UNIVERSITY OF GHANA

COLLEGE OF HEALTH SCIENCES

SCHOOL OF NURSING AND MIDWIFERY

EXPERIENCES OF LGBTQ COMMUNITY MEMBERS DURING UTILISATION OF HEALTHCARE SERVICES IN ACCRA METROPOPLIS

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THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN PARTIAL
FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF MASTER OF
PHILOSOPHY IN NURSING DEGREE

NOVEMBER, 2024

DECLARATION

I, Anuga Donald Womonia, declare that except for other researchers‘work which have been duly acknowledged, this thesis is the result of research undertaken for the award of MASTER OF PHILOSOPHY IN NURSING at the University of Ghana, Legon

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ABSTRACT

Lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ) individuals experience higher rates of mental health disorders and sexually transmitted infections (STIs) including HIV, and substance abuse compared to their heterosexual counterparts. The purpose of this study was to explore the experiences of LGBTQ community members during utilisation of healthcare services in Accra Metropolis. The Andersen's health utilisation (AHU) model was used as an organising guide for this study. This qualitative study adopted an exploratory descriptive design. Fifteen (15) LGBTQ community members who met the inclusion criteria within the Accra Metropolis were purposively selected. Data was collected by means of face-to face and phone interviews using a pretested semi structured interview guide. The study adopted Braun and Clarks‘ reflexive thematic analysis approach in analysing the data. six (6) themes were generated and include the following;

Patterns of healthcare utilisation among the LGBTQ community, Health challenges of the LGBTQ community, Facilitators of healthcare utilisation, Barriers to healthcare utilisation, life experiences of the LGBTQ community and recommendations for improved healthcare access. The study found STIs, and mental health issues to be of health concern and negative experiences including discriminations and services denial, while negative provider attitude and financial constraints present major barriers to healthcare. Considering the findings of the study, development of inclusive and non-discriminatory healthcare policies was recommended for implementation by the Ghana Health service to enhance healthcare access by this minority population in Ghana.

DEDICATION

I dedicate this thesis to my Father, the late Mr Anuga Simon Womonia, who continues to be a source of inspiration in my life. I also dedicate this thesis to all individuals and stakeholders who continue to dedicate their lives and resources to assisting the marginalised in society.

ACKNOWLEDGEMENT

I am extremely grateful to God Almighty for the immeasurable mercies and the gift of life through the course of this program. I am very thankful to the wonderful participants who willingly shared their experiences for advancement of science. To my assiduous supervisors: Dr. Kennedy D. Konlan esq and Mrs. Iddrisu Merri (PhD.) both of School of Nursing and Midwifery of the University of Ghana, Legon, thank you for your expert guidance and support. I am equally thankful to all faculty members of the School of Nursing and Midwifery for the distinctive role you each played in my life both socially and academically while I was pursuing the Mphil Nursing program.

Special thanks to my dear friends Solomon, Jacob and Agana who contributed to the successful completion of this project.

To my Children, Wedam, Wedana, and Welana thank you for your patience and understanding as I went through the course of study. Finally, my gratitude goes to my dear wife, Jennifer Nyaaba for her encouragement and support throughout the program.

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LIST OF ABBREVIATIONS

AHUM:	Andersen's Health Utilization Model
ASMM:	Adolescent sexual minority men
DOVVSU:	Domestic Violence and Victim Support Unit
ED:	Emergency Department
EHC:	Emergency Healthcare
GSS:	Ghana statistical service
HBM:	Health Belief Model
HCP:	Health care professional
HIV:	Human immunodeficiency virus
HPV:	Human papillomavirus
KBTH:	Korle-Bu Teaching Hospital
LGBTQ:	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning
MSM:	Men who have sex with men
NHIS:	National Health Insurance Scheme
PrEP:	Pre-exposure prophylaxis
PHC:	Primary Healthcare
SOGI:	Sexual orientation and gender identity
SRH:	Sexual and reproductive health
STI:	Sexually transmitted infection
TPB:	Theory of Planned Behavior

UNICEF:	United Nations Children's Fund
WHO:	World Health Organisation
SHC:	Specialist Healthcare

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background

Since the 1990s, the Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning (LGBTQ) community, comprising individuals whose sexual orientations and gender identities differ from traditional heterosexual norms, has gained increased visibility globally (Sekoni et al., 2022). However, accurate global data on LGBTQ population remains limited due to challenges such as underreporting, discrimination, and inconsistent definitions of sexual orientation and gender identity (Conyers et al., 2023). Despite growing international recognition of the rights to health and equality, access to healthcare for LGBTQ individuals continues to be impeded by deeply rooted sexual and social stigmas, contributing to disproportionate rates of preventable and treatable health conditions within this population (Sekoni, 2020).

