

Research

## Enablers and inhibitors to the utilization of healthcare services by members of the LGBTQ+ community in Accra, Ghana

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### Abstract

**Background** Globally, lesbian, gay, bisexual, transgender and queer (LGBTQ+) individuals experience higher rates of mental health disorders, sexually transmitted infections and substance abuse compared to their heterosexual counterparts. This implies that this special population requires tailored healthcare services. However, their practice is criminalized in most countries and abhorred by many, including some health professionals leading to isolation and poor health-seeking behaviors. We explored the enablers and inhibitors to the utilization of healthcare services by members of the LGBTQ+ community in Accra, Ghana.

**Methods** In this cross-sectional study. We collected qualitative data through snowballing sampling technique. Fifteen (15) self-reported persons claiming to be sexually different and being members of the LGBTQ+ community in Accra were recruited for this study. The participants were involved in an in-depth interview using a pre-tested interview guide and the interviews were recorded and transcribed verbatim. We adopted Braun and Clarks' reflexive thematic analysis approach in analyzing the data with the aid of NVivo 10.0

**Results** The results identified the facilitators of health seeking as community-friendly health services, affordable and accessible services, and provider-awareness of LGBTQ+ community members' status. Specifically, privacy, anonymity, confidentiality, inclusivity, positive attitudes, welcoming and supportive environment, and gender-appropriate communication, were identified as community friendly attributes that enhance health-seeking. On the barriers militating access to health care, the following factors were identified: negative provider attitude, financial constraints, and stigmatization among health providers. Participants frequently recounted instances where provider attitudes made them feel dismissed, disrespected, or judged. Instances of discrimination, accusations, poor healthcare largely based on ignorance of unique health needs related to LGBTQ+ and judgmental attitudes of health providers were identified as major barriers to health seeking.

**Conclusion** Positive provider attitudes and LGBTQ+ community-friendly health services promote health-seeking behavior among LGBTQ+ individuals. However, members of the LGBTQ+ community in Ghana are stigmatized by health providers and most health workers are ignorant about the special needs of the LGBTQ+ persons. We recommend that in-service training units of hospitals and health training institutions need to provide comprehensive education to health workers particularly nurses and doctors as well as other professionals on the unique health needs of LGBTQ+ persons as well as inclusive care that addresses the needs of members of the LGBTQ+ community.

**Keywords** Enhancers to health-seeking · Ghana · LGBTQ+ community · Inhibitors to health-seeking

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## Abbreviations

KBTH	Korle-Bu teaching hospital
LGBTQ	Lesbian, gay, bisexual, transgender, queer/questioning
MSM	Men who have sex with men
SSA	Sub-Saharan Africa

## 1 Introduction

Globally, lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ) individuals experience higher rates of mental health disorders, sexually transmitted infections (STIs) including HIV, and substance abuse compared to their heterosexual counterparts [1, 2]. Worldwide, men who have sex with men (MSM) are disproportionately affected by HIV/AIDS [1]. A United Nations report indicates that MSM are twenty-two (22) times more likely to be living with HIV than the general population [2]. Disparities in health outcomes are well-documented among various sexual orientation groups, particularly lesbian, gay, and bisexual (LGB) populations and these health disparities manifest in areas such as mental health, anal wax, HIV/AIDS, and other sexually transmitted conditions as well as substance abuse [3–5]. Additionally, several studies [1, 3, 5] also reveal that gay and bisexual men account for more than half of all individuals in the United States of America living with HIV and that lesbian and bisexual women are less likely to have screening for breast cancer, cervical cancer, or sexually transmitted infections due to stigma and discrimination [5–7].

The non-availability of culturally competent care, stigmatization, and discrimination in healthcare settings frequently jeopardizes the health of LGBTQ+ people [3, 6]. Alarming, one in five transgender people claim to have experienced service denial by health care professionals (HCPs) owing to their gender identity, and it is said that one in three have put off receiving necessary medical care out of fear of prejudice [2, 7]. Despite the recent advancements in legal protection globally, discrimination and exclusion of people based on their sexual orientation and gender identity (SOGI) are still widespread [8, 9]. According to the literature [1–5, 10], the effects of SOGI-related exclusion and abuse go far beyond just affecting an individual's sexual health to include their general wellbeing, the welfare of their homes and communities, and even the social and economic structure of the entire society.

The Republic of Ghana, like most countries worldwide define the fundamental liberties of all citizens as the right to life, personal security, freedom of expression, and protection from prejudice [3, 9, 11]. Again, under the parameters of a few provisions of the Republic of Ghana's 1992 Constitution, several rights are protected, including the right to universal access to healthcare, however, persons attracted to the same sex do not enjoy the benefits provided by the Constitution of Ghana [1, 11]. It's noteworthy that sexual minorities, compared to the heterosexual majority, tend to encounter more adverse health outcomes with limited access to care [2, 3] and if interventions are not put in place to address the situation, it stands the chance of jeopardizing their overall attainment of the universal health coverage. Despite many countries upholding the premise that everyone has a fundamental right to health and maintaining health as a public benefit and a right to health care as being ideal [12], there exist systems of exclusion and violations of fundamental human rights in many nations, especially for socially excluded populations [3, 9, 12]. One such community that faces these disparities and exclusion is the LGBTQ community members [12].

## 2 Aim

We explored the enablers and inhibitors to the utilization of healthcare services by members of the LGBTQ+ community in Accra, Ghana.

## 3 Methods

### 3.1 Research design

This study adopted a descriptive qualitative design to collect in-depth data on the enablers and inhibitors of health seeking among members of the LGBTQ+ community in Ghana.

