based lubricants, working together with CSOs such as GALZ, Voices of Hope and OUT Well Being.

The gap between policy and implementation was reported mainly in Bulawayo and a few isolated cases in Pretoria through the criminalization of homosexuality which forced gays and lesbians, as a cue to action, to use underground methods to acquire some of the products and services they required. Another cue to action that gays and lesbian used was the preference to seek services only at the few drop-in centres instead of public health facilities in the two cities because of the fear of victimisation by the security agents and risks of being judged by health care workers. This inconsistency must be addressed through improving the respect for constitutional and policy rights for gays and lesbians to promote access of SRH services in the two cities.

The quality of the SRH services, coupled with the poor state of public health facilities and the absence of comprehensive services was a gap that was identified in both cities, but was more prominent in Bulawayo than in Pretoria. Gays and lesbians confirmed the irregularity of the outreach services provided by civil society organizations, which were hailed for providing stop-gap products and services. One barrier mentioned by both gays and lesbians was that the mobile outreach points provided fewer services than those available at static facilities.

7.2 Facilitators and Barriers to Sexual and Reproductive Health Services

7.2.1 Extent to which gays and lesbians access quality SRH services

The first question that the study answered was the extent to which gays and lesbians access quality sexual and reproductive health services in Pretoria and Bulawayo. The study found that respondents knew where to get condoms and health centres, clinics, drop-in centres and shops were the main sources for condoms in the two cities. In addition to the availability of various health facilities, various programmes and outreach activities were conducted to enhance awareness and

promote access to free condoms and lubricants by civil society organizations such as Population Services International (PSI), Population Services Zimbabwe (PSZ) and GALZ in Bulawayo and Society for Family Health (SFH) and Health4Men and OUT Well Being in Pretoria.

Three types of condoms were accessed which were the free government-supplied public sector condoms, found mainly in public clinics and hospitals and were shunned for their bad smell. The socially marketed condoms were distributed by the PSI in Bulawayo and SFH in Pretoria, sold for about USD 2 or R 20 in Bulawayo and Pretoria respectively were better appreciated and utilized than the public sector brand. The private sector condoms supplied by various companies, sold at about USD 3-5 in Bulawayo and R 53 in Pretoria were the best preferred.

The respondents mentioned that these private sector condom brands such as Carex, Durex, Choice, Clicks, Contempo, LifeStyles and Skyn were regarded to be of the best quality and had various flavours and scents. These attributes acted as facilitators for their use, making them the most preferred during both oral and penetrative sex. The socially marketed condoms such as Protector plus and Trust were ranked second in terms of quality and were more widely available in both Bulawayo and Pretoria than the private sector condoms. The free unbranded public sector condoms such as the blue or white panthers were not favoured, despite being the most stocked at drop-in centres and all public health facilities. A few drop-in centres had female condoms, but their uptake was very low and irregular.

There were low levels of condom use among gays and lesbians interviewed despite the availability of the products on the market in both Bulawayo and Pretoria. The main barriers to condom use among gays and lesbians included the misconception that condoms were not necessary for same sex relationships due to the low-risk perceptions and the low self-efficacy to use condoms especially among lesbians in both cities. The low-risk severity also manifested in the limited appreciation of

the utility of condoms as preventive products against HIV and other STIs. General dislike of condoms was reported among the respondents, attributed mainly to the inconveniences of wearing, removal and disposal processes and this was linked to the self-efficacy and limited knowledge on the importance of condom use.

Another barrier to condom use was the trust of one's partner that was reinforced by knowing their HIV and circumcision status for gays and HIV and other STIs status for lesbians. This was mentioned along with the inability to negotiate for safe sex when drunk or high as one of the reasons why condom use at last sex was low. The barriers showed that low rates of condom use at last sex were not because of their unavailability, but several factors contributed to this. Gays and lesbians' cues to action were to access post exposure prophylaxis (PEP) to minimize the risks of STIs including HIV, a service that was available in both cities.

The use of lubricants at last sex was very high (95%) among both gays (99%) and lesbians (90%) in Bulawayo and Pretoria. Use of lubricants was very high despite the availability of only the less preferred water-based lubricants at the civil society organizations' health facilities. All surveyed public health facilities in Bulawayo did not have both the water based or silicone-based lubricants as the products were not among those supplied by the Zimbabwe Ministry of Health's DTTU system. In Pretoria, only a few of the surveyed public health facilities had water-based lubricants supplied by the Department of Health. The systems did not stock these products because of the policy issues in Zimbabwe whereas in South Africa, they were distributed up to Provincial level facilities.

A few pharmacies had different brands of silicone-based and natural lubricants that gays and lesbians preferred in both cities and a few drop-in centres in Pretoria. The main barrier to accessing these preferred lubricants was the high cost, especially the silicone-based lubricants (about R 96 per 50 millilitres) and the centralized nature of pharmacies away from localities where most of gays

and lesbians lived. However, the high use of lubricants was attributed to the fact that they were easy to apply, meaning that self-efficacy was high as most gays and lesbians knew how to use them.

The study observed that the absence of dental dams for the lesbians in both cities was a barrier which affected the availability of comprehensive services and products. In Bulawayo, the dental dams were not available at all the public or private health facilities including pharmacies and drop-in centres. In Pretoria, dental dams were available in very few pharmacies at very high prices, for example, the Trust Latex Dam costed R 60. Similarly in Pretoria, latex gloves were available from selected pharmacies but at very high cost of about R 80 for a box of 50 while only surgical gloves were available in Bulawayo pharmacies. Therefore, the cost, low self-efficacy and unavailability were the main barriers which contributed to the very low knowledge and use of the dental dams and latex gloves for the prevention of STIs and germs such as E. coli and shigella among gays and lesbians in the two cities.

Regarding services, the study found that the most commonly available sexual and reproductive health (SRH) services for gays and lesbians were contraceptive services (99%), STI services as indicated by 97% of the respondents and HIV services (Pre and post exposure Prophylaxis - PrEP and PEP, HIV testing and counselling, treatment, adherence counselling) reported by 97% of gays and lesbians. The services were provided by public health facilities in the two cities, drop-in centres and through outreach activities operated by civil society organizations and network organizations of gays and lesbians such as GALZ, Voices of Hope and PSI sites in Bulawayo and OUT Well-Being, TEN 81 Clinic, Health4Men, SFH clinics and Zola Health Care Centre in Pretoria.

The limitation of outreach activities in Bulawayo was that the mobile teams visited once a quarter and offered a few services such as routine HIV testing and counselling, ARVs resupply, STIs screening and condom distribution and selling. The healthcare workers then refer gays and lesbians

to local clinics which have perennial challenges of improperly trained staff, absence of key drugs, supplies and disease management equipment for further management. These barriers forced gays and lesbians in Bulawayo not to rely on the outreach services only but instead visited static sites to access comprehensive SRH services.

The least available services in Bulawayo and Pretoria that gays and lesbians required as part of a comprehensive package were access to information, education and communications (IEC) materials (34% among lesbians and 46% among gays), mental health and psychosocial support services (27% among gays and 38% among lesbians) and other non-health services such as domestic violence prevention (12% among gays and 16% among lesbians) and life skills and literacy building (0%). In comparison, there were more respondents in Pretoria who had access to these services compared to Bulawayo indicating that there are disparities between the two cities.

Several service providers in both Bulawayo and Pretoria were not fully using the World Health Organization (WHO) guidelines for provision of comprehensive services for key populations (KP) including gays and lesbians. The guidelines stipulate that staff should be specially trained to handle the health care needs of gays and lesbians, specific KPs-only facilities and KP-only hours of business should be available at community level. The guidelines also indicate that there should be a well-documented referral system to manage specialized needs of gays and lesbians and as much as possible, services should be provided under one roof using a supermarket approach. These barriers resulted in gays and lesbians questioning the quality of the SRH services at their disposal causing them to seek healthcare at a few selected facilities in both cities.

Linked to this, it was noted that gays and lesbians required similar SRH services as the general population in some of the cases, except a few specialized services such as treatment of anal STIs, cancer screening and accessing lubricants, PEP and PrEP. Presence of convenient KP only working

hours by SRH service providers such as GALZ in Bulawayo, OUT Well Being and TEN 81 in Pretoria was an important consideration for gays and lesbians to effectively utilise available facilities and services. The absence of such convenient hours in public health facilities made them inconvenient as some of the respondents did not feel comfortable mixing with the general population, a barrier that was mentioned widely in both Bulawayo and Pretoria.

7.2.2 Facilitators and Barriers for Accessing SRH services

The second question that the study answered was an understanding of the facilitators and barriers for accessing sexual and reproductive health services by gays and lesbians in Pretoria and Bulawayo. The limitations regarding access to quality SRH services for gays and lesbians in both cities were not just external but also internal to the individuals themselves as guided by the Health Belief Model (Hochbaum, 1958, modified by Rosenstock, 1974 and Siddiqui, 2016). External factors related to issues that gays and lesbians had little control of such as the physical environment, infrastructure, legal, social barriers and benefits and internal factors were about gays and lesbians' individual risk susceptibility and perceptions regarding severity, self-efficacy, cues to action, attitudes and practices to access the SRH services.

The quality of some of the facilities and services provided in both cities did not meet the expectations of gays and lesbians and this acted as a barrier to their health seeking behaviour. About two thirds (67%) of lesbian respondents pointed out that the package of health care they received at the last facility they visited did not satisfy their needs at points of delivery or referral linkages. There were concerns about the competency of health service providers in dispensing services tailored to gays and lesbians and the unavailability of the option to be seen by the same health personnel during the clinic visits further affected gays and lesbians' health seeking behaviour. This emanated from the understanding by the key populations that healthcare workers

needed special training to manage health concerns of special populations according to the WHO guidelines.