Although many countries advocate for health as a public good and a fundamental human right (Coleman et al., 2022; Zeeman et al., 2019), systemic exclusions and violations of these rights persist, especially for socially marginalised groups such as the LGBTQ community (Conyers et al., 2023). A 2021 global survey across 27 countries revealed that about 30% of respondents identified as LGBTQ, with countries like Ireland, Sweden, and the Netherlands demonstrating higher levels of acceptance (Marti-Pastor et al., 2022). In the United States, a Gallup poll reported a rise in LGBTQ identification from 3.5% in 2012 to 4.5% in 2017, equivalent to approximately 14.65 million adults (Freeman, 2020). Social acceptance has also improved, with 60% of Americans in 2016 regarding gay or lesbian relationships as morally acceptable, compared to 40% in 2001 (Valdiserri et al., 2019).

Despite these advances, the implementation of LGBTQ rights remains uneven across the globe. Since the UN Human Rights Council's resolution in 2011 recognising LGBTQ rights, same-sex activity remains criminalised in over 70 countries and is only legal in about 30 (Marti-Pastor et al., 2022). The Netherlands led the way by legalising same-sex marriage in 2001, followed by countries such as Belgium, Canada, and Spain. However, global acceptance varies significantly—from high levels in Sweden (94%), the Netherlands (92%), and Spain (89%) to extremely low levels in Nigeria (7%), Tunisia (9%), and Indonesia (9%) (Pew Research Center, 2020). Spain, particularly Barcelona, holds historical significance for being one of the first cities in the world to advocate for LGBTQ rights, beginning with a major demonstration in 1977 (Marti-Pastor et al., 2022).

In Africa, accurate statistics on LGBTQ populations are hard to obtain due to legal and cultural constraints (Sekoni, 2020). Approximately 6.4% of men in sub-Saharan Africa engage in same-sex relationships, yet face severe legal consequences in many countries (Valdiserri et al., 2019; Izugbara et al., 2020). For example, Sudan, Mauritania, Somalia, and parts of northern Nigeria impose the death penalty for homosexual acts, while other nations like Uganda, Tanzania, and Sierra Leone impose life imprisonment (Izugbara et al., 2020). In Nigeria, even allies and supporters of LGBTQ individuals risk up to ten years in prison (Ogunbajo et al., 2018). Even in African countries where same-sex relationships are legal—such as South Africa and Cape Verde—LGBTQ individuals still face widespread discrimination, violence, and social exclusion (Conron et al., 2018).

Ghana reflects a similarly complex situation. Although public discourse around LGBTQ rights has grown—spurred by academics and social advocates calling for decriminalisation (Atieku-

Boateng, 2023)—there is widespread resistance from religious bodies, civil society groups, and the general public (Abubakari et al., 2021; Atieku-Boateng, 2023). Parliament has recently passed a bill awaiting presidential assent that, if approved, would criminalise LGBTQ activities. The heightened public discourse and legal scrutiny have further forced LGBTQ individuals into secrecy, which severely limits their access to healthcare services despite high morbidity risks (Marti-Pastor et al., 2022).

Globally, LGBTQ individuals experience comparable health challenges to the general population but suffer disproportionately in terms of quality of life, including elevated risks of suicidal ideation and attempts (Sekoni et al., 2022b; Zeeman et al., 2019). Men who have sex with men (MSM) are especially vulnerable to HIV/AIDS, with UNAIDS (2018) reporting that they are 22 times more likely to be living with HIV compared to the general population. Health disparities are also prominent among lesbian and bisexual women, who are less likely to receive screenings for breast cancer, cervical cancer, or sexually transmitted infections due to stigma (Ramsey et al., 2022; Reeves et al., 2023).

Healthcare settings often fail to provide LGBTQ-competent care, leading to widespread stigmatisation and discrimination. Research shows that one in five transgender individuals have been denied care due to their gender identity, while one in three have avoided medical care out of fear of mistreatment (Agency for Healthcare Research and Quality, 2014). These disparities persist despite legal advancements, affecting not only individual health but also the broader socio-economic and public health systems (Conron et al., 2018; Izugbara et al., 2020).

In Ghana, fundamental rights such as access to healthcare, life, and protection from discrimination are guaranteed under the 1992 Constitution (Atieku-Boateng, 2023). However, sexual minorities consistently report poorer physical and mental health outcomes compared to heterosexual individuals (Atieku-Boateng, 2023; Marti-Pastor et al., 2022). Without targeted interventions to address these inequities, the country risks undermining the health and well-being of LGBTQ populations and compromising the national goal of achieving Universal Health Coverage (WHO, 2021).