### 3.2 Study setting

This study was conducted in the Accra Metropolis, which is the town with the largest population size in Ghana [13]. Accra Metropolis is an urban area within the Greater Accra Region and has a total area of about 20.4 Km<sup>2</sup>. Majority of the population are females (50.9%) and the remaining are males (49.1%) [13]. The selection of the Accra Metropolis as the study's setting stemmed from its urban diversity [9, 14]. Moreover, the decision was also substantiated by a nationwide behavioral epidemiological survey targeting men who have sex with men (MSM) in Ghana [3, 9]. The findings of this survey unveiled a significant HIV prevalence rate of 17.5% among MSM across the country, with the Greater Accra Region exhibiting the highest rate at 34%. Additionally, the Greater Accra Region accommodates the largest population of MSM in Ghana, with estimates ranging from 4187 to 20,822 individuals [9, 14]. It was based on these considerations that the Accra Metropolis, which is located in the Greater Accra Region was purposively chosen as the study's setting.

### 3.3 Population, sampling, and sample size

The study population were members of the LGBTQ+ community in Accra, Ghana.

We identified the first participant who had visited a hospital with a complication found mostly among members of the LGBTQ+ community [14]. We then adopted snowballing sampling technique to recruit the other additional participants via referral scheme from the previous participants [15].

The data collection continued up until the fifteenth (15) interview when data saturation was reached with no new information being elicited from the participants.

### 3.4 Inclusion criteria

The inclusion criteria was self-identified members of the LGBTQ+ community for the past one year in Accra, Ghana who were of the age of majority (Eighteen years) as provided by the laws of Ghana related to informed consent.

### 3.5 Exclusion criteria

The study excluded minors and individuals who were less than one year as members of the LGBTQ+ community in Ghana.

### 3.6 Selection of participants and data collection

Recruitment of the participants was done on weekdays by the researchers in Accra via snowball sampling. The first participant was identified in a clinic in the Accra metropolis who was receiving treatment for a complication common to persons with LGBTQ+. This first contact person who consented to be part of the study then introduced another member of the LGBTQ+ community who was subsequently recruited after the person too had equally consented to be part of the study. This technique of participants recommending other members of the LGBTQ+ community for recruitment was followed during the recruitment process for all the participants.

Even though the interviews were supposed to be conducted in English and any of the local languages within the Accra metropolis depending on the participant's language preference, all the participants spoke English during the interviews.

Data collection took place over a two-month period, from April, 2024 to May, 2024.

A pre-tested semi-structured interview guide was developed, and it had two parts; A and B. Section A captured the participants' demographic data, including age, sex, educational level, occupation, gender identity, and sexual orientation. Section B comprised open-ended questions, supplemented with probes where necessary, which helped explore the facilitators and barriers to health seeking by the study participants. Each participant's interview lasted between 35 to 45 min.

Throughout the course of gathering data, the researcher maintained a field journal. The diary entries were organized in a chronological order based on the time and date of each interview. The participants' non-verbal clues, such as facial expressions, were recorded in the field diary. Additionally, we documented any other events that occurred during data collection that influenced the collected information.

Data redundancy started occurring after interviewing the twelfth participant and data saturation was reached at the fifteenth interview.

### 3.7 Data analysis

The data analysis was done concurrently with data collection with the aid of Nvivo 10.0. The researchers adopted the thematic analysis approach to data analysis as recommended in literature [15]. The interviews that were audio recorded were transcribed word for word as soon as they were concluded. The audio transcripts in English were confirmed as verbatim transcripts of the audio files. The verbatim transcripts and the field notes recorded in the diary were used in the thematic analysis. We read, re-read, organized, integrated, and interpreted the interview transcripts until we found themes that described the enablers and inhibitors to the utilization of healthcare services by members of the LGBTQ+ community in Accra, Ghana. Specifically, the authors read the transcribed data several times and familiarized themselves with the data and made sure the data conformed to what was audio taped. The authors then proceeded to code the data, creating initial codes that captured significant portions of information within the content. The authors diligently looked for patterns, connections, and recurring ideas. These recurring patterns and ideas provided the foundation for identifying the themes. These themes were carefully reviewed and scrutinized to see whether the themes accurately and comprehensively reflect the nuances and depth of the data. Each validated theme was then precisely defined and given a descriptive name. These well-defined themes were eventually used to write the results section. Throughout the analytical journey, the researchers remained vigilant about his own biases, assumptions, and positions. Acknowledging and reflecting on these factors ensured transparency and credibility of the analysis.

### 3.8 Data quality control

To ensure quality control in the data collection, the interview guide was pre-tested at the Kumasi in the Ashanti Region of Ghana among a similar population. This exercise helped to ascertain the clarity of the questions in the interview guide and determine whether the questions sought to answer the research questions. Questions that produced narrow and restrictive responses were modified to include the words “describe” or narrate to broaden the responses and to give the participants the opportunity to speak more on the topic. During the data collection, the researchers adhered strictly to methodological rigour as described below and also enhanced member checking with the participants to ensure that their views had been properly represented in the transcripts from the interviews. At the end of the data collection, the audio transcripts in English were confirmed as verbatim transcripts of the audio files to ensure the quality of the data collected.

### 3.9 Methodological rigour

To ensure credibility, the interview guide was pre-tested among two individuals who met the inclusion criteria in Kumasi, Ghana. This allowed the researchers to make necessary modifications to aspects of the interview guide that seemed not to elicit responses that were relevant to the objectives of the study. Additionally, a snowballing sampling technique was employed to ensure only individuals who identified as part of the LGBTQ+ community for more than one year who could give a vivid account of the facilitators and barriers to health-seeking by members of the LGBTQ+ community were recruited. Probing and iterative questioning was also used to elicit responses from participants and situations where there were ambiguities in the responses; clarifications were sought from the participants. To achieve transferability, the research process was described in detail so that others can evaluate the applicability of data to other contexts and settings. Records of the transcribed interviews and the analysis, as well as the results of the study, were kept for audit trail and are in custody of the 1st author. To ensure dependability in the study, a semi-structured interview guide was used for all the interviews to ensure consistency in the line of questioning among the participants. Again, a detailed description of the study design, sampling method, data collection, and analysis were also documented. To ensure confirmability, the context of data collection was documented in a field notebook during the interviews. This enhanced interpretation of the data during analysis to reflect the exact responses of the participants. The authors also bracketed their experiences as heterosexuals and presuppositions to avoid any influence in the interpretation and analysis of the data.