The quality of the facilities was a barrier mentioned by the respondents in Bulawayo, particularly the unavailability of KP only spaces, the condition of the toilet facilities for both lesbians and gays which were not user-friendly. The respondents mentioned that facilities at some of the PSI-run sites were poorly maintained and discouraged them from making repeat visits or recommending to their peers.

Even though the legal environment mainly in South Africa and marginally in Zimbabwe is amenable to same sex relationships, there are still barriers in both cities to translate this into actual practice. Constitutionally, discrimination based on gender, sex and sexual orientation is prohibited in both countries, yet the societal perspectives, practice of public health officials and high incidences of discrimination still act as barriers to access of SRH services especially in Bulawayo.

Gays and lesbians in the two cities reportedly experienced cases of social stigma, discrimination and abuse by the society, security agents and healthcare workers. Many of these barriers that gays and lesbians experienced in accessing quality health care ranged from outright discrimination to more subtle substandard care such as not addressing their special health care needs, trauma or behavioural health issues. About 23% of gays and 41% of lesbians indicated that they were denied care that they should have received because they were gays or lesbians. Due to their sexual orientation, some gays and lesbians reported that they were denied some SRH services.

In Bulawayo, those who were denied care were told that the facilities did not have the healthcare workers specially trained to handle medical conditions of gays and lesbians such as anal STIs. In Pretoria, some of the reasons for denial of care were personal and religious beliefs of the health

care workers who denied the clients referral letters for sterilization procedures, sex change and in-vitro fertilization. In some instances, in both cities, cases of denial of care were reported when gays or lesbians were turned away from health facilities or experienced inadequate or substandard care including verbal abuse, disrespectful behaviour, or the provider gave divided attention to the patient's needs.

Across public health facilities, stigma and discrimination from healthcare workers was a huge barrier affecting access where more gays (35%) than lesbians (16%) were treated with disrespect when they visited a health facility in the two cities. The disrespect involved being frowned upon, passing some unpleasant remarks during treatment or counselling sessions in both Bulawayo and Pretoria. These acts of stigma and discrimination affected the perceptions that gays and lesbians had regarding the quality of the SRH services and compromised their access in both cities.

Some of the respondents (24% gays and 51% lesbians) were excluded from social events after being told that they were not welcome due to their sexual orientation or the company of friends they had. Linked to this and showing further the hostile environment that gays and lesbians lived under, 31% gays and 56% lesbians experienced some form of sexual assault from strangers while 32% lesbians lost property after being chased away from their homes by parents or partners. This deterred other key populations from disclosing and opening about their sexual orientation and consequently acts as a barrier to accessing sexual and reproductive health services.

The findings on stigma and discrimination confirm results of a study conducted in Zimbabwe by Hunt et al (2017) which found that participants described considerable unmet needs and barriers to accessing basic healthcare due to discrimination regarding key population status, exacerbated by the socio-political and legal environment. The three main themes that contributed to the stigma and discrimination in the evidence were that key populations' illnesses were caused by their

behaviour, equal access to healthcare is conditional on key populations conforming to 'sexual norms' and perceptions that healthcare workers' personal attitudes affected care delivery.

On the other hand, gays indicated that the CSO-run facilities (especially the drop-in centres such as those operated by OUT Well Being, TEN 81, Voice of Hope) had generally good reputation and they would recommend them to their friends, while lesbians had the same opinion but would not recommend the facilities to fellow lesbians. The main factor for the good reputation was that the facilities were managed by peer KP members and specially trained health care workers who provided services only to key populations. In Pretoria, there was goodwill from different funding agencies who financially supported the refurbishments at TEN 81 and Health4Men, bringing modern equipment and services.

Self-efficacy was a critical facilitator for using the protective SRH products such as condoms and lubricants and accessing quality SRH services such as HIV testing, counselling, treatment and prevention, STIs screening, cancer screening and MHPSS services for both gays and lesbians in the two cities. Gays and lesbians mentioned that they knew where to go and what to do to access the SRH services and to use both condoms and lubricants. However, lack of confidence to access the public health facilities was shared by some of gays and lesbians in the two cities, due to the non-availability of KP only hours and fear of mixing with the general population which could result in them being identified. As a cue to action, gays and lesbians used drop- in centres and other CSOs operated facilities at the expense of public health facilities such as Council or Government owned clinics and hospitals.

On equitability, gays felt more comfortable visiting various health care facilities regardless of their age than lesbians who did not feel welcome at over two thirds (69%) of the facilities because of their sexual orientation or age. The comfort by gays was reinforced by the presence of supplies for

medical testing and treatment at the facilities which encouraged them to access the SRH services in the two cities. However, the non-availability of some specialized services for lesbians such as cervical cancer screening services, dental dams and latex gloves acted as a barrier affecting their access of SRH services. Regarding privacy and confidentiality, the study showed that the environment at the civil society operated health facilities was conducive and ensured privacy for both gays and lesbians.

The third question the study answered was exploring how the current health systems in Pretoria and Bulawayo could be improved to cater for gays and lesbians' sexual and reproductive health needs. This question was answered through exploring the gaps identified in the health systems and among gays and lesbians across the HBM's six dimensions of risk susceptibility, risk severity, benefits and barriers to action, cues to action and self-efficacy and recommend improvements to ensure provision of quality SRH services. The limitations identified acted as barriers to accessing quality SRH services and products in Bulawayo and Pretoria.

The high cost of branded private sector condoms such as Carex, Durex, Choice, Clicks, LifeStyles and Skyn was identified as a barrier which resulted in low condom use as gays and lesbians did not prefer the free unscented, unflavoured, and unbranded public sector condoms. Linked to this gap was the unavailability of dental dams and latex gloves, critical products that lesbians required. Stakeholders, both public and private should partner to ensure that affordable scented, flavoured, and coloured condoms, dental dams and latex gloves are availed at drop-in centres and public health facilities to improve access and utilization.

The unavailability and high cost of silicone-based lubricants was mentioned by both gays and lesbians in the two cities as a limitation, and their cue to action was using the less preferred water-based lubricants or not using any at all. The public health products procurement and delivery

system by the Zimbabwe government does not supply any type of lubricants due to policy issues, while in Pretoria, lubricants were only distributed up to Provincial level, gaps that must be addressed to ensure the right lubricants are accessed by all gays and lesbians. The distribution systems in the two countries should supply both water and silicone-based lubricants with financial assistance from CSOs who act as service providers for gays and lesbians in Bulawayo and Pretoria.

The gap between policy and implementation was evident in both cities. In Zimbabwe, the criminalization of homosexuality forced gays and lesbians to use underground methods to acquire some of the products and services they required. Purchase of lubricants in pharmacies, for example, was not done freely as there were always suspicions that security agents may follow gays and the lesbians after purchase. The preference of seeking services only at the few drop-in centres instead of public health facilities in the two cities was also linked to the fear of victimisation by the security agents and risks of being judged by health care workers. In Pretoria, despite the non-criminalization of homosexuality by the government, a total of 211 cases of overzealous security agents harassing gays, lesbians and sex workers including invasion of private functions were recorded by the organization OUT Well Being since 2017. This inconsistency must be addressed through improving the respect for constitutional and policy rights for gays and lesbians to promote access of SRH services in the two cities including the retraining of security agents on human rights and constitutionalism.

The quality of the SRH services, coupled with the poor state of public health facilities and the absence of comprehensive services was a barrier that was identified in both cities, but was more prominent in Bulawayo than in Pretoria. About 69% of lesbians in Bulawayo and 62% of lesbians in Pretoria indicated that the package of health care accessed at the last health facility they visited did not meet their needs at point of delivery or referred points. Gays and lesbians confirmed the

irregularity of the quarterly services provided by civil society organizations through outreaches and preferred a monthly schedule.

7.2.3 Limitations Identified Using the Health Belief Model

Using the Health Belief Model, several limitations were identified which need to be addressed to promote access to SRH products and services for gays and lesbians in the two cities. These were external (outside gays and lesbians' locus of control) such as absence of the right SRH products such as condoms, lubricants, dental dams, latex gloves in the right places and at the right cost, negative attitudes towards public health care workers and high levels of stigma and discrimination from society and the health workers. Efforts should be made to improve the supply chains of the SRH products and increase information dissemination to ensure that gays and lesbians change their attitudes towards healthcare workers.

Institutional barriers were also identified, such as the unavailability of medical supplies and such as PrEP, PEP and cancer screening equipment. The absence of gays or lesbians 'only' spaces or hours at public clinics or hospitals and the poor quality of some of the ablution and sanitation facilities contributed to the respondents avoiding such facilities. Private and public stakeholders should actively engage potential funders to invest in infrastructural renovations to improve the layout and quality of the facilities to make them attractive to gays and lesbians in the two cities.

The second category of barriers were internal (those that gays and lesbians could control) including their reluctance to recommend good facilities to friends, limited discussions of SRH issues with parents, fear of cancer screening, low self-efficacy towards condoms and dental dams use and preferences for service providers. Civil society organizations need to intensify awareness and conduct tailored health demonstrations on correct, consistent and regular use of SRH products and services among gays and lesbians in the two cities.

Low knowledge levels about the SRH needs of gays and lesbians contributed to high levels of stigma and discrimination, at community and health facilities level. This forced gays and lesbians to either avoid seeking the services or travel longer distances to other health facilities with staff deemed less stigmatizing. Efforts to retrain health care workers and security agents should be made to ensure that they respect the rights and privileges enshrined in the constitutions of the two countries including access to health care and non-discrimination based on sexual orientation. The relevant stakeholders must work to promote the delivery of quality health services to gays and lesbians with full respect for human dignity, health rights and within the WHO guidelines.

7.3 Contributions to Knowledge, Policy and Practice

Firstly, there is need for public health authorities in both cities, assisted by their central governments, to address the bottlenecks and barriers affecting access to SRH services and products while reinforcing the facilitating factors promoting access. The limitations identified through analysing the six dimensions of the Health Belief Model should be minimized so that gays and lesbians can utilize both the health systems in Bulawayo and Pretoria.