1.2 Statement of Problem

Despite the recognition of health as a fundamental human right, members of the LGBTQ community often encounter discrimination, stigma, and inadequate healthcare services, which exacerbate their vulnerability to various health issues (Sekoni et al., 2022). Globally, LGBTQ individuals experience higher rates of mental health disorders, sexually transmitted infections (STIs), including HIV, and substance abuse compared to their heterosexual counterparts (Jennings et al., 2019). Studies also indicate that LGBTQ individuals frequently avoid seeking medical care due to fear of discrimination or previous negative experiences with healthcare providers (Conron et al., 2018).

In Ghana, where cultural and legal frameworks do not fully support LGBTQ rights, these disparities are even more pronounced (Atieku-Boateng, 2023). For instance currently, a private member's bill has been passed by Ghana's parliament awaiting presidential assent and its aimed at further criminalising LGBTQ activities, fueling public debates and pushing LGBTQ individuals into secrecy, thereby limiting their access to healthcare services despite the several health challenges and unique health needs of this population (Abubakari et al., 2021). Despite several public health initiatives, the unique healthcare needs of the LGBTQ population, including issues related to HIV/AIDS, mental health challenges, substance abuse, and other sexually transmitted infections (STIs), remain largely unaddressed (Gonzales et al., 2021).

Addressing these healthcare disparities within sexual and gender minorities is vital for achieving universal health coverage, aligning with the objectives of the World Health Organisation (Muller et al., 2016). During my clinical practice as a nurse, I encountered a young man who presented with symptoms suggestive of a sexually transmitted infection but was visibly distressed and hesitant to disclose his sexual history. After building trust, he confided that he was gay and feared being judged or reported due to the prevailing anti-LGBTQ sentiments. His reluctance to seek care earlier had led to complications that could have been prevented. This experience underscored, on a personal level, how the fear of stigma and criminalisation directly impacts the health-seeking behaviours of LGBTQ individuals.

Notably, Ogunbajo et al. (2018), a nationwide study in Ghana revealed alarmingly high HIV rates of 17.5% among men who have sex with men (MSM). The Greater Accra Region recorded even higher rates at 34%, compared to 5-14% in other regions. Additionally, the study revealed that this region houses the largest population of MSM in Ghana, ranging from 4,187 to 20,822. In conjunction with these concerning statistics, there is a dearth of empirical data on the specific experiences of LGBTQ individuals within the healthcare system in Accra Metropolis. Without a clear understanding of these experiences, it is challenging to develop effective interventions to reduce the existing health disparities and improve health outcomes for this population. Therefore, this study seeks to explore the healthcare experiences of LGBTQ community members in Accra Metropolis, aiming to identify the challenges they face and to propose actionable solutions that can enhance the quality and accessibility of healthcare for this marginalised group.

1.3 Purpose of the study

The purpose of the study was to explore experiences of LGBTQ community members during utilisation of healthcare service in the Accra metropolis

1.4 Objectives of the study

The specific objectives of this study were informed by a critical review of existing literature, observed healthcare disparities during clinical practice, and the urgent need to understand and respond to the unique healthcare challenges faced by LGBTQ individuals in Ghana, particularly in the Accra Metropolis. Additionally, preliminary insights gained from public health reports, international health guidelines, and personal clinical encounters with LGBTQ patients underscored significant gaps in both service delivery and accessibility. These gaps guided the formulation of the following objectives, aimed at generating empirical evidence to support inclusive healthcare policies and practices:

The specific objectives are:

1. To describe the pattern of healthcare utilisation among members of LGBTQ community.
2. To describe the healthcare needs of the LGBTQ community.
3. To explore the factors that facilitate the utilisation of healthcare services among the LGBTQ community.
4. To explore barriers to utilisation of healthcare services among the LGBTQ population.

1.5 Research questions

1. What is the pattern of healthcare utilisation among members of LGBTQ community?

2. What are the unique healthcare needs of the LGBTQ community?
3. What are the facilitating factors to healthcare utilisation by the LGBTQ community?
4. What are the Barriers to the LGBTQ health services utilisation?

1.6 Significance of the study

This study holds significant relevance within the field of nursing legal research and education, particularly in addressing systemic gaps in the equitable delivery of healthcare to LGBTQ individuals. In many healthcare settings, including within the Accra Metropolis, there remains a lack of legal clarity and educational preparation among nurses regarding the rights, protections, and care needs of LGBTQ populations. This contributes to persistent health disparities, including elevated rates of mental health disorders, substance abuse, and chronic illnesses within this community (Izugbara et al., 2020).

From a nursing legal research perspective, this study contributes to the understanding of how existing legal and policy frameworks—or lack thereof—impact the accessibility and quality of care available to LGBTQ individuals. It exposes how stigma, discrimination, and the absence of protective legal mechanisms can lead to violations of ethical and professional standards in nursing practice. Identifying these legal gaps can support advocacy for reforms that ensure compliance with human rights principles and the ethical obligations of nurses to provide non-discriminatory care.