## 4 Results

### 4.1 Socio-demographic characteristics

Fifteen (15) participants took part in the study. Out of the fifteen participants, four (4) of the participants were females and the rest of the eleven (11) participants were males. Their ages ranged from twenty-two (22) to thirty (30) years. Twelve (12) of the participants who took part in the study claimed they were Christians while the other three (3) claimed that they were Muslims. With regards to their educational background, all the fifteen participants had a minimum education up to Junior High school. Eight (8) of the participants were educated up to tertiary level, two (2) participants were Senior High School graduates while two (2) dropped out of Senior high School education. One (1) dropped out of the university and two (2) were junior high School graduates. In terms of occupation, six (8) of the participants were employed (driving, fashion designing, research assistant, program officer, graphic designing, bakery attendant, and teaching). Four (4) out of the fifteen (15) participants were students at different educational levels including tertiary (5) and Senior High School (1). Only one (1) participant was a national service personnel, three (3) were school dropouts, i.e. two (2) Senior High School dropouts, one (1) University dropout and all these dropouts were not working. Regarding the sexual orientation and gender identity (SOGI) of the participants, seven (7) were bisexuals, five (5) were gays, one (1) was transgender and two (2) were lesbians. There were no queer or questioning participants among the fifteen (15) participants who participated in the study. Table 1 provides the details of socio-demographic characteristics of the participants.

The data analysis yielded some main themes and sub-themes based on the objective of the study. Table 2 presents the details of the major themes and sub-themes.

### 4.2 Facilitators of healthcare utilization

This analysis delved into participants' perspectives and personal experiences on key factors that enabled and encouraged effective healthcare engagement. Participants expressed diverse views and shared personal experiences that motivated them to access health services from certain health facilities. The analysis of the transcripts identified factors such as community friendly facilities, community friendly services, community friendly providers, affordable

**Table 1** Socio-demographic characteristics of the participants

Participant (pseudonyms)	Sex	Age	Gender identity/sexual orientation	Marital status	Religion	Occupation	Level of education
CM1	F	22	Transgender	Not Married	Christian	Student	Tertiary (University Student)
CM2	M	26	Gay	Not Married	Christian	Program Officer (NGO)	Tertiary
CM3	M	25	Bisexual	Not Married	Christian	Fashion Designer	SHS
CM4	M	29	Bisexual	Not Married	Christian	Research Assistant	Tertiary
CM5	F	29	Lesbian	Not Married	Christian	Sales person in a bakery	JHS
CM6	M	29	Bisexual	Not Married	Muslim	Driver	JHS
CM7	F	27	lesbian	Not Married	Christian	Teacher (NSS)	Tertiary
CM8	M	24	Gay	Not Married	Christian	Student	Tertiary (University student)
CM9	M	25	Bisexual	Not Married	Christian	Student	Tertiary
CM10	M	30	Bisexual	Not Married	Muslim	SHS drop Out (Not working)	SHS (drop out)
CM11	M	22	Gay	Not Married	Muslim	University dropout	University drop out
CM12	M	27	Gay	Not Married	Christian	Student	Tertiary
CM13	M	25	Gay	Not Married	Christian	SHS dropout (learning graphic designing)	SHS
CM14	F	30	Bisexual	Not married	Christian	Teaching	Tertiary
CM15	M	28	Bisexual	Not married	Christian	IT	Tertiary

**Table 2** Synthesis of theme and sub-themes

S/N	Themes	Subthemes
1	Enablers of healthcare utilization by members of the LGBTQ+ community	<ul style="list-style-type: none"> <li>a. Community-friendly health services</li> <li>b. Affordable and accessible services</li> <li>c. Provider awareness of community member status</li> </ul>
2	Barriers to healthcare utilisation by members of the LGBTQ+ community	<ul style="list-style-type: none"> <li>a. Negative provider attitude</li> <li>b. Financial constraints</li> <li>c. Behavioral cues of community members</li> <li>d. Nondisclosure of community status</li> <li>e. Stigma among health providers</li> </ul>

services, accessible services, quality care, health insurance use and acceptance as well as opened/receptive health providers. Based on these shared experiences and narratives, the following subthemes were generated; community-friendly health services, affordable and accessible services, and provider awareness of community members status.

### 4.3 Community-friendly health services

Through a critical analysis of participants' narratives and shared experiences, issues surrounding privacy, anonymity, confidentiality, inclusivity, positive provider attitudes, welcoming and supportive environment, and gender-appropriate communication, were identified as community friendly attributes.

For instance, participants shared their experiences reflecting how they place value on the issue of privacy, anonymity, and confidentiality in their quest to access health services. One participant shared how he avoided facilities closer to his place of residence and preferred facilities far away from where he stays in order to avoid seeing known individuals. He indicated:

—Yes because it is far from my home and nobody will get to know that I go there for treatment, there are some clinics around where they take care of such diseases but I told my friend that I don't like hospitals which are around my area, because you might meet someone you may know and I don't like that, so my friend was the one who took me to the Legon hospital.... (CM 10 bisexual)

Another participant who also appreciated facilities without explicit signs indicating their identity as members of the LGBTQ+ community also shared his experience. This is what he said:

The room where I have been going to is opposite the Eye clinic so if you are going there and anyone ask you, you just say I am going to the eye clinic and is closer to the maternity ward too, so it's close to those two clinics and there is no indication to show what goes on there, they have just written physical unit (CM 11 gay)

Participants' voices were also captured sharing various pieces of perspectives and experiences repeatedly emphasizing the importance of having healthcare services that are inclusive and welcoming. Here are two quotes highlighting how these unique attributes significantly enhance healthcare engagement. One participant explains that:

...When I walk into a clinic and see staff that respect and understand my background, I feel more comfortable and valued. (CM 2 gay)

Another noted:

Facilities that cater for our community members make a great difference. It's not just about medical care; it's about feeling safe and understood. (CM 12 gay)