Addressing barriers will create a more conducive environment for gays and lesbians to access and utilise SRH services in the two cities without fear of stigma and discrimination. Promoting utilization of SRH services by key populations such as gays and lesbians will contribute to the decline of the incidence and prevalence of HIV and STIs, cancers and other social vices such as alcohol and drug abuse. The starting point to address this is raising awareness and respect on the constitutional and policy rights of gays and lesbians and ensure enforcement of the same by public health and security

officials. Deliberate interventions should be instituted to ensure human rights and the legal framework relating to key populations are part of the training for medical and security personnel.

Furthermore, the respondents mentioned that healthcare workers will need further training on how to provide comprehensive user-friendly services for gays and lesbians in the two cities according to the WHO guidelines. The guidelines stipulate that health service providers should be specially trained on management of health conditions of gays and lesbians and that they should have in place a clear well-documented referral system to manage specialized needs of gays and lesbians.

The WHO guidelines also recommend that health systems should have specific KPs-only facilities and KP-only hours of business to ensure separation between the general population from the key populations at community level. Health services should be made available, accessible and acceptable to key populations, based on the principles of medical ethics, avoidance of stigma, non-discrimination and the right to health (WHO, 2016).

Regarding the health and security staff who are already in service, the information can be disseminated through trainings, mentoring or exchange visits and will help reduce their own prejudices and provide services from a public health perspective. The security agents need conscientization on respecting the freedoms and rights of gays and lesbians as enshrined in the constitutions of the two countries.

Secondly, there is need for public health authorities in Pretoria and Bulawayo to build upon the identified positive factors which facilitated the access to SRH services and use of products such as condoms and lubricants. These include maintaining the good reputation of drop-in centres as one stop service delivery points with their comfortable and clean environments and the conducive

spaces for confidentiality and individual privacy. Facilities need regular sprucing up to ensure that the standards of the infrastructure are maintained.

Thirdly, there were positive health seeking behaviours among gays and lesbians including access to platforms for discussion of SRH issues with their social networks and KP community support systems which motivated them to seek SRH services and products. These factors require establishment, initiation and strengthening of community-based organizations or networks that work directly with gays and lesbians in both Bulawayo and Pretoria, by providing social support and advocacy for improved SRH services. Networks facilitate easier mobilization of resources for community-based solutions and can be utilized to implement a package of interventions to enhance community empowerment among the key populations.

The interconnectedness and complementarity of static and outreach activities that were conducted by civil society organizations such as PSI, PSZ, SFH, GALZ and OUT Well Being and Health4Men was commendable in Bulawayo and Pretoria. However, there is need to provide the community-based services with more regularity such as monthly, implement a strong referral and follow up mechanism to ensure that there is continuum of health care from point of entry to exit for the clients. The central government should actively support and strengthen the referral system and ensure all the referred services are available and functional for the key populations. The CSOs need to ensure that their mobile outreach teams return to the communities for follow up or links gays and lesbians to community-based support networks to continue accessing quality SRH services and products.

Fourthly, there was a combination of positive facilitators and good behaviours by gays and lesbians in both Bulawayo and Pretoria that need to be supported to further promote the effective utilisation of SRH services. These included the peer recommendation of SRH services by gays and

lesbians, equitable treatment by some SRH service providers regardless of gender and sexual orientation, availability of medical testing and treatment facilities and positive perceptions that their SRH records were kept confidentially and in privacy by health officials. If utilized strategically, the facilitating factors will ensure universal access of SRH services by gays and lesbians. These positive behaviours can be amplified through tailored and specific behaviour change messaging that utilizes preferred channels of communications to reach the targeted gays and lesbians in Bulawayo and Pretoria.

7.4 Recommendations

There are several key barriers and limitations that need to be addressed to promote access to SRH products and services for gays and lesbians in the two cities. These included lesbians' reluctance to recommend facilities to their peers because of their bad experiences once they had reached these facilities. There were limited discussions of SRH issues between gays and lesbians and their parents because of the socio-cultural and religious context. Absence of the right SRH products such as condoms, lubricants, dental dams, latex gloves in the right places and at the right cost contributed to the low rates of their use among gays and lesbians. High levels of stigma and discrimination at community level and from health care workers caused some of gays and lesbians to avoid certain facilities, especially public clinics and hospitals in preference of drop-in centres in the two cities.

Against the guidelines of the WHO, all public health facilities had no KP 'only' spaces or hours and the poor quality of some of the ablution facilities were some of the limitations mentioned by gays and lesbians. Most of the referral facilities had limited drugs, equipment and supplies for cancer screening, PrEP, PEP, sex change, in-vitro fertilization, and sterilization procedures.

To address the above gaps, it is recommended that positive messages should be shared with gays and lesbians to encourage their peers to access SRH services. The central governments through the

Ministries of Health need to include SRH products such as lubricants, dental dams and latex gloves in their basket of the products transmitted through the DTTU system and the Department of Health to reach all public health facilities in the two cities. Availability of these products was a major factor affecting access and the delivery systems need to be strengthened.

The healthcare workers need further information, mentoring and training on implementing the WHO guidelines on provision of comprehensive services for key populations, including gays and lesbians to ensure that they discharge their duties without prejudices in a stigma free environment. This will encourage gays and lesbians to seek the services without fear of stigma, discrimination, or abuse. The WHO recognized the global public-health burden that discrimination against members of any marginalized group places on those individuals, *"magnifying their poverty and ill-health as well as the burden it places on society as a whole, specifically the LGBT community*" (WHO, 2011). Promoting equal access to health services in national policies and legislation and strengthening universal comprehensive social protection policies, including health promotion and health care should be prioritized by both state and non-state actors.

The SRH services and products offered either at public health facilities or CSO-operated facilities need to have comprehensive services including PrEP, PEP, ART initiation, mental health, and psychosocial support services (MHPSS), lubricants, dental dams and latex gloves under one roof to ensure that there is a supermarket approach when gays and lesbians are accessing services. The facilities need to be continuously upgraded and maintained to ensure that the standards are not deteriorating and act as barriers to gays and lesbians intending to utilize them.

There were critical SRH services that were not readily available to most of gays and lesbians in Bulawayo which included sex change, life skills building and mental health and psychosocial support (MHPSS) services. In Pretoria, OUT Well Being provided MHPSS services through online and

telephonic hotline means and the beneficiaries of this service had positive reviews of its functionality. There is need to mobilize financial, technical and human resources for CSO-operated health service providers such as Bambanani Trust, PSI and GALZ in Bulawayo to adopt this model of providing MHPSS services to gays and lesbians. This strategy will ensure that no one is left behind in the provision SRH services by allowing even those with limited financial resources to still access the services over the phone or online.

There was absence of adequate and tailored information, educational and communications (IEC) materials. Government key informants indicated that most of the IEC materials were targeted towards the general population and excluded unique information about homosexuality issues. This was a greater challenge in Bulawayo than in Pretoria, as the digital footprint of gays and lesbians' platforms and networks was more visible in Pretoria. There is need to strengthen gays and lesbians' networks and platforms that disseminate tailored messages to address the SRH issues of the key populations. Regarding general health behaviour change communications, the central and local health departments need to raise awareness about the constitutional rights of gays and lesbians from a public health perspective, to help reduce stigma, discrimination, and homophobia.

There was a total of 18 drop-in centres in Pretoria and only three in Bulawayo. The drop-in centres were largely manned by registered nurses who provided professional, free, safe, confidential, non-judgmental, and inclusive services such as HCT, PrEP, STI screening and basic treatment, Tuberculosis screening and referral, PEP, Anti-Retroviral Treatment (ART), HIV management (CD4 and viral load), basic wound care, general medical, sexual health and safer sex consultations, individual and couples counselling, condoms and lubricants. In Bulawayo, the drop-in centers had less services compared to those in Pretoria and the shortage of financial, technical and human resources was attributed for the disparity. The study recommends that the CSOs and public health

facilities adopt the model of Drop-in centers in Pretoria which provide a one stop center for all SRH services and products.

Limitations related to patient confidentiality, while important to all patients, were particularly important to key populations, especially those who had not yet disclosed their sexual orientation in their communities. Disclosure of such status in Bulawayo raises concerns regarding arrest, discrimination and sometimes physical harm. Some of gays and lesbians in the two cities felt that confidentiality and privacy were not assured and decided not to seek services or withheld key information from providers for fear of their safety. Such disclosures are not relevant for provision of SRH services or promotion of public health goals and may negatively affect adherence and patient retention in the health system. Lastly, it is important to highlight some areas that require further research that were identified in the execution of this study;

i. Considering the critical role played by CSOs: there is need to understand further the role and contribution of outreach services and the preferences of gays and lesbians between static and outreach services.
ii. To ensure continuum of care: understanding feasible models to strengthen community-based networks and referral and follow up mechanism is important to ensure continuum of care and access of SRH services and products.
iii. In view of the legal environment that is punitive to homosexuality, what mechanisms can be adopted for improving acceptance of different genders and sexual orientations considering constitutional provisions that are against stigma, discrimination, segregation, abuse and homophobia. Further understanding issues of intra-LGBTIQ violence, substance use and abuse and mental health and psychosocial issues among the key populations.

iv. Contextualizing the WHO guidelines into each country's context to ensure that the key populations access a standard minimum package of SRH services and products.

v. In line with the Sustainable Development Goal 10 on reducing inequalities and 17.18 on collection of disaggregated data, it is critical to conduct formative research to collect data about population size estimates and how privacy rights affect access to health services for gays and lesbians. This information will strengthen the planning, delivery, monitoring and robust evaluation of health care and services, and health related policies and laws for gays and lesbians.

References

Abbott, S. A., et al. (2013). *Female sex workers, male circumcision and HIV: a qualitative study of their understanding, experiences, and HIV risk in Zambia*. PloS One, 8(1), e53809.