From an educational standpoint, the findings can inform the integration of LGBTQ health content into nursing curricula, particularly in areas such as cultural competence, patient advocacy, ethical decision-making, and health equity. The study can serve as an empirical foundation for developing training modules and continuing professional development programs aimed at equipping nurses with the knowledge and skills required to deliver inclusive, legally sound, and culturally sensitive care to LGBTQ patients.

Moreover, by documenting real-life healthcare experiences of LGBTQ individuals in the Accra Metropolis, the study helps nursing educators and researchers highlight the importance of evidence-based policy-making. It encourages the inclusion of diverse patient narratives in nursing education, fostering a deeper understanding of the intersection between health, human rights, and legal accountability in nursing care.

In summary, this research is vital not only for improving health outcomes for LGBTQ populations but also for enhancing legal literacy, ethical awareness, and cultural responsiveness within nursing education and practice. It underscores the role of nurses as advocates for vulnerable populations and supports the development of a more just and inclusive healthcare system.

1.7 Operational Definitions

LGBTQ: is an acronym that refers to lesbian, gay, bisexual, transgender and queer or questioning

LGBTQ community refers to a diverse group of individuals who identify as Lesbian, Gay, Bisexual, Transgender, Queer (or Questioning), or any other non-heterosexual or non-cisgender identity. This community encompasses people who share experiences, challenges, and advocate for recognition for people of all sexual orientations and gender identities

Healthcare utilisation: The use of healthcare services for curative, preventive and cosmetic purposes.

Lesbian refers to women who are sexually attracted to women,

Gay refers to men who are sexually attracted to men,

Bisexual refers to individual who is sexually attracted to both sexes.

Transgender: Transgender individuals have a gender identity different from their birth-assigned sex. They may transition through medical or social means.

Queer is an umbrella term that individuals may use to describe a sexual orientation, gender identity, or gender expression that does not conform to dominant societal norms

Questioning refers to those uncertain about their sexual orientation or gender identity.

Inclusivity: means creating an environment where LGBTQ individuals feel safe, respected, and adequately supported in all their healthcare needs.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

This chapter is made up of two sections. The first section explains the theoretical framework that guided the study and how the different constructs were used throughout. The literature review makes up the second section of the chapter where relevant literature is reviewed on the various objectives of the study.

2.2 SELECTION AND JUSTIFICATION OF THE THEORETICAL FRAMEWORK

Prior to settling on the Andersen‘s health utilisation model (AHUM), The health belief model (HBM) and the theory of planned behaviour (TPB) were reviewed, however, when the researcher compared and contrasted the three framework‘s applicability in the study, Andersen's model was chosen over the theory of planned behaviour and the health belief model because it offers a thorough framework that considers many aspects of health utilisation and it‘s constructs are in line with the aim and objectives of this study. Anderson health utilisation model acknowledges that a variety of factors, including individual, societal, and structural determinants, influence healthcare utilisation (Lederle et al., 2021).

The theory of planned behaviour does not adequately reflect the assumptions and goal of this study or the complexity of healthcare utilisation among the LGBTQ population because it largely focuses on individual views, subjective standards, and perceived behavioural control. Similarly, the health belief model largely focuses on individual views and beliefs, which does not adequately cover the complexity of influences of health utilisation among the LGBTQ population.

However, Andersen's model considers a wide range factors regarding healthcare utilisation among the LGBTQ population including the impact of socio-structural factors on the use of healthcare services. It also acknowledges that broader social, economic, and policy settings have an influence on how people access and use healthcare services (Lederle et al., 2021). The LGBTQ population, which faces health disparities and obstacles brought on by social prejudice, provider bias, and unequal access to resources for healthcare (Conyers et al., 2023; Jennings et al., 2019), makes this model particularly significant to the study of healthcare experiences among the LGBTQ population. The theory of planned behaviour and the health belief model, on the other hand, do not cover the bulk of the components and aims that are being investigated in this study.

2.3. ANDERSEN'S BEHAVIOURAL AND HEALTH UTILISATION MODEL

Andersen's behavioral model of health services utilization (1995), often referred to as Andersen's health utilisation model, is a widely recognised model that seeks to explain the complex interplay of factors influencing an individual's use of health services. Developed by sociologist Ronald M. Andersen, the model was first introduced in the late 1960s and has since undergone several refinements (Andersen, 1995). It provides a comprehensive way to understand the determinants of healthcare utilisation, considering individual, contextual, and systemic factors. The goal of