A participant also explained:

—I always go to hospital where I know that I am accepted, that is why I go to hospital like Legon hospital and Adabraka polyclinic, that one I go with a peer educator at first when I was not a peer educator (CM 3 bisexual)

A participant also shared his view on the issue of anonymity:

—If there is any way that people with issues will be attended to in a most anonymous and virtual way, unless they have to come to the hospital directly but they don't have to, then I think there is a way we can come up with solutions where we can communicate with the member having an issue, so they talk about their experience, they talk about whatever they are going through, is possible for them to be attended to in a virtual and undisclosed way that could also go a long way to help, like telling the person what to do over the phone or what kind of drugs to get, that is if they don't necessarily have to go to the hospital sort of. (CM 8 gay)

Also reflecting on how community members place value on the issue of privacy and community sensitive providers in seeking healthcare, a participant also explained his experiences:

...It is just like the normal person going to the hospital, just the normal procedure, everybody gets their privacy when they walk into the consulting room, there is nothing special just that you are talking to somebody who understands you and knows the point you are trying to make, just like a normal person walking into the consulting room. (CM 12 gay)

A participant shared his perspective on how providers should not automatically assume that everybody's partner is necessarily the opposite sex. He shared:

—When I visit your facility for a sexually transmitted infection, you wouldn't tell me to go and bring my wife, automatically assuming that all our partners are the opposite sex (CM 2 gay)

Some participants also expressed their satisfaction and delight in how some providers can create a welcoming environment with their positive interactions. One noted:

Even the first time meeting you the way she will be smiling and asking questions as if she knew you before, and be asking you about you partner and that kind of thing. (CM 10 bisexual)

When a participant was probed on available community friendly facilities and the special role they play, he had this to say:

...For the health facilities I know of the one at Haatso the official name for the place is called... Anonymity is assured, you wouldn't go there with your problem and later find out it's been posted on social media or something. (CM 2 gay)

A participant also appreciated facilities with well trained and community sensitive providers when he said in his narrative:

—There is no special consulting room or special clinic, there is just a Nurse who is well trained and then she knows whatever you are already, so when you come she attends to you with open mind no discrimination and sees you as a normal person. (CM 12 gay)

#### 4.4 Affordable and accessible services

Participants shared varied experiences detailing how the presence of affordable healthcare options eases healthcare access for the LGBTQ community. Experiences on free services, peer educator-facilitated services and enjoying health

services at subsidized cost were shared by participants and indicated how all these factors go a long way to ease health-care utilization among community members. Below are selected shared experiences of community members:

For free services, a participant indicated how he only need to get his transportation fare to enable him get to the facility and every other service will be free even laboratory services.

This is what he said:

I don't pay anything, I just go with my transportation fare and they don't take any money, sometimes they don't charge for the labs as well. (CM 10 gay)

Another also stated he patronizes certain facilities because he will have free and easy access as well as people who listen. He remarked:

Just the fact that you have free access and easy access to everything, and you have someone who will listen. (CM 12 gay)

A participant also explains how health insurance makes the cost of health services moderate and how community members enjoy free services for STI treatment. He stated:

Okay I must say is moderate since health insurance covers part of the cost, and like if the person gets STDs and the person go to the hospital, that person will receive free healthcare, it doesn't cost much, the medicine or the drugs that they give to you, you won't pay anything and if you don't have insurance you can still receive it. (CM 9 bisexual)

Experiences were also shared on how helpful the services of peer educators in the community are, with regards to easy accessibility to healthcare. A participant indicated:

We have one of my friends who is a Peer Educator, so he normally takes me to the clinic as well, anytime I have a challenge I tell him and if he has medicine he will give me or assist me to the health facility (CM 11 gay)

One participant also remarked:

—So as soon as I go with a peer educator, I know that the Nurse knows that I am into this already..... yeah when you go to the hospital with a peer educator the cost will be more lesser than going there on your own, walking in (CM 3 bisexual)

On the issue of proximity one participant stated closeness and low cost of service as reasons for patronizing his current health facilities. He remarked:

It is closer to me that is why....and also the cost is low than the private hospital. (CM 9 bisexual)

Excerpts from the narrative of one participant revealed:

Oh okay the facility is being supported by a foreign NGO so they usually subsidize the cost, it is not cheap and is not expensive too, it is moderate (CM 2 gay)

#### 4.5 Provider awareness of community member status

A detailed examination of the results under this sub-theme shows that majority of participants viewed openness and disclosure to health providers as a facilitator to healthcare within the community.

For instance, a participant explained how he gets quality healthcare anytime he goes to the hospital because he always opens. He noted:

Some of the community members when they go to the facility, they are afraid to tell their problem to the Nurse, maybe they are dying but they can't, because the Nurse is a female or something or they are afraid that maybe the person is not on their side or something like that, but for me I am open minded person and that helps me to always get good care. (CM 3 bisexual)

Another participant in giving his comparative narrative stated how he had his treatment fast because he never felt shy or afraid to open up to the providers. He narrated:

...Likewise I visited community friendly facility where I was able to open up, rapidly I had treatment at that place without feeling shy or afraid of anything (CM 4 bisexual)

In giving his perspective on openness and making providers aware of relevant health information, a participant explained how that makes health delivery easier. He explained:

When you go to the hospital they take care of you as a normal person, as anybody who is of a normal person but then when you are lucky and you meet a community person and you open up then you get to receive education and good treatment as well because if the person gets to know and you just open yourself that I am this and that, then I think it makes the treatment easier and educative. (CM 13 gay)

Another participant appreciated the importance of provider awareness in facilitating health service delivery when he stated:

—Yeah so I don't have to hide anything, I will not go into details too much but I will not hide the things that will help me or I will benefit from, I will not hide it, like for instance I am coming to treat maybe STD I won't hide it, that I don't have it, I will tell the truth that this and this is wrong with me, so that they can be able to help me (CM 3 bisexual)