Abbruzzese, B. (2002). *Massachusetts youth risk behavior survey results*. Massachusetts Department of Education. http://www.doe.mass.edu/hssss/yrbs/01/results.pdf. Accessed 22 March 2018

Albarracin, D. et al., (2005). *A test of major assumption about behavior change: A comprehensive look at HIV prevention interventions since the beginning of the epidemic*. *Psychological Bulletin, 131,* 856-897.

Andrade C. (2021). *The Inconvenient Truth About Convenience and Purposive Samples.* Indian J Psychol Med. 2021;43(1): 86–88.

Anna Glasier, et al. (2006). *Sexual and reproductive health: a matter of life and death*. The Lancet Sexual and Reproductive Health Series, October 2006.

Avert. (2016). *AVERT Annual report 2016*. Available at www.avert.org. (Accessed: 22 March 2018)

Avert. (2017). *AVERT Annual report 2017*. Available at www.avert.org. (Accessed: 22 March 2018)

Avert. (2018). *AVERT Annual report 2018*. Available at www.avert.org. (Accessed: 4 August 2019)

Avert. (2019). *AVERT Annual report 2019*. Available at www.avert.org. (Accessed: 11 May 2020)

Avert. (2020). *https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/south-africa*. (Accessed: 16 July 2020)

Babbie, E. (2008). *The Basics of Social Research*. Washington DC: Thomson Higher Education.

Bailey, N., & Phariss, T. (1996). *Breaking through the wall of silence: Gay, lesbian, and bisexual issues for middle level educators*. Middle School Journal, 27(3), 38-46.

Bandawe. (2015). *A Survey on Alternative Sexual Reproductive Health services available for the LGBTIQ when not provided by government facilities. Malawi.* Centre for Human Rights and Rehabilitation.

Bauer, G., & Welles, S. (2001). *Beyond Assumptions of Negligible Risk: Sexually Transmitted Diseases and Women Who Have Sex with Women*. American Journal of Public Health, 91 (8), 1282-1286.

Blake, S.M., Ledsky, R., Lehman, T., Goodenow, C., Sawyer, R., & Hack, T. (2001). *Preventing sexual risk behaviors among gay, lesbian, and bisexual adolescents: The benefits of gay-sensitive HIV instruction in schools*. American Journal of Public Health, 91(6), 940-946.

Bryman, A., & Cramer, D. (1994). *Quantitative data analysis for social scientists* (rev. Taylor & Frances/Routledge.

Casebeer, A. L., and Verhoef, M. J. (1997). *Combining Qualitative and Quantitative Research Methods; Considering the Possibilities for Enhancing the Study of Chronic Diseases'*, Chronic Diseases in Canada, Volume 18, Number 3.

Carpenter, C.J. (2010). *A meta-analysis of the effectiveness of health belief model variables in predicting behavior.* Health Communication. 25 (8): 661–669.

Chersich, M. F. et al. (2013). *Priority interventions to reduce HIV transmission in sex work settings in sub–Saharan Africa and delivery of these services.* Journal of the International AIDS Society, 16(1).

Colucci, E. (2007). '*Focus groups can be fun': The use of activity-oriented questions in focus group discussions.* Qualitative Health Research, 17 (10): 1422-1433.

Cowan, F. M.et al. (2013). *Engagement with HIV Prevention Treatment and Care among Female Sex Workers in Zimbabwe: A Respondent Driven Sampling Survey*. PLoS ONE, 8(10).

Creswell, J. W. (2002). *Educational research: Planning, conducting, and evaluating quantitative*. Prentice Hall.

Creswell, J. W., Clark, V. L. P., Gutmann, M. L., and Hanson, W. E. (2003). *Advanced Mixed Methods Research Designs, in Tashakkori A and Teddlie C (eds.): Handbook of Mixed Methods in Social and Behavioural Research,* Sage, Thousand Oaks, p209– 240.

Creswell, J. W. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches.* Sage Publications, Incorporated.

Daly, F. (2015). *Claiming the human right for women who have sex with women through South Africa's national strategic plans for HIV and STI.* Policy brief June 2015: HEARD UKZN.

Davis, V. (2005). *Lesbian health*. The Obstetrician & Gynaecologist, 7, 98-102.

Department of Health. (2008). *High quality care for all*: *NHS next stage review final report*. London: The Stationery Office.

Diamant, A., Schuster, M., McGuigan, K., & Lever, J. (1999). *Lesbians' sexual history with men: Implications for taking a sexual history*. Arch Intern Med, 159, 2730-2736.

Di McIntyre and John Ataguba. (2017). *Access to quality health care in South Africa: Is the health sector contributing to addressing the inequality challenge?* University of Cape Town

Duby, Z et al. (2018). *"Scared of going to the clinic": Contextualising healthcare access for men who have sex with men, female sex workers and people who use drugs in two South African cities'.* Southern African Journal of HIV Medicine, Volume 19, Issue 1.

Dutta MJ, Basu A. (2011). *Culture, Communication, and Health: A Guiding Framework*. In: Teresa L. Thompson, Roxanne Parrott, & Jon Nussbaum (eds.) *The Routledge Handbook of Health Communication.* New York: Taylor & Francis.

Gall, M. D., Borg, W. R., Gall, J. P. (2003). *Educational research: An introduction*. (7th Edition). White Plains, New York: Longman.

GALZ. (2018). *August 2018 Report*. www.galz.org. Accessed 22 May 2019

Gay, Lesbian and Straight Teachers Network. (2005). *What You Can Do: Ideas and Resources for Educators Working to End Homophobia in Schools.*

Gayet, Cecilia and Fernández-Cerdeño, Araceli. (2009*). Time Location Sampling and Respondent Driven Sampling: Techniques implementation for monitoring concentrated HIV/AIDS epidemic in Mexico.* University of California, San Diego / San Diego State University. Mexico

GenderDynamix. (2013). *'Sexual and Reproductive Health for Transgender and Gender Non-Conforming People: Guidelines for Health Care Workers in Primary Care'*. www.genderdynmix.org (Accessed on 1 June 2018)

Gibson, P. (1989). *Gay male and lesbian youth suicide*. In M. Feinleib (Ed.), Report of the Secretary's Task Force on Youth Suicide, 3, 110-142.

Girl's Best Friend Foundation and Advocates for Youth. (2005). *Creating Safe Space for GLBTQ Youth: A Toolkit.* 15-19.

Glanz, Karen; Bishop, Donald B. (2010). *The role of behavioral science theory in development and implementation of public health interventions.* Annual Review of Public Health. 31: 399–418.

Glanz, Karen; Barbara K. Rimer; K. Viswanath (2008). *Health behavior and health education: theory, research, and practice*. (PDF) (4th ed.). San Francisco, CA: Jossey-Bass. pp. 45–51.

Government of Zimbabwe. (2017). '*Extended Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) 2015-2020'. Available at:* www.nac.org.zw. (Accessed on 21 March 2020).

*G*rossman, A.H., & D'Augelli, A.R. (2006). *Transgender youth; Invisible and vulnerable*. Journal of Homosexuality, 51(1), 111-128.

Gulliford et al. (2002). *What does 'access to health care' mean?* Journal of Health Services Research and Policy, 2002 Jul;7(3):186-8 in PubMed Journal July 1, 2002.

Hammerberg, K; Kirkman, M; de Lacey, S. (2016). *Qualitative Research Methods: when to use them and how to judge them.* Human Reproduction, Volume 31, Issue 3, March 2016. Pages 498-501.

Havnar T. 2019. *Health rights: LGBTIQ community Sexually Transmitted Infection* in BMJ Journals (Volume 95, Issue Suppl 1). Available at: http://dx.doi.org/10.1136/sextrans-2019-sti.395. (Accessed 26 October 2021).

Health Systems Trust. (2016). *South African Health Review 2016*. Durban, South Africa. ISSN 1025-1715. May 2016

Hesse-Biber, S.N. & Leavy, P. (2011). *The Practice of Qualitative Research*. Los Angeles: Sage Publications

Hivos. (2013). *Responding to the Safety and Security Needs of LGBTI Communities and Organisations: A situational analysis of Malawi, South Africa, Zambia and Zimbabwe*. Available: https://www.hivos.org/sites/default/files/report_by_rosa_regional. (Accessed: 24 January 2018)

Hivos. (2016). *KP Reach Programme Baseline Survey Report: Southern Africa.* Hivos. Harare.

Hoff, T., & Greene, L. (2000). *Sex education in America: A series of national surveys of students, parents, teachers, and principals.* The Henry J. Kaiser Family Foundation.

Hsiao, W & Saidat B (2008). "*Health Systems: Concepts and Deterministic Models of Performance. A Background Paper prepared for the Workshop on Research Agendas on Global Health Systems*. Available at: http://siteresources.worldbank.org/INTHSD/Resources/376278-1114111154043/1011834124644911052 4/HsiaoSiadatInSearchOfaCommonConceptualFramework ForHSSDraft62309. pdf. Accessed: 2 July 2018

Human Sciences Research Council (HSRC). (2014). *South African National HIV Prevalence, Incidence and Behaviour Survey 2012*. Available at: http://heaids.org.za. (Accessed: 28 January 2018)

Hunt et al. (2017). *'They will be afraid to touch you': LGBTI people and sex workers' experiences of accessing healthcare in Zimbabwe—an in-depth qualitative study* in BMJ Global Health 2017;**2:**e000168. (Accessed 25 October 2021).

INS et al. 2013. *Final Report: the Integrated Biological and Behavioral Survey among Men who have Sex with Men, Mozambique*. UCSF. San Francisco.

Institute of Medicine. (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C.: National Academy Press.*

Janz NK et al. (2002). The Health Belief Model. In: Glanz K, Rimer BK, Lewis FM, editors. *Health behavior and health education: theory, research, and practice*. San Francisco: Jossey-Bass, 2002: 45-66.