Andersen's behavioral model was to scientifically assess access disparities to healthcare in the USA (Andersen, 1968). It addresses the issue that some societal segments, particularly those who belong to ethnic minority groups, live in inner cities, and reside in rural areas, receive less health care than the general population (Andersen & Newman, 1973). Andersen‘s health model is a multilevel model that incorporates both individual and contextual determinants of health utilisation (SoleimanvandiAzar et al., 2020) Individual characteristics are evaluated at the individual level, whereas contextual characteristics such as families, communities, and national healthcare systems are measured at an aggregate level (Lederle et al., 2021). Andersen‘s model provides a useful framework for informing the analysis of contributing factors to health utilisation (SoleimanvandiAzar et al., 2020) and it is built upon three components, which are presumably associated with health utilisation and could be applied as predictors of utilisation, as follows:

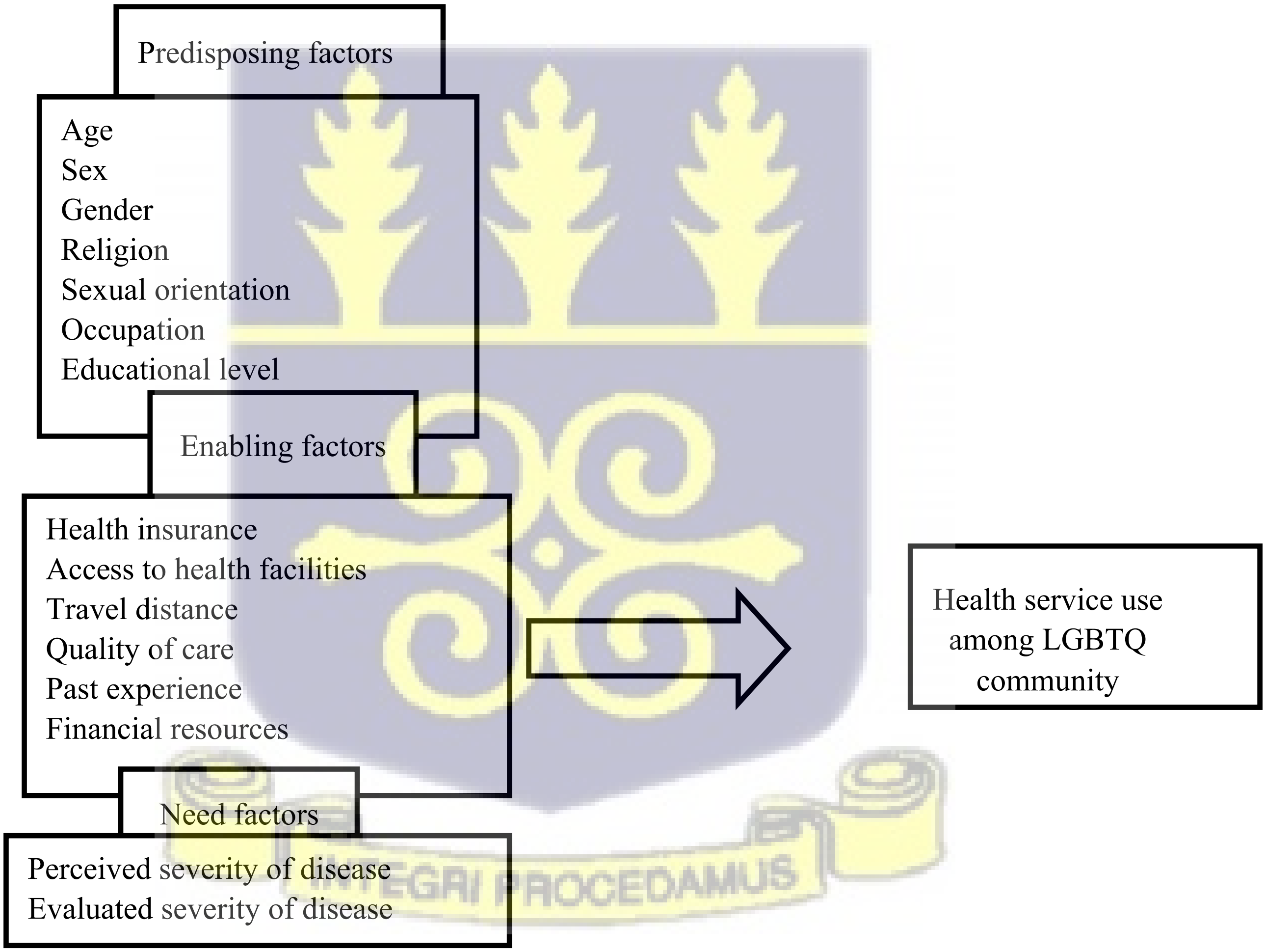

Figure 1: Andersen‘s behavioural and health service utilisation model (1995)

2.3.1 PREDISPOSING FACTORS

Predisposing factors comprised of the sociodemographic characteristics that create the condition to increase the probability of health service use (SoleimanvandiAzar et al., 2020). At the individual level, these factors include age, sex, marital status, and ethnicity, along with attitudes, beliefs, values, and knowledge vis-à-vis health and health services (Lederle et al., 2021). The contextual factors that predispose individuals to health service use encompass the demographic and social composition of communities and their collective and organisational values, as well as cultural norms (Lederle et al., 2021; SoleimanvandiAzar et al., 2020).