A participant who identifies as lesbian also explained how she now continues to enjoy the services of a DOVU center when she made the providers aware of who she was on her first visit. She explained:

I went there and then there was this DOVU centre there, and I was like okay let me try it, so I went there I was talking to them and then I opened up to them and then and it was a bit okay, I wanted help on how to help me live life healthy and they were giving me some advice and how not to contract any disease and stuff like that, through that we become very cool so I had their numbers and stuff like that, so anytime I go to the hospital I just call any of them to accompany me to go and see the Doctor or I just go to the DOVU office and then I complain to them and they take me to wherever I have to go to. (CM 7 lesbian)

In a follow up interaction during the interview, the same participant had this to say:

Well, to me personally I think when you go to the hospital or the health facility, if you don't identify yourself as a community member they won't know, until you tell them no one knows, but some people are very obvious when you see them, you see that okay this person is like this but I think that if you don't say it they won't know so until they get to know they will treat you like the others (CM 7 lesbian)

#### 4.6 Barriers to healthcare utilisation

Participants expressed diverse experiences and perspectives on factors that hinder their healthcare utilization. A deeper reflection and analysis of the shared experiences and perspectives resulted in the generation of five sub-themes. These include negative provider attitude, financial constraints, behavioral cues of community members, nondisclosure of community member status and stigmatization among health providers.

#### 4.7 Negative provider attitude

Participants frequently recounted instances where provider attitudes made them feel dismissed, disrespected, or judged. They cited instances of discrimination, accusations, poor healthcare, and judgmental attitude of health providers.

For instance, a participant who identifies as a bisexual recount how he spent almost two hours in a facility being forced by nurses to confess before they treat him and that really put him off and he had to leave without been treated. He stated:

Well I spent almost two hours there, and they were forcing me to say the truth about what I do before they treat me, I couldn't take it anymore so I left and it looked like they were not ready to treat me, so there was no need wasting my time there. (CM 2 gay)

A participant also narrated how the attitude of health providers made his friend develop complications and finally had to undergo a surgery in a different facility amidst family challenges. He recounted:

This friend of mine is a bit obvious, by the appearance they already have perception about him, he visited this hospital when he had the anal warts and initially he thought it was just a rash but developed into something else and he went, so he went there and you know this Nurses, they talk, they were saying all kinds of things and he went to the Doctor and the Doctor was all judgmental, that when we advise you people you don't listen to us, bla, bla, bla so he decided not to go there at all and got other medications and it was like it was going down but it came back

again, so he was rushed to the hospital and now they said they had to do surgery and other things, and the Doctor was like this has to do with infections then I think the Doctor asked him for confirmation and he opened up to the Doctor, so the Doctor informed the parents about it and the parents were mad at him (CM 4 bisexual)

One participant also narrated how he felt bad when he was being persuaded to stop LGBTQ+ by a nurse at the hospital. He said:

I have experienced a bad one just one time in the past and it was about, I went to the facility to have some help because I had some unprotected sex with someone and when I went there I felt discriminated in some sort of way because the Nurse who was supposed to take care of me was sort of persuading me to stop the whole thing, and in my mind I felt like who told you I am doing it because I felt like doing it? (CM 6 bisexual)

Another participant also narrated how he experienced accusation and undue judgment from a doctor when he had an infection and went to the hospital for treatment. He narrated:

So personally I will say I once had an infection so I went to the general hospital and they were asking me a lot of questions, the Doctor was asking me a lot of questions how come this, how come that, I was restricted because I didn't know how to go about it, and she was like this infection that you have here is strange, you know all this things you people have being doing is not good... (CM 4 bisexual)

On a follow up question on barriers to healthcare utilization, this is an excerpt of what a female participant said:

Some of them too should be welcoming, they shouldn't discriminate because that make some people shy away from the hospitals (CM 7 lesbian)

And one also noted:

Yes is one of the greatest thing, the stigma and perceptions and especially in this government hospitals and most healthcare providers especially the Nurses they act so unprofessional, because they join most of this professions to make their parents proud, not because it was something they wanted to do and not because its something they are passionate about (CM 4 bisexual)

## 5 Financial constraints

Financial barriers, including lack of active health insurance, high out-of-pocket costs, high unemployment rate among community members, and lack of lorry fares were among constraints shared by participants as impediments that affect their health seeking behavior and ultimately healthcare utilization.

A participant recounted how he could not pay for a bed and had to sit on a chair to receive a drip; He explains:

...They also put a drip on me so I wanted them to give me a bed, but they told me is 100 Ghana but because I couldn't afford the 100 Ghana, I sat in a plastic chair for the drip (CM 9 bisexual)

Another participant also noted in his submission how some community members cannot even afford lorry fare to enjoy free healthcare. Here is what he said:

Due to the finances some even don't have the lorry fare to attend this healthcare facilities.... due to that even if they are going through something they rely on herbs or what their friends tell them to do, and at the end of the day their situation gets out of hand. (CM 2 gay)

A participant also revealed some challenges with national health insurance making it difficult to easily access health service with it. He explains:

But personally in Ghana here you know that the health insurance doesn't cover much so is either you improvise and then you get some money for yourself, if really you want to get certain treatment, you have to gather money yourself to pay and get that treatment that you need, because the health insurance it usually delays when you must be attended to, I remember with Ridge for instance I didn't have the insurance, but I had my capital I went there for whatever I wanted to do, I just paid and they just gave me my digital card and other

things and I received my treatment, but those with the health insurance you have to go and form another queue and is long process (CM 4 bisexual)

A participant who identifies as lesbian also shared how expensive it is without health insurance. She noted:

...The cost is quite expensive, like is very expensive especially when you don't have health insurance ..... the last time I went to the hospital, I spent like 250 cedis for my lab and small things. (CM 5 lesbian)

In the narrative of one participant, he revealed how unemployment is a challenge within the community and is affecting healthcare utilization. He revealed:

...A good number of community members they are unemployed.... therefore, they do not have the money to access some of these facilities (CM 2 gay)

## 6 Behavioral cues of community members

Behavioral cues, encompassing elements such as dressing, appearance, tattoos, piercings, and other visible identifiers, can significantly affect the interactions between LGBTQ individuals and healthcare providers. The perception and interpretation of these behavioral cues by healthcare providers can negatively influence the quality of care received. The analysis uncovered the impact of appearance and other behavioral cues on the quality of care received by community members. Participants noted that their appearance, such as dressing, grooming styles, tattoos, piercings, and other visible identifiers, often attracted negative attention and poor care from providers.