Ji H et al. (2021). *Overview of the epidemiological conditions of HIV among key populations in Africa* in Journal of the Internal AIDS Society 24 (S3). Available at: https://doi.org/10.1002/jia2.25716. (Accessed: 26 October 2021).

Lane, T. (2002). *Among sexually experienced male adolescents, those with partners of both sexes exhibit riskiest behavior.* Perspectives on Sexual and Reproductive Health, 34 (3).

Maguen S et al. (2000). *Predictors of HIV antibody testing among gay, lesbian, and bisexual youth*. J Adolesc Health 2000; 26:252-257.

McIntyre D, Thiede M, Birch S (2009). *Access as a policy-relevant concept in low- and middle-income countries*. Health Economics, Policy and Law 4: 179-193.

McLafferty, I. (2004). *Focus Group Interviews as a data collecting strategy*. Journal of Advanced Nursing, 48(2): 187–194.

Ministry of Health and Child Care Zimbabwe. (2019). '*Zimbabwe Population-Based HIV Impact Assessment (ZIMPHIA) 2015-2016*'. https://phia.icap.columbia.edu/countries/zimbabwe/. (Accessed 8 March 2019)

Ministry of Health, Zimbabwe. (2017). '*Comprehensive Sexuality Education and Life Skills: Zimbabwe's Experiences [presentation slides]*. www.malecircumcision.org. (Accessed on 11 May 2020).

Mukandavire et al. (2018). *Estimating the contribution of key populations towards the spread of HIV in Dakar, Senegal* in Journal of the International AIDS Society. Available at: https://doi.org/10.1002/jia2.25126. (Accessed on 26 October 2021).

Morrow, K.M., Allsworth, J.E. (2000). *Sexual risk in lesbian and bisexual women*. J Gay & Lesbian Medical Association. 4, 149-165.

Motana, R. (2016). *Sex work must be legalised for the best interests of South Africa***,** Mail & Guardian 01 June 2016. Available at: http://mg.co.za/article. (Accessed: 12 February 2018)

Muller, A. (2017). *Scrambling for access: availability, accessibility, acceptability and quality of healthcare for lesbian, gay, bisexual and transgender people in South Africa*. Müller BMC International Health and Human Rights (2017).

Nakanagwi et al. (2016). *Facilitators and Barriers to Linkage to HIV Care among Female Sex Workers Receiving HIV Testing Services at a Community-Based Organization in Periurban Uganda: A Qualitative Study.* Journal of Sexually Transmitted Diseases Volume 2016. Hindawi Publishing Corporation

Neuman, W. L., & Robson, K. (2004). *Basics of social research*. London: Pearson Publishers.

Neuman, W. L., & Neuman, W. L. (2006). *Social research methods: Qualitative and quantitative approaches.* London: Pearson Publishers

Pettifor et al. (2015). *Tailored combination prevention packages and PrEP for young key populations* in Journal of the International AIDS Society. Available at: https://doi.org/10.1002/jia2.25650. (Accessed on 24 October 2021).

Poteat, T, et al. (2017). *'HIV prevalence and behavioral and psychosocial factors among transgender women and cisgender men who have sex with men in 8 African countries: A cross-sectional analysis'*.PLoS Medicine, Volume 14, Issue 11, e1002422.

Ricardo et al. (2015). *In the Picture: A situational analysis of LGBTI Health & Rights in Southern Africa.* COC Netherlands: Amsterdam.

Robson, C. (2002). *Real world research (Vol. 2)*. Oxford: Blackwell Publishers.

Rosenstock IM. (1974). *Historical origins of the Health Belief Model*. Health Education Monogr 1974

Saewyc, E., Bearinger, L., Blum, R., & Resnick, M. (1999). *Sexual intercourse, abuse and pregnancy among adolescent women: Does sexual orientation make a difference?* Family Planning Perspectives, 31(3), 127-131

Savin-Williams RC. (1994). *Verbal and physical abuse as stressors in the lives of lesbian, gay male, and bisexual youths: Associations with school problems, running away, substance abuse, prostitution, and suicide.* Journal of Consulting and Clinical Psychology, 62, 261-69.

Semaan S, Lauby J, Liebman J. (2002). *Street and Network Sampling in Evaluation Studies of HIV Risk reduction Interventions*, AIDS Rev 2002: 4: 213-223.

Seale, C*. ed. (2009). Researching Society and Culture.* Los Angeles: Sage Publications.

Shakarishvili G et al. (2010). *Converging Health Systems Frameworks: Towards A Concepts-to-Actions Roadmap for Health Systems Strengthening in Low and Middle Income Countries*. GLOBAL HEALTH GOVERNANCE, VOLUME III, NO. 2 (SPRING 2010) http://www.ghgj.org

Siddiqui, T.R., Ghazal S., Bibi S., Ahmed W., Sajjad S.F. (2016). *Use of the Health Belief Model for the Assessment of Public Knowledge and Household Preventive Practices in Karachi, Pakistan, a Dengue-Endemic City***.** PLOS Neglected Tropical Diseases 10(11).

South Africa National Department of Health. (2011). *National Strategic Plan on HIV, STIs and TB, 2012–2016*. Pretoria: Department of Health; 2011. Available at: h*ttp://www.nicd.ac.za.* (Accessed 28 May 2018).

South Africa National AIDS Council. (2017). '*The South African National LGBTI HIV Plan, 2017-2022'*. www.sanac.co.za Accessed on 3 April 2019

Stone et al. (2021). *Estimating the contribution of key populations towards the spread of HIV in South Africa* in Journal of the International AIDS Society. Available at: https://doi.org/10.1002/jia2.25650. (Accessed on 26 October 2021).

Sullivan et al. (2020). *HIV prevalence and incidence in a cohort of South African men and transgender women who have sex with men: the Sibanye Methods for Prevention Packages Programme (MP3) project* in Journal of the International AIDS Society. Available at: https://doi.org/10.1002/jia2.25591 (Accessed on 27 October 2021).

Telljohann, S., Price, J., Poureslami, M., & Easton, A. (1995). *Teaching about sexual orientation by secondary health teachers*. Journal of School Health, 65(1), 18-22.

Thaler, T.H. & Sunstein, C.R. (2009). *Nudge: Improving decisions about health, wealth, and happiness*. New York: Penguin Group.

Trochim, W. M., & Donnelly, J. P. (2001). *Research methods knowledge base*. Oxford: Sage Publishers.

UN. (1994). *Report of the International Conference on Population and Development, Cairo, 5-13 September 1994*. New York: United Nations, 1995: Sales No. 95.XIII.18.

UN. (1999). *Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development*. New York: United Nations, 1999.

UN. (2005). *World Summit Outcome*. New York: United Nations, 2005.

UN. (2016). *United Nations Millennium Declaration.* New York: United Nations, 2000: A/RES/55/2, Section II.

UNAIDS. (2017*). 2016 Annual Report*. Available at www.unaids.org (Accessed: 14 March 2018)

UNAIDS. (2019). 'UNAIDS Data 2019'. www.unaids.org. Accessed on 23 May 2020

UNFPA. (2017). www.unfpa.org. Accessed 3 February 2020

University of California, San Francisco. (2015). *Report of the South Africa men-who-have-sex-with men Data Triangulation Project.* San Francisco: UCSF. Global Health Sciences.

WHO. (2000). *Maternal mortality in 2000: estimates developed by WHO, UNICEF and UNFPA*. Geneva, World Health Organization, 2004. 1

WHO. (2017). *Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets.* Geneva: World Health Organization, 2004.

WHO. (2017). Available at www.who.int. (Accessed: 11 February 2018)

Whyte, A., Tedds, J. (2011). '*Making the Case for Research Data Management*'. DCC Briefing Papers. Edinburgh: Digital Curation Centre.

UNDP. (2009). *Handbook on Planning, Monitoring and Evaluation for Development Results.* New York: United Nations Development Programme

University of California San Francisco. (2015). *South African Health Monitoring Study (SAHMS), Final Report: The Integrated Biological and Behavioural Survey among Female Sex Workers, South Africa 2013-2014.* San Francisco, California.

University of California San Francisco. (2015). *Report of the South Africa men-who-have sex-with men.* Data Triangulation Project. San Francisco: UCSF. Global Health Sciences.

Zimbabwe Ministry of Health. (2019). *GARPR Zimbabwe Country Progress Report 2018*. Available at www.unaids.org (Accessed: 22 January 2018)

Zimbabwe National Statistics Agency. (2012). *Zimbabwe Demographic and Health Survey 2010-11*. Available at: http://dhsprogram.com/pubs (Accessed: 23 January 2018)

Zimbabwe National Statistics Agency. (2015). '*Zimbabwe Demographic and Health Survey 2015: Key Indicators'*. www.measureevaluation.org. Accessed on 23 September 2019.

Appendices

Appendix A

QUESTIONNAIRE IDENTIFICATION NUMBER |____|____|____|____|

SPEAK TO THE RESPONDENT: Hello. My name is……working with a local Researcher in this place. We are interviewing people here in [……name of PLACE] to obtain their views and opinions about access to health services.

Your answers will be completely confidential. Your name will not be written on this form and will never be used in connection with any of the information you tell me. You do not have to answer any questions that you do not want to answer, and you may end this interview at any time you want to. However, your honest answers to these questions will help us better understand what people think, say and do about certain kinds of behaviours which would help design better health care interventions to protect the health of citizens in this country. We would greatly appreciate your help in responding to this survey. It will take between 40 and 50 minutes to ask the questions. Would you be willing to participate?