2.3.2 ENABLING FACTORS

Enabling factors are considered those that can hinder or facilitate health service use (SoleimanvandiAzar et al., 2020). At the individual level, these factors include income, wealth, health insurance status, and regular sources of care. At the contextual level, the enabling factors consist of per capital community income; the rate of health insurance coverage; the amount, variety, location, structure, and distribution of health service facilities and personnel; providerrelated factors; physician and hospital density; distance from healthcare services (Lederle et al., 2021) the availability of transportation, the quality of healthcare, and health policies (Lederle et al., 2021; SoleimanvandiAzar et al., 2020).

2.3.3 NEED FACTORS

Need factors are understood as variables concerning the perception of a change in an individuals' health status. At the individual level, these factors encompass both the perceived need for health services and the evaluated need. At the contextual level, the need factors comprise not only environmental need features, namely occupational and traffic- and crime-based accidents and death rates but also health indices including the epidemiological indicators of mortality, morbidity, and disability (Lederle et al., 2021; SoleimanvandiAzar et al., 2020)

According to Andersen, access and utilisation of services are deemed equitable if they can be determined by fixed demographic traits like age and sex or purely by need criteria, such as disease (Andersen & Aday, 1978). However, access is deemed unfair if it can be entirely or partially predicted by elements like enabling factors or ethnicity (Andersen & Newman, 1973).

The current phase of Andersen's health care utilisation model was produced in 2013, after four previous phases. The initial phase was created in 1960, and the following phases followed in 1970, 1980/1990, 1995, and 2013 accordingly. Many authors have utilised the model, including Petrovic and Blank (2015), Feijen-de Jong et al. (2015), Rutaremwa, Wandera, Jhamba, Akiror, and Kiconco (2015); Willis, Glaser, and Price. (2007). Saeed and his colleagues utilised the model in Ghana (2012) for a study on determinants of health utilisation of the aging population.

In conclusion, Andersen's Health Care Utilization Model was adopted as a conceptual lens to understand the multi-level factors influencing health service use. Although qualitative studies often explore phenomena inductively (Andersen & Newman, 1973), this research used Andersen's model both as a sensitising framework to guide data interpretation and to categorise emerging themes. The model's classification of predisposing, enabling, and need factors provided a structured way to examine how individual and contextual elements shape healthcare utilisation.

2.4 Review of empirical Literature

Searches were conducted using key phrases based on the study's objectives. Utilising a variety of databases, including ScienceDirect, PubMed, Google Scholar, JSTOR, and the websites of important international organisations including UNICEF and WHO.

This review of studies was done in order to address the issue of LGBTQ community members _experiences during utilisation of healthcare services in the Accra Metropolis. The search was conducted using terms and phrases such as: LGBTQ health services, predictors of LGBTQ health service use, barriers to LGBTQ healthcare utilisation, facilitators of LGBTQ healthcare utilisation, health needs and priorities of the LGBTQ community. Based on the constructs of the guiding theoretical model and the objectives of the study, the literature was reviewed and organized into key thematic areas. The first area explores patterns of healthcare utilization among members of the LGBTQ community, providing insight into how and to what extent individuals within this group access health services. The second focus is on the specific healthcare needs of the LGBTQ population, highlighting unique medical, psychological, and social considerations. Third, the review examines the facilitators that promote the use of healthcare services within the LGBTQ community, identifying factors that encourage engagement with the healthcare system. Finally, the literature addresses the barriers that hinder healthcare utilization, shedding light on the challenges and obstacles that members of this community may face when seeking care.

2.4.1 PATTERNS OF HEALTHCARE UTILISATION AMONG THE LGBTQ COMMUNITY

Healthcare utilisation among LGBTQ individuals has gained significant attention in recent years due to the recognition of disparities compared to their heterosexual counterparts. This section of the review focuses on the pattern of health service utilisation among the LGBTQ specifically focusing on primary healthcare, emergency healthcare, and specialist healthcare services. It takes into accounts available data from the different subgroupings of the LGBTQ community thus, lesbians, gays, bisexuals, transgender and the queer. It incorporates recent studies to provide a comprehensive overview of these trends with respect to these different subgroupings.