A participant who identifies as gay explained how dressing and appearance of community members could attract poor care and stigma from providers. He explained:

Okay well, I think for the community members, I don't know if you know some community members or you have met some in person, the way majority of us dress, the way we behave sometimes with braided hair, piercing all over, the way you dress, if you go to any facility with that even if you are seeking for employment and someone sees you, if you are the overqualified person with all the experience and all the certificates, they wouldn't even mind or they wouldn't even give you attention, if you go to any health facility with this appearances they will gossip about you, they will ridicule you, and the thing too is, you can't force someone on how they should dress or how they should behave (CM 2 gay)

And to buttress the above submission by CM 2, a participant revealed how even her customers at the workplace are uncomfortable with her appearance. She noted:

I get some difficulties at work, especially with my customers, yes with my customers some are not comfortable with my appearance and then with my look also....they always complain about my look, they always complain about how I dress to work since they see me as a guy (CM 5 lesbian)

One participant also shared how he was tagged by nurses as a gay for having a tattoo. He shared:

I think I once had an encounter at the hospital I was a bit younger, I have a tattoo on my chest, and I was behaving some kind of fame, so the Nurse said I am gay, so I saw her telling her friend he is one of them, you get that thing? (CM 12 gay)

A participant also recounted how his friend with an obvious and classical appearance had judgmental treatment from health providers when he accompanied him to the hospital. He recounted:

This friend of mine is a bit obvious by his appearance they already have perception about him, he visited this hospital when he had the anal warts and initially he thought it was just a rash but developed into something else and he went, so he went there and you know this Nurses, they talk, they were saying all kinds of things and he went to the Doctor and the Doctor was also judgmental, that when we advise you people you don't listen to us, bla, bla, bla... (CM 4 bisexual)

## 6.1 Non-disclosure of community status

This analysis uncovered a lot of evidence of non-disclosure among community members as shared by participants. For instance, a participant outrightly said he does not disclose himself when he is seeking healthcare because LGBTQ is illegal in Ghana. He stated:

I don't disclose myself because I know that here in Ghana is illegal, so if you feel sick and you go there and disclose it to them that you are into this, they might not treat you well, and I must also respect my reputation, is also important thing to me. (CM 9 bisexual)

Another participant also confirmed the fact that there are instances of nondisclosure of community status among community members when he said:

... But when they go to unfriendly facility, it will be difficult for them to go and disclose it, depending on their situation, some have peculiar problems which definitely they won't want anybody to know about or maybe disclose that they have watt in the anal part of themselves or something like that, because when you go to the facility and the facility is not MSM friendly they won't say anything like that for them to know whatever they are doing. (CM 6 bisexual)

Another confirmation of high incidence of nondisclosure among community members came from another participant when he indicated how difficult it is to take that risk in an unfriendly environment. This is what he said:

Well I think that there is the issue of not taking that risk and also there are no so many community members in facilities around that I will personally feel comfortable with when I ever have that issue, so I wouldn't know how to disclose that information if I ever find myself in a situation where I need to tell them, fortunately I have friends who are like community members and they are also in the healthcare industry and so I rather take advice from them and I ask them what I need to do, that kind of thing, so I will prefer if there was someone who was within the circle or rather somebody that I have to take chances of disclosing. (CM 8 gay)

In sharing her perspective, a participant explained how failure to open up to health providers could make them to treat you like any other normal person. He explained:

\_Well, to me personally I think when you go to the hospital or the health facility, if you don't identify yourself as a community member they won't know, until you tell them no one knows, but some people are very obvious when you see them, you see that okay this person is like this but I think that if you don't say it they won't know so until they get to know they will treat you like the others. (CM 7 lesbian)

## 6.2 Refusal to provide services (overt discrimination)

This analysis revealed diverse instances of stigmatization and discrimination against community members. For instance, a participant narrated how he was stigmatized and prejudiced by nurses in the hospital just for the mere fact he has a tattoo on his chest. He narrated:

I think I once had an encounter at the hospital I was a bit younger, I have a tattoo on my chest, and I was behaving some kind of funny so the Nurse said I am gay, so I saw her telling her friend he is one of them, you get that thing? (CM 12 gay)

One participant also narrated how he felt discriminated when he was being persuaded to stop LGBTQ by a nurse at the hospital. He said:

I have experienced a bad one just one time in the past and it was about, I went to the facility to have some help because I had some unprotected sex with someone and when I went there I felt discriminated in some sort of way because the Nurse who was supposed to take care of me was sort of persuading me to stop the whole thing, and in my mind I felt like who told you I am doing it because I felt like doing it? (CM 6 bisexual)

On a follow up question on barriers to healthcare utilization, a participant who is very aware of discrimination at health facilities cautioned health providers against discrimination. This is an excerpt of what she said:

Some of them too should be welcoming, they shouldn't discriminate because that make some people shy away from the hospitals (CM 7 lesbian)

And one also noted:

Yes is one of the greatest thing, the stigma and perceptions and especially in the government hospitals and most healthcare providers most of this Nurses they act so unprofessional, because they join most of this professions to make their parents proud, not because it was something they wanted to do and not because its something they are passionate about (CM 4 bisexual)

In sharing his perspective on the barriers to health access by community members, a participant expressed how prevalent stigma is both in society and within the health facilities. He said:

The stigma in the society and even sometimes too at the hospital the bullying too, for me I have not experienced such before I think is because I am bisexual that is why... (CM 3 bisexual)