IDENTIFICATION ID01 : Country _____ ID02 : Province _____ ID03 : District _____ ID04: Locality Name _____ Rural----------1 Urban----------2
INTERVIEWER VISITS Visit 1 Visit 2 Visit 3 DATE _____ _____ _____ Interviewer Number_____ Supervisor Number _____
INTERVIEW STATUS Completed interview----------1 Partially completed interview----------2

SECTION 1: Socio-Demographic Characteristics				
NO	Question	Response	Code	Skip Pattern
Q101	How old were you on your last birthday?	…….. Don't know No response	1 2 3	

Q102	How long have you lived here?	Number of months {
		}
		Record 00 if less than 1 month
		Don't know
		No response
			1
			2
			3
			4	

Q103	Where else have you lived in the past 5 years before coming to this place?	…… …… …… Never lived elsewhere before No response	1 2 3 4 5	
Q104	What is the highest level of school you completed?	Primary Secondary Tertiary (Polytechnics, Colleges) University None	1 2 3 4 5	
Q105	What is your religion?	Traditional Roman Catholic Protestant Pentecostal Apostolic sect Islam Hindu None Other religions No response	1 2 3 4 5 6 7 8 9 10	
Q106	Race of the respondent:	Black African White Coloured (mixed race) Asian Other (State)_____	1 2 3 4 5	
SECTION 2: Sexual History and Behavior				
Q201	How do you identify yourself	Lesbian Gay Bisexual Transgender Intersex Queer	1 2 3 4 5 6	
Q202	Have you ever had sexual intercourse?	Yes No	1 0	If No, Skip to Q301
Q203	How old were you when you first had sexual intercourse? *[Interviewer: If Don't Know or Can't Recall Code 98]*	1. _____	1 98	
Q204	In the last 6 months, did you have any form of sexual intercourse?	Yes No	1 0	If No, Skip to Q207
Q205	In the past 30 days, have you had any form of sexual intercourse?	Yes No	1 0	

Q206	How many women did you have any form of sex with in the past 30 days?	Number: _____		
Q207	How many women did you have any form of sex with in the past six months?	Number: _____		
Q208	How many men did you have any form of sex with in the past 30 days?	Number: _____		
Q209	How many men did you have any form of sex with in the past six months?	Number: _____		
Q210	How many of these were your regular[2] partners?	Number: _____		
Q211	Any comments to the responses you have given in this section?			
Section 3: Condom and Lubricants Access and Use				
Q301	Do you know of any place or any person where you can obtain condoms?	Yes No No response	1 0 3	
Q302	Which places or persons do you know where you can get condoms?	Clinic Hospital Health centre Health worker Pharmacy Shop Bar Guest House Hotel Peer educator Friend Work place Drop in centre Don't know	1 2 3 4 5 6 7 8 9 10 11 12 13 14	
Q303	Did you use a condom the last time you had sex with a regular partner?	Yes No	1 0	
Q304	Did you use a condom the last time you had sex with a non-regular partner?	Yes No	1 0	If No go to 308
Q305	Where did you purchase the condom?	Liquor outlet Pharmacy Supermarket Vendor Given by a friend Free from a health facility Free from a drop-in centre Other (Specify) _____	1 2 3 4 5 6 7 8	
Q306	Who suggested condom use that time?	Myself Partner Joint decision No response	1 2 3 4	
Q307	With what frequency did you and your partner(s) use a condom over the last 6 months?	Every time Almost every time Sometimes Never Don't remember No response	1 2 3 4 5 6	

[2] P*artners that you have sex multiple times in past and plan to have sex with in the future*

Q308	Why didn't you and your partner use a condom that time? CIRCLE ALL ANSWERS MENTIONED	Not available at that time Too expensive Partner objected Don't like them Didn't think it was necessary Didn't think of it Other…….. No response	1 2 3 4 5 6 7 8	
Q309	What should be done to improve the availability, access and use of condoms among gays and lesbians?			
Q310	Did you use lubricants the last time you had sex with a regular partner?	Yes No	1 0	
Q311	Did you use lubricants the last time you had sex with a non-regular partner?	Yes No	1 0	If No, go to 315
Q312	Where did you purchase the lubricants?	Liquor outlet Pharmacy Supermarket Vendor Given by a friend Free from a health facility Free from a drop-in centre Other (Specify) _____	1 2 3 4 5 6 7 8	
Q313	Who suggested the use of the lubricants that time?	Myself Partner Joint decision No response	1 2 3 4	
Q314	With what frequency did you and your partner(s) lubricants over the last 6 months?	Every time Almost every time Sometimes Never Don't remember No response	1 2 3 4 5 6	
Q315	Why didn't you and your partner use lubricants that time? CIRCLE ALL ANSWERS MENTIONED	Not available at that time Too expensive Partner objected Don't like them Didn't think it was necessary Didn't think of it Other…….. No response	1 2 3 4 5 6 7 8	
Q315	What should be done to improve the availability, access and use of lubricants among gays and lesbians?			
Q316	Any comments you have regarding use of condoms and lubricants among gays and lesbians?			
Section 4: Sexually transmitted infections and Cancer Screening				
Q401	Have you ever heard of diseases that can be transmitted through sexual intercourse?	Yes No	0 1	
Q402	Have you had a genital discharge in the past 12 months?	Yes No No response	1 0 3	
Q403	Have you had a genital ulcer in the past 12 months?	Yes No No response	1 0 3	

Q404	What should be done to improve the treatment of STIs among gays and lesbians?			
Q405	Any comments you have regarding STIs among gays and lesbians?			
Q406	Have you ever been screened for cancer at the health facilities?	Yes No	0 1	
Q407	Which type of cancer were you routinely screened for?	Breast Cervical Bone Penile Prostate Other.	1 0 3 4 5 6	
Q408	When do you intend to go for another routine screening?	30 days 3 months 6 months Don't know	1 0 3 4	

Section 5: Access and Evaluation of the SRH Services

No	Indicator (Sub Indicators)	Yes	No	Skip Pattern
Q501	Have you ever visited a health facility in the last 6 months?	1	0	
Q502	Did you receive the services you wanted?	1	0	
Comment with reference to the last health facility you visited for assistance;				
Q503. Accessibility		**Yes**	**No**	
A	Convenient opening hours (after hours, weekends)	1	0	
B	Availability of transport to facility	1	0	
C	Services are affordable or free	1	0	
E	Awareness of location, hours and services	1	0	
F	Appointments available	1	0	
H	Gay/Lesbian-only hours	1	0	
I	Appointments available online or by text/call	1	0	
J	Social media presence for services	1	0	
K	Facilities open during entire posted time	1	0	
L	Partners welcome	1	0	
Q504: Acceptability		**Yes**	**No**	
B	Provider demographics reflect clients (young, similar gender, KPs)	1	0	
C	Client would recommend the facility to friend	1	0	
E	Client willingness to return to facility	1	0	
F	Facility has good reputation	1	0	
Q505. Appropriateness		**Yes**	No	
A	Package of care fulfils needs either at point of delivery/referral linkages	1	0	
B	Client has choice of treatment options	1	0	
C	Data collected to determine KP's health needs in community	1	0	
Q506: Equitability		**Yes**	**No**	
A	Welcome regardless of age, gender, race/tribe and sexual orientation	1	0	
D	Open to all religious groups	1	0	
E	Welcome regardless of marital status	1	0	
F	Welcome regardless of relationship status	1	0	
G	Open to persons of all sexual orientations	1	0	
H	Females and males receive equal access to services	1	0	
I	Males and females receive similar service care and respect	1	0	
Q507. Effectiveness		**Yes**	**No**	
A	Supplies available onsite (medical testing, treatment)	1	0	

B	Providers are medically competent	1	0	
C	Provider takes client history	1	0	
D	Client follows healthcare worker's advice, adherence to treatment	1	0	
E	Equipment to provide services available	1	0	
F	Infection control procedures are followed	1	0	
G	Provider takes appropriate physical examination according to guidelines	1	0	
Q508: Administrative Procedures		**Yes**	**No**	
A	Waiting time is okay	1	0	
B	Choice to be seen by the same clinician during next visit	1	0	
C	Plan for follow up care explained and scheduled	1	0	
D	Referral care available, explained, and scheduled	1	0	
E	Sufficient time for consultation	1	0	
F	Results are not available instantly; you have to plan another visit	1	0	
Q509: Staff Characteristics and Competency		**Yes**	**No**	
A	Non judgemental	1	0	
B	Client receives adequate information from provider	1	0	
C	Friendly	1	0	
D	Respectful	1	0	
F	Client has opportunity to ask all questions	1	0	
G	Listens to client problems	1	0	
I	Positive attitude	1	0	
K	Provider uses language that is understandable to clients	1	0	
N	Provider develops relationship with client	1	0	
S	Provider answers questions to client's satisfaction	1	0	
Q510: Confidentiality and Privacy		**Yes**	**No**	
A	Confidentiality and privacy is respected	1	0	
B	Client consultation cannot be heard or seen by other clients or staff	1	0	
D	Staff explains services are confidential	1	0	
G	Passive disclosure of services avoided (being seen in the waiting room)	1	0	
J	Staff uses shielded language when calling for appointment or follow-up	1	0	
Q511: Environment		**Yes**	No	
A	Comfortable and clean	1	0	
B	Reading and entertainment materials available	1	0	
D	KP-only space	1	0	
F	Private waiting room for KPs	1	0	
G	Ease finding services within the facility	1	0	
H	Adequate lighting and ventilation	1	0	
I	Toilet facility is of good quality	1	0	
J	Clean piped water	1	0	
L	Not overcrowded	1	0	
Q512: Services Available		**Yes**	**No**	
A	Counselling services	1	0	
B	Contraceptive services	1	0	
C	STI services (counselling, testing, treatment and prevention)	1	0	
D	HIV services (PreP, PEP, HTC, treatment, adherence counselling)	1	0	
E	Parenting services	1	0	
F	Mental health and Psychosocial support services	1	0	
G	Life skills and literacy building	1	0	
H	Non-health services (youth development services, domestic violence)	1	0	
I	Entertainment and education materials available	1	0	
J	Others	1	0	
Q513	What are your recommendation to improve access of SRH services that you access here?			