2.4.1.1 Primary health service utilisation

Primary healhcare care is a critical component of healthcare, serving as the first point of contact for individuals seeking medical attention. It plays a vital role in disease prevention, early detection, and management of chronic conditions. However, the utilisation of primary care services among LGBTQ individuals is notably lower compared to their heterosexual counterparts (Marti-Pastor et al., 2022). This disparity raises concerns about health outcomes in this population, particularly in marginalised subgroups. Research indicates that various barriers, including concerns about discrimination and lack of adequate knowledge by healthcare providers, contribute to this phenomenon (Dayrit et al., 2022). Dayrit and colleagues found that LGBTQ individuals frequently report avoiding primary care due to concerns about discrimination and a lack of understanding from healthcare providers. According to them, this avoidance behaviour is especially prevalent among those belonging to multiple marginalised groups, such as LGBTQ people of color, the aged, those with lower socioeconomic status, or individuals with intersecting identities (e.g., a transgender person of color). The fear of encountering bias or hostile attitudes from healthcare providers is a significant barrier, as it can lead to delayed diagnoses, untreated health conditions, and overall poorer health outcomes. According to their study, another critical factor contributing to the lower utilisation rates of primary care services among LGBTQ individuals is the perceived or actual lack of cultural competency among healthcare providers and many LGBTQ individuals report that healthcare providers often lack understanding of their specific health needs. For instance, transgender patients may face difficulties in finding providers knowledgeable about gender-affirming care, while gay and bisexual men may encounter providers who are not well-versed in discussing sexual health in a non-judgmental manner. This lack of competency not only undermines the quality of care received but also contributes to the reluctance of LGBTQ individuals to engage with the healthcare system (Conyers et al., 2018).

The findings of Dayrit et al. (2022) and similar studies have significant implications for healthcare policy and practice. To address the lower utilisation rates of primary care among LGBTQ individuals, it is essential to implement strategies aimed at reducing discrimination and increasing cultural competency among healthcare providers. This could include mandatory training for healthcare professionals on LGBTQ health issues, the development of inclusive healthcare environments, and the adoption of policies that protect LGBTQ patients from discrimination. Additionally, targeted outreach efforts may be necessary to engage LGBTQ individuals who are particularly vulnerable to avoiding care due to intersecting forms of marginalisation.

To add to the findings of Dayrit and his colleagues, Shaver et al. (2018) also found that LGBTQ individuals often encounter providers who are not well-versed in LGBTQ-specific health needs and this often discourages them from seeking regular care.

Furthermore, Coleman et al., (2022) reported that the discomfort with disclosing sexual orientation or gender identity in primary care settings further inhibits the utilisation of these services. Disclosure of sexual orientation and gender identity is a fundamental aspect of patientprovider communication that can significantly impact the quality of care received. When LGBTQ individuals feel uncomfortable or unsafe disclosing these aspects of their identity, it can lead to a lack of tailored care, reduced patient satisfaction, and lower adherence to medical advice (Coleman et al., 2022). Coleman and colleagues highlight that the fear of judgment, stigmatisation, or even outright discrimination by healthcare providers contributes to this discomfort. As a result, many LGBTQ patients may choose to withhold important information, thereby limiting the effectiveness of the care they receive. The reluctance to disclose sexual orientation or gender identity in primary care settings has direct consequences for health outcomes. The study emphasised that the reduced utilisation of primary care services due to disclosure-related discomfort can lead to delayed diagnoses, untreated conditions, and poorer overall health among LGBTQ individuals. For instance, the absence of routine screenings and preventive care such as cancer screenings, vaccinations, and health education can increase the risk of developing serious health issues. Additionally, LGBTQ individuals may miss opportunities for early intervention, which is crucial in managing chronic diseases and maintaining long-term health (Gonzales et al., 2022).

Addressing the discomfort associated with disclosing sexual orientation or gender identity in primary care may require a multifaceted approach including providers adopting practices that foster a safe and welcoming environment for LGBTQ patients. This could also include training providers to communicate in a non-judgmental and inclusive manner, ensuring that healthcare settings visibly support LGBTQ rights (e.g., through inclusive signage and policies), and implementing standardised procedures for collecting information about sexual orientation and gender identity in a way that respects patient privacy and autonomy.

Moreover, institutional changes at the policy level can play a crucial role in enhancing disclosure comfort. Policies that mandate the inclusion of LGBTQ health education in medical training, along with the enforcement of non-discrimination policies in healthcare, can help reduce the stigma associated with LGBTQ identities in clinical settings. These efforts can contribute to a more inclusive healthcare environment where LGBTQ individuals feel safe and supported in disclosing their identities, thereby improving their access to and utilisation of primary healthcare services.