A participant also shared how he preferred distant facilities faraway from where he stays in order to ensure anonymity and to prevent stigma. This is what he said:

Yes because it is far from my home and nobody will get to know that I'm going there for treatment, there are some clinics around who take care of such diseases but I told my friend that I don't like hospitals which were around my area, because you might meet someone you may know and I don't like that, so my friend was the one who took me to Legon hospital (CM 10 bisexual)

Another participant also expressed his disquiet on how some providers could be bias and discriminatory to the extent of denying community members their medication. He said:

If you dress those girlish dressing if you go they will even tell you there is no medicine for you and that you should go and come the next day (CM 11 gay)

In a follow-up question on why the public facilities accept health insurance yet community members are complaining of lack of affordability, a participant shared his perspective:

They wouldn't like to go to government facilities too because of their intolerance and discriminatory nature of Nurses over there (CM 2 gay)

## 7 Discussion

The study found that facilities that ensure confidentiality and do not explicitly indicate their purpose were preferred by members of the LGBTQ+ community. The study also revealed that participants preferred facilities located far away from their immediate communities to avoid recognition and potential stigma. This aligns with the findings of Coleman et al. [12], who noted that fear of exposure and lack of confidentiality are significant barriers to healthcare for LGBTQ individuals. It also resonates with the recommendations of Reeves et al. [6], who advocate for creating welcoming clinical environments. The preference for facilities that ensure confidentiality and do not explicitly indicate their purpose suggests a significant concern about privacy among the LGBTQ community. To a certain extent these findings support the need for discretion in healthcare settings including the need to create welcoming clinical environments as recommended by Reeves et al. [6] and [16, 18]. The preference for confidentiality and discretion in healthcare settings has significant health implications for LGBTQ individuals [17–20]. When healthcare facilities do not ensure privacy, it may lead to delays in seeking care, avoidance of necessary treatments, and ultimately poorer health outcomes. This is particularly concerning for LGBTQ individuals, who already face higher rates of mental health issues, substance abuse, and sexually transmitted infections (STIs) compared to the general population [16–20]. Ensuring that healthcare settings are welcoming and discreet could help mitigate these risks and encourage timely and appropriate care. However, the focus on discretion should not come at the expense of accessibility and quality of care.

While privacy is important, healthcare providers must also ensure that services are readily accessible, and that care is delivered competently and inclusively. Balancing these factors could be crucial in improving health outcomes for LGBTQ individuals [18]. The findings of this study have several policy implications. First, healthcare policies should prioritize the creation of welcoming and inclusive environments that protect patient confidentiality [19]. This may involve

implementing design features that obscure the purpose of healthcare facilities, such as generic signage and separate entrances, to reduce the risk of recognition and stigma [16, 18]. Additionally, policies should encourage the development of LGBTQ+ specific training for healthcare providers to ensure that care is delivered competently and sensitively [3, 16–19].

A similar study conducted by [14], found that affordable healthcare options and the role of health insurance in promoting healthcare access play a crucial role in healthcare within the LGBTQ+ community. This finding of, [14] corroborates with the findings of this current study where participants consistently emphasized the importance of insurance and how helpful it is especially if one is accessing general health services that are not community related. This current study also discovered that community members enjoy subsidized and free services for STIs and community related infections in most community friendly facilities especially when an individual is taken to the facility by a peer educator. Taking into accounts the findings of this study, one can hypothesize that, by offering subsidized and free services, these facilities ensured that cost does not become a prohibitive factor in seeking care, thereby promoting early diagnosis and treatment, which are vital for better health outcomes [16, 19]. Essentially the result also highlights the effectiveness of targeted support systems and the critical role of peer educators which can lead to more consistent and regular healthcare engagement [9, 17].

Another important discovery of this study was the fact that the participants who felt comfortable being open about their sexual orientation or gender identity with healthcare providers reported better healthcare experiences and outcomes. The results further showed that effective communication and trust between patients and providers were facilitated by the providers' awareness and understanding of the LGBTQ+ -community status of the individual. These findings are consistent with the study by [12]. These findings also align with the studies [6–10] that emphasize the importance of creating spaces where LGBTQ+ individuals feel comfortable discussing their sexual identity and health concerns. The positive impact of provider awareness and understanding of LGBTQ-specific health needs is also noted in the study by [12], which advocates for training healthcare professionals in gender appropriate communication.

Delving deeper into the nuances of the findings, it is further revealed that lesbians reported positive healthcare experiences and did not mention any instance of bad experiences with healthcare utilization. This finding contrasts with existing literature that highlights the potential for discrimination and stigma faced by lesbians in healthcare settings [21]. This finding could be because of the limited number of lesbian participants in this study which may not have fully captured the diversity of experiences within the broader lesbian population in Ghana. Further research with a larger and more diverse sample of lesbians is necessary to determine if these positive experiences are representative of the wider community.

The study recorded significant cases of judgmental, discriminatory, and other attributes of negative provider attitude towards LGBTQ+ community members by health providers in their quest to seek healthcare leading to feelings of dismissal and disrespect. This agrees with existing studies [1, 9, 12] that noted that reluctance to disclose sexual orientation or gender identity often stems from fear of receiving non-affirming or discriminatory care. The participants provided vivid accounts of such negative interactions, reinforcing the impact of negative provider attitudes on healthcare utilization by the community. It is possible that these adverse attitudes not only discourage individuals from seeking necessary care but also contributes to a broader sense of mistrust towards the healthcare system. When patients experience discrimination or disrespect in healthcare settings, they may be more likely to delay or forgo necessary medical care, leading to the progression of untreated conditions, increased mental health issues, and overall poorer health outcomes [11, 16]. Furthermore, the mistrust generated by negative provider attitudes can lead to a broader disengagement with the healthcare system [21]. When individuals feel unwelcome or unsafe in healthcare settings, they are less likely to participate in preventive care, screenings, and routine check-ups, which are crucial for early detection and management of health issues [8, 21]. This disengagement can result in late-stage diagnoses, higher healthcare costs, and a widening of health disparities between the LGBTQ population and the general population [21].