Q514	What are your recommendations to improve quality of SRH services that you access here?					
Section 6: Social Constructs Influencing Access						
Q601: Quality of SRH services		Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
A	Staff members are very careful not to reveal private patient information.	5	4	3	2	1
B	Any SRH test results and records are kept confidentially.	5	4	3	2	1
C	SRH services are affordable.	5	4	3	2	1
Q602: Social norms						
A	It is acceptable in my community to go for SRH services	5	4	3	2	1
B	Most KPs in my community visit a health facility for SRH services	5	4	3	2	1
C	KPs in my community usually go for SRH services with their partners	5	4	3	2	1
D	KPs in my community would rather suffer quietly than go for SRH services	5	4	3	2	1
E	KPs in my community do not go for SRH services because of poor quality services	5	4	3	2	1
Q603: Social norms (Discussing SRH services)						
	How often do you discuss the quality of SRH services with your……	Always	Sometimes	Rarely	Never	
A	Friends	4	3	2	1	
B	Partner/Spouse	4	3	2	1	
C	Parents	4	3	2	1	
D	Any other family member	4	3	2	1	
Q604: Social support		Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
A	My friends talk a lot about going for SRH services	5	4	3	2	1
B	My partner/spouse encourages me to go for SRH services	5	4	3	2	1
C	My parents encourage me to go for SRH services	5	4	3	2	1

D	My friends and I encourage each other to go for SRH services	5	4	3	2	1
E	My family encourages me to go for SRH services	5	4	3	2	1
Q605: Self-efficacy		Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
A	I am confident that I can go and access any SRH services I want	5	4	3	2	1
B	I know where to go and what to do if I want to access SRH services	5	4	3	2	1
C	I can go for SRH services on my own.	5	4	3	2	1
D	I can talk to my partner about SRH services	5	4	3	2	1
E	I am very confident that I can cope with whatever test results I get	5	4	3	2	1
F	I am confident that I can reveal my status to my partner even if I test positive	5	4	3	2	1
G	I am confident that I can access treatment and care for any health problem I have	5	4	3	2	1
Q606	Based on your responses, what is your recommendation?					

Section 7: Stigma and discrimination

No.	Question	Responses	Code	Skip to
Q701	Have you ever been made to feel bad because of things people did or said to you because you are gay/lesbian?	Yes No Don't remember No response	1 2 3 4	
Q702	In the past 12 months, have you ever found yourself avoiding friends or family because you are gay/lesbian?	Yes No Don't remember No response	1 2 3 4	
Q703	What have been the most difficult things that have happened in your life since you started being gay/lesbian?	2. …… …… 2 ……		
Q704	Has the following ever happened to you;			
A	Some people avoid greeting you once they know you are gay/lesbian?	Agree Unsure Disagree	1 2 3	
B	Some people seem uncomfortable being around you once they learn that you are gay/lesbian?	Agree Unsure Disagree	1 2 3	
C	Some people act as though it is immoral to be gay/lesbian?	Agree Unsure Disagree	1 2 3	

Q705	Have you ever experienced any of the following and you thought it was because you are a woman who sex with other women?	Yes	No	
A	Excluded from social events?	1	0	
B	Abandoned by your spouse or partner?	1	0	
C	Abandoned by other family members?	1	0	
D	Sexually assaulted by anyone?	1	0	
E	Verbally abused or ridiculed?	1	0	
F	Physically assaulted by anyone?	1	0	
G	Expelled from home?	1	0	
H	Had property taken away?	1	0	
I	Denied access to health services?	1	0	
Q706	Based on your responses, what is your recommendation?			
	Stigma and Discrimination among Health Care Workers			
Q707	When you use health services, has any of the following happened to you and you thought it was because you a woman who has sex with other women	Yes	No	
A	Staff ignored you or avoided taking care of you because you are a woman who sex with other women?	1	0	
B	You were denied care that you should have received because you are a woman who has sex with other women?	1	0	
C	You received less care or worse care than others because you are a woman who has sex with other women?	1	0	
D	The staff seemed uncomfortable with you because you are a woman who has sex with other women	1	0	
E	The staff seemed to use more precautions when treating you than when treating others because you are a woman who has sex with other women?	1	0	
F	You were treated with disrespect or abused because you are a woman who has sex with other women?	1	0	
Q708	Based on your responses, what is your recommendation?			
Section 8: Preferred Communication Channels to Access SRH Information				
Q801	Have you ever seen or heard any messages encouraging gays and lesbians to go for any SRH services?	Yes No	1 0	**If No, go to 804**
Q802	Where did you see or hear these messages? CIRCLE ALL RESPONSES	Newspaper Magazine Posters/Leaflets Radio TV Theatre groups Roadshows Public health facility Private health facility Drop in centre Billboards	1 2 3 4 5 6 7 8 9 10 11	

		Twitter	12	
		Facebook	13	
		Instagram	14	
		WhatsApp	15	
		Other	16	
Q803	Would you say you have accessed SRH services as a result of these messages?	Yes	1	
		No	2	
		Partially	3	
		Did not access services	4	
Q804	Which communication media channels would you prefer to receive SRH services messages? CIRCLE ALL RESPONSES	Newspaper	1	
		Magazine	2	
		Posters/Leaflets	3	
		Radio	4	
		TV	5	
		Theatre groups	6	
		Roadshows	7	
		Public health facility	8	
		Private health facility	9	
		Drop in centre	10	
		Billboards	11	
		Twitter	12	
		Facebook	13	
		Instagram	14	
		WhatsApp	15	
		Other	16	

That is the end of the questionnaire. Thank you very much for taking time to answer these questions. We appreciate your help.

Appendix B

Key Informant Interviews Guide: Government and Civil Society

SPEAK TO THE RESPONDENT: Hello. My name is……working with a local Researcher in this place. We are interviewing people here in [……name of PLACE] to obtain their views and opinions about access to health services.

Your answers will be completely confidential. Your name will not be written on this form and will never be used in connection with any of the information you tell me. You do not have to answer any questions that you do not want to answer, and you may end this interview at any time you want to. However, your honest answers to these questions will help us better understand what people think, say and do about certain kinds of behaviours which would help design better health care interventions to protect the health of citizens in this country. We would greatly appreciate your help in responding to this survey. It will take between 40 and 50 minutes to ask the questions. Would you be willing to participate?

This key informant interview guide is for officials from the government, quasi-government and civil society organizations in Bulawayo (Zimbabwe) and Pretoria (South Africa).

INTRODUCTION

1. What is your official position and official duties?
2. For how long have you been in this position?

POLICY POSITION

3. What is the official position towards key populations in this country, especially LGBTIQ community?
4. Does the government /your organization officially recognize gays and lesbians' key population groups?

   Probe: If not, why?
5. Informally, is there recognition that gays and lesbians are a key population in this country?
6. Are there any policies that recognize and protect the rights of the LGBTIQ community?

   Probe: If no, why?

ACCESS TO HEALTHCARE SERVICES

7. Are there any government/non-government run LGBTIQ programmes in this city?
8. Where do gays and lesbians access medical care in this city?
9. Are there health care centers and/or organizations (e.g., NGOs) that specifically offer health care services to the LGBTIQ in this city?
10. What is your perception of the services offered to the LGBTIQ in these health facilities and/or organizations?

Probe:

a) Are they adequate? Are they effective?
b) What are the quality issues?
c) Does the health facility protect the privacy of gays and lesbians?
d) Do they have all the required medical supplies and equipment necessary in a health facility?

11. What is your perception of the medical personnel in these health facilities?

Probe

a) Do they have the required skills to provide health care services to the LGBTIQ?
b) Do they offer health care services to the LGBTIQ without prejudice, discrimination or stigma?

Sexual and Reproductive Health (SRH) Information and Programming

12. Does the govt. or organization make information on SRH services available to the LGBTIQ community?

13. How do they provide this information?

Probe:

a) Booklets, newsletters made available by the govt. or organization
b) Available literature in public and private health facilities
c) Use of media (print, electronic, social)
d) Information made available in virtual places (safe places) for the LGBTIQ community

14. As the govt. or organization, what SRH programmes do you have in place for the LGBTIQ community?

Probe:

a) **Behavioral support:** Sex education, counselling and other forms of psycho-social support, stigma and discrimination reduction programme
b) **Biomedical interventions:** Testing and treatment of sexually transmitted infections, HIV testing and counselling, distribution of condoms and lubricants, cancer screening services, antiretroviral drugs

15. What are the strengths and weaknesses of your LGBTIQ SRH programming?

Probe

a) Relevant LGBTIQ policies and frameworks are in place
b) Available budget for LGBTIQ SRH programming
c) Skilled staff in LGBTIQ SRH interventions
d) Strong LGBTIQ referral system
e) LGBTIQ and SRH policy implementation process

Challenges and Weaknesses

16. Are there any challenges you face in reaching LGBTIQ in your HIV prevention, care and treatment programming?

Probe:

a) What challenges do you face in reaching this target group?
b) What do you think can be done to address these challenges?

17. What are the weaknesses of your LGBTIQ SRH programming?

Probe

a) Incomplete or non-existent LGBTIQ policies and frameworks
b) Inadequate skilled staff/lack of knowledge in LGBTIQ SRH needs
c) Lack of LGBTIQ SRH policy implementation
d) Inadequate funding for LGBTIQ SRH programs in the country
e) Inability to reach the LGBTIQ community with SRH programs due to various reasons
f) Few SRH programmes implementing partners

18. As the government/organization what are you doing to address these weaknesses?

19. If you were to create a package of SRH services for LGBTIQ, which SRH services would advocate for and why?

That is the end of the questionnaire. Thank you very much for taking time to answer these questions. We appreciate your help.

Appendix C

Focus Group Discussion Guide: Gays and Lesbians Members

A. Introduction

1. Ask the members to self-identify themselves.

B. SRH Services

2. Where do most gays and lesbians access medical care here?
3. Are there health care centers and/or organizations that specifically offer SRH services for LGBTIQ in this city?
4. What SRH services do these health facilities and/or organizations specifically offer to the LGBTIQ community?
   Probe:
   c) **Behavioral support:** Sex education, counselling and other forms of psycho-social support, stigma and discrimination reduction programme
   d) **Biomedical interventions:** Testing and treatment of sexually transmitted infections, HIV testing and counselling, distribution of condoms and lubricants, cancer screening services, antiretroviral drugs
5. What is your perception of the services offered to LGBTIQ in these health facilities and/or organizations?
   Probe:
   - Are they adequate? Are they effective? Are they of high quality?
   - Does the health facility protect the privacy of patients? Are patients attended to without any form of discrimination?
   - Do they have all the required medical supplies and equipment necessary in a health facility?
6. What is your perception of the medical personnel in these health facilities?
   Probe
   - Do they have the required skills to provide health care services to LGBTIQ?
   - Do they offer health care services to LGBTIQ without prejudice, discrimination or stigma?

Motivations and Barriers for Accessing SRH services.

C. Perceived susceptibility

1. Do you think you are at risks of contracting illnesses because you are gays/lesbians?
   Probe
   a) If yes, what are the perceived risks?
   b) What makes you think you are at risk?
   c) What measures are you undertaking to mitigate the risks?
   d) Do you think you need SRH services only because you are risk of illness? Explain

D. Perceived severity

1. Do you have to seek health services every time you are not feeling well? Why or why not.
2. What are you doing to reduce the severity of the risks?

E. Perceived benefits

1. What motivates you to seek medical help for SRH problems you may face?
2. Do you think seeking medical help for any SRH problems is beneficial to you? Why
3. Are preventive methods effective in stopping negative outcomes of SRH problems? Explain
4. Have you ever failed to take recommended prescriptions or preventive action to avoid SRH problems? Why
5. What do you think are the benefits of seeking early medical attention if you have any SRH problems?

F. Perceived barriers

1. What are the challengers or barriers you face in seeking medical help for any SRH problems?
   Probe
   - cost/benefit analysis
   - effectiveness of the actions
   - side effects
   - time-consuming
   - inconvenience
2. Are you able to overcome these barriers? If yes, how. If no, what are the limitations?
3. What do you think should be done to help you overcome the barriers?

Appendix D

UREC Ethical Clearance Certificate

University of Fort Hare
Together in Excellence

ETHICAL CLEARANCE CERTIFICATE
REC-270710-028-RA Level 01

Certificate Reference Number:	MOY011SJAS01
Project title:	**A comparative appraisal of access and quality of sexual and reproductive health services for gays and lesbians in Pretoria (South Africa) and Bulawayo (Zimbabwe).**
Nature of Project	Doctor of Philosophy: Sociology
Principal Researcher:	Phineas Jasi
Supervisor:	Prof P. Moyo
Co-supervisor:	N/A

On behalf of the University of Fort Hare's Research Ethics Committee (UREC) I hereby give ethical approval in respect of the undertakings contained in the above-mentioned project and research instrument(s). Should any other instruments be used, these require separate authorization. The Researcher may therefore commence with the research as from the date of this certificate, using the reference number indicated above. This certificate is valid for a year from the date of approval; thereafter, the Principal investigator/s will be expected to apply for renewal.

Please note that the UREC must be informed immediately of

- Any material change in the conditions or undertakings mentioned in the document;

- Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research.

The Principal Researcher must report to the UREC in the prescribed format, where applicable, annually, and at the end of the project, in respect of ethical compliance.

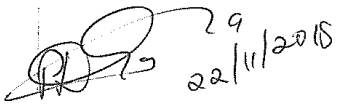
Special conditions: *Research that includes children as per the official regulations of the act must take the following into account:*
Note: The UREC is aware of the provisions of Department of Health Charter of Ethics in Health Research Principles, Processes and Structures; DOH 2015, signed by the Minister of Health in March 2015. This certificate is granted in terms of the provisions of the above-mentioned document.

The UREC retains the right to

- Withdraw or amend this Ethical Clearance Certificate if
  - Any unethical principal or practices are revealed or suspected;
  - Relevant information has been withheld or misrepresented;
  - Regulatory changes of whatsoever nature so require;
  - The conditions contained in the Certificate have not been adhered to.
- Request access to any information or data at any time during the course or after completion of the project.
- In addition to the need to comply with the highest level of ethical conduct principle investigators must report back annually as an evaluation and monitoring mechanism on the progress being made by the research. Such a report must be sent to the Dean of Research's office.

The Ethics Committee wished you well in your research.

Yours sincerely



Professor Pumla Dineo Gqola
Dean of Research

12 November 2018

Appendix E

Informed Consent Form

University of Fort Hare Together in Excellence

University of Fort Hare Together in Excellence

Ethics Research Confidentiality and Informed Consent Form

Project Title:

A Comparative Appraisal of Access and Quality of Sexual and Reproductive Health Services of Gays and Lesbians in Pretoria (South Africa) and Bulawayo (Zimbabwe)

Principal Investigator: Phineas Jasi

Phone number(s): +880 1799 763 584/+263 777 005 215

What you should know about this study:

- We give you this consent so that you may read about the purpose, risks, and benefits of this research study
- The main goal of this study is to explore the extent to which gays and lesbians access quality sexual and reproductive health services in Pretoria and Bulawayo within the context of a public health model
- We cannot promise that this research will benefit you directly and immediately
- You have the right to refuse to take part, or agree to take part now and change your mind later
- Whatever you decide, it will not affect your access to services or health care
- Please review this consent form carefully
- Ask any questions before you decide
- Your participation is voluntary

Our University of Fort Hare, Department of Sociology is conducting research regarding Access and Quality of Sexual and Reproductive Health Services (SRH) of Gays and Lesbians. We are interested in finding out more about the extent to which gays and lesbians access quality sexual and reproductive health services in Pretoria and Bulawayo within the context of a public health model. We are carrying out this research to help the understanding regarding the barriers and facilitators

PURPOSE

If you take part in this study you will be asked to respond to questions on sexual and reproductive health (SRH) issues. The purpose of the study is to explore the extent to which gays and lesbians access quality

sexual and reproductive health services in Pretoria and Bulawayo within the context of a public health model. You have been randomly selected to participate in this study because you are aged 18 years and years. A total of 200 respondents will take part in this study in Zimbabwe and another 200 in South Africa. You have been chosen purposively from key populations available in this area through the organizations that you work with.

Please understand that you are not being forced to take part in this study and the choice whether to participate or not is yours alone. However, we would really appreciate it if you do share your thoughts with us. If you choose not take part in answering these questions, you will not be affected in any way. If you agree to participate, you may stop me at any time and tell me that you do not want to go on with the interview. If you do this there will also be no penalties and you will NOT be prejudiced in ANY way. Confidentiality will be observed professionally.

I will not be recording your name anywhere on the questionnaire and no one will be able to link you to the answers you give. Only the researchers will have access to the unlinked information. The information will remain confidential and there will be no "come-backs" from the answers you give.

PROCEDURES AND DURATION

The interview will last around 45 minutes. I will be asking you questions and ask that you are as open and honest as possible in answering these questions. Some questions may be of a personal and/or sensitive nature. I will be asking some questions that you may not have thought about before, and which also involve thinking about the past or the future. We know that you cannot be certain about the answers to these questions but we ask that you try to think about these questions. When it comes to answering questions, there are no right and wrong answers. When we ask questions about the future, we are not interested in what you think the best thing would be to do, but what you think would happen.

RISKS AND DISCOMFORTS

The primary risk in this study is breach of confidentiality. This may happen if private and sensitive information provided for this study is obtained by person(s) outside of the research project. All data will be kept and handled in a confidential manner and informed consent will be obtained from each respondent. The risk of being followed up by law enforcement agents is a potential risk that may be experienced. All the ethical issues explained will be adhered to minimize this risk of endangering the participants. In addition, the respondent may be inconvenienced if the survey is administered at an inconvenient time or place or simply takes too long to administer.

BENEFITS AND/OR COMPENSATION

There is no compensation for participating in this study. There are no immediate direct benefits to you as a participant in this study. However, at a higher dimension, the study will generate new knowledge about the current state of sexual and reproductive health services for gays and lesbians within the prevailing public health, legal and policy contexts in both countries. This study will seek to influence the review and implementation of new gays and lesbians' policies and legislation in the two countries and be used as an advocacy tool benchmarked against the WHO guidelines on the comprehensive package of services for key populations. The study results will have potential to inform and assist the countries to understand the challenges and solutions to the issues surrounding access to sexual and reproductive health services for gays

and lesbians in the fight against SRH issues. However, your out of pocket expenses covering transport and food will be paid to an amount not exceeding an equivalent of USD 5.

IN THE EVENT OF REQUEST FOR MORE INFORMATION

In the event that you require further information or any follow up done as a result of your participation in this study, or any issues you may want assistance with, please contact the Principal Investigator, Mr. Phineas Jasi, on +880 1799 763 584/+263 777 005 215.

If possible, we would like to come back to this area once we have completed our study to inform you and your community of what the results are and discuss our findings and proposals around the research and what this means for people in this area.

INFORMED CONSENT

I hereby agree to participate in research regarding the extent to which gays and lesbians access quality sexual and reproductive health services in Pretoria and Bulawayo within the context of a public health model. I understand that I am participating freely and without being forced in any way to do so. I also understand that I can stop this interview at any point should I not want to continue and that this decision will not in any way affect me negatively.

I understand that this is a research project whose purpose is not necessarily to benefit me personally. I have understood that the study will be conducted according to the International Declaration of Helsinki and best practices of research with human subjects.

I have received the telephone number of a person to contact should I need to speak about any issues which may arise in this interview.

I understand that this consent form will not be linked to the questionnaire, and that my answers will remain confidential.

I understand that if at all possible, feedback will be given to my community on the results of the completed research.

……..

Signature of participant Date:…… ……..

I hereby agree to the tape recording of my participation in the study

……..

Signature of participant Date:……..