Furthermore, financial barriers emerged as a critical impediment to healthcare access. High out-of-pocket costs, especially for private facilities, health insurance constraints including expired insurance and lack of money to register as well as unemployment and employment in low-paying jobs were frequently cited by participants. This finding is consistent with studies [10, 22], which highlighted that LGBTQ individuals often face higher healthcare costs and financial instability, exacerbating access issues. The specific example from participant, such as being unable to afford a hospital bed for one hundred Ghana cedis (Ghc100) and had to sit on a chair to take a drip, underscores the severe impact of financial constraints on healthcare utilization by the community members. The financial barriers identified in the study could have significant health implications for LGBTQ individuals. When people are unable to afford necessary healthcare, they are more likely to delay or skip treatments, leading to the progression of untreated conditions and the development of more severe health issues [1, 8, 10]. This can result in higher rates of chronic diseases and preventable conditions within the LGBTQ community [1, 22]. The inability to afford healthcare services, as illustrated by the participant who had to sit

on a chair instead of receiving proper treatment, can also contribute to feelings of helplessness and frustration, exacerbating mental health issues such as anxiety and depression [6, 11]. Moreover, financial barriers can lead to a reliance on emergency care and other less effective alternative care rather than preventive services, which is both associated with higher cost and less effective in managing health over the long term. This reactive approach to healthcare could increase the overall burden on the healthcare system and contribute to worse health outcomes for individuals [12, 21].

The study further revealed that behavioral cues and visible identifiers, such as dressing, tattoos, piercings and grooming styles, often attracted negative attention from healthcare providers. This finding is supported by existing studies [3, 20–23] that indicated how LGBTQ individuals with visible tattoos and piercings often encounter biased assumptions regarding their health behaviors and lifestyles. These biased assumptions can result in healthcare providers focusing on irrelevant aspects of the patient's appearance rather than their actual medical needs, leading to inadequate care [7, 22]. Given the above revelation, it is reasonable for one to make the assertion that there exists a knowledge gap that requires research and training of health providers on enhanced cultural competencies in healthcare delivery which has the potential to avert biased assumptions among health providers.

The study also found that fear of mistreatment and legal repercussions led many participants to conceal their LGBTQ status from healthcare providers. Nondisclosure on many occasions resulted in incomplete medical histories and inadequate treatment plans, as providers lack crucial context about the patient's health and lifestyle. When LGBTQ individuals withhold information about their sexual orientation or gender identity, healthcare providers may be unaware of specific risks or health needs associated with these identities. For example, the provider might not screen for sexually transmitted infections (STIs) appropriately or may miss critical psychosocial issues. This lack of complete information can lead to inappropriate or inadequate treatment, resulting in poorer health outcomes for LGBTQ patients [17, 20–23].

## 8 Implications of the findings

This finding of the study points to the critical need for policy interventions that protect the rights of LGBTQ individuals and foster safe, supportive healthcare environments. One key policy implication is the decriminalization of LGBTQ identities and behaviors, which would reduce the fear of legal repercussions and encourage individuals to disclose their status when seeking care. Decriminalization could also contribute to reducing societal stigma, making it easier for LGBTQ individuals to access healthcare services without fear of mistreatment [12, 22]. Healthcare systems should also implement confidential reporting mechanisms for patients who experience discrimination or mistreatment. These mechanisms would provide LGBTQ individuals with a safe avenue to report negative experiences, enabling healthcare institutions to address and correct such issues. This would contribute to building trust between LGBTQ patients and healthcare providers, encouraging more open communication and better health outcomes [7, 23].

Additionally, policies should support the establishment of LGBTQ-friendly clinics and healthcare services, particularly in regions where discrimination and stigma are prevalent. These specialized services can offer a safe space for LGBTQ individuals to receive care without fear of mistreatment, legal repercussions, or judgment. By creating healthcare environments that affirm and respect LGBTQ identities, policymakers could be helping to ensure that all individuals receive the care they need to achieve optimal health outcomes [22].

## 9 Conclusion and recommendation

Positive provider attitudes and LGBTQ+ community-friendly health services promote health-seeking behavior among LGBTQ+ individuals. However, members of the LGBTQ+ community in Ghana are stigmatized by health providers and most health workers are ignorant about the special needs of the LGBTQ+ persons.

We recommend that in-service training units of hospitals and health training institutions need to provide comprehensive education to health workers and students on unique health needs of LGBTQ+ persons as well as inclusive care that addresses the needs of members of the LGBTQ+ community.

We further recommend that future studies look at comparison of care received by members of the LGBTQ+ community in various jurisdictions in SSA as compared to the rest of Europe and the United States of America. Findings from such comparative studies could be useful in developing care models to enhance the care received by members of the LGBTQ+ community particularly in SSA.

## 10 Limitations of the study

The results of this study can only speak to limited population studied who were residents of Accra. Therefore, the results cannot be generalized for the entire LGBTQ+ population in Ghana.

The study found that some of the participants claimed they wanted to move out of the jurisdiction. This could have been due to other socio-economic factors aside being LGBTQ+ persons.

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**Data availability** The datasets generated and/or analyzed during the current study are available from the corresponding author on request.

## Declarations

**Ethics approval and consent to participate** All the study methods were carried out in accordance with the declaration of Helsinki. The study was conducted in conformity with the Helsinki Declaration on Human Experimentation, 1964 with subsequent revisions, latest Seoul. This study was approved by the Institutional Review Board of the Noguchi Memorial Institute for Medical Research, Ghana (Protocol Approval Number: NMIMR-IRB CPN 059/23-24). Written informed consent was also obtained from each participant before recruitment into the study. Each participant was informed of his/her right to withdraw from the study at any time without suffering any negative consequences. Names of the participants were not revealed in the study report and all information gathered from the study participants were treated confidentially as special codes were used to represent the responses of each participant.

**Consent for publication** Not applicable.

**Competing interests** The authors declare that they have no any competing/financial interests.

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