Research indicates that the lower engagement in primary care among LGBTQ individuals leads to missed opportunities for early detection and management of chronic conditions and that this disparity contributes to worse health outcomes and higher long-term healthcare costs for LGBTQ individuals compared to their heterosexual peers (Gonzales et al., 2022). Early detection and timely management of chronic conditions are critical to preventing complications and improving longterm health outcomes. When LGBTQ individuals do not regularly engage with primary care services, they are more likely to miss routine screenings, health assessments, and preventive interventions that could detect chronic conditions at an early stage (Gonzales et al., 2022). Their study emphasised that this missed opportunity for early intervention is a significant factor contributing to the higher prevalence of untreated or poorly managed chronic conditions within the LGBTQ population. For example, conditions such as hypertension, and certain cancers may go undiagnosed or inadequately managed, leading to increased morbidity and mortality in this population. In addition to the adverse health outcomes, the lower engagement in primary care among LGBTQ individuals also has significant economic implications. Gonzales and his colleagues highlighted that the delayed diagnosis and management of chronic conditions contribute to higher long-term healthcare costs. When conditions are not managed early, they often require more intensive and costly treatments down the line, including emergency room visits, hospitalisations, and specialised care. Furthermore, the lack of preventive care can lead to the development of multiple co-morbid conditions, which further complicates treatment and increases the financial burden on both individuals and the healthcare system (Gozale et al., 2022).

2.4.1.2 Emergency health service utilisation

Emergency departments (EDs) serve as a critical component of the healthcare system, providing immediate care for acute and severe conditions. However, LGBTQ individuals are disproportionately more likely to use emergency services compared to their heterosexual counterparts, often for conditions that could have been managed through regular primary care (Becker et al., 2019). Becker and colleagues indicated that this increased reliance on emergency services is largely due to lack of culturally competent providers. LGBTQ individuals face numerous barriers to accessing regular primary care, which drives them to seek care in emergency departments instead. Their identified several key barriers, including discrimination and stigma in healthcare settings, lack of insurance or underinsurance, and a shortage of LGBTQ-competent healthcare providers. These barriers contribute to a pattern where LGBTQ individuals avoid or delay seeking primary care until their health issues become severe enough to warrant emergency intervention. This pattern not only increases the burden on emergency departments but also leads to suboptimal health outcomes, as conditions that could have been managed or prevented in a primary care setting are left untreated until they reach a critical point (Becker et al., 2019). The fear of discrimination, whether based on previous experiences or anticipation of negative treatment, creates a barrier to building on-going relationships with primary care providers, which is essential for effective preventive care and chronic disease management.

According to their study, financial barriers also play a significant role in the overutilisation of emergency services by LGBTQ individuals. They noted that LGBTQ individuals, particularly those who are transgender or gender non-conforming, are more likely to be uninsured or underinsured compared to their heterosexual peers. This lack of adequate insurance coverage makes accessing regular primary care financially unfeasible for many LGBTQ individuals, leading them to delay care until they require emergency services. Additionally, even those with insurance may face high out-of-pocket costs or have policies that do not cover LGBTQ-specific healthcare needs, such as gender-affirming treatments, further exacerbating the reliance on emergency care.

The over-utilisation of emergency services by LGBTQ individuals may have significant implications for both their health outcomes and the broader healthcare system. Relying on emergency care for non-emergent issues may lead to poorer health outcomes, as emergency departments are not equipped to provide the continuous, preventive care necessary to manage chronic conditions or address the broader social determinants of health. This pattern of care could contribute to the exacerbation of health disparities within the LGBTQ community, including higher rates of chronic diseases, mental health issues, and preventable complications.

From a healthcare system perspective, the increased use of emergency services by LGBTQ individuals could cause a strain on resources, as emergency care is typically more expensive and resource-intensive than primary care. This inefficiency drives up healthcare costs and diverts resources from other critical areas. Furthermore, the high reliance on emergency departments for routine care can lead to overcrowding, longer wait times, and reduced quality of care for all patients.

Addressing the over-utilisation of emergency services by LGBTQ individuals may require a multifaceted approach focused on improving access to primary care. Becker and colleagues suggested that healthcare systems implement policies to increase the availability of LGBTQ competent providers, including integrating LGBTQ health issues into medical education and offering continuing education for existing providers. Additionally, expanding insurance coverage to include LGBTQ-specific services, such as gender-affirming care, would reduce the financial barriers that drive LGBTQ individuals to emergency departments.

This is further supported by a study by Moore et al. (2020), which highlighted that LGBTQ individuals, particularly those with minority stress, frequently use emergency services as a result of inadequate routine care, Stigma and discrimination in healthcare settings contribute to the increased emergency service utilisation among LGBTQ individuals. They demonstrated that LGBTQ individuals experience significant levels of discrimination in healthcare settings, which leads them to avoid non-emergency care and rely on emergency services. Similarly, the fear of encountering bias and discrimination in healthcare settings is a significant deterrent for LGBTQ individuals seeking regular healthcare. Holt et al. (2023) emphasised that many LGBTQ patients have had negative experiences in the past, including being judged, misgendered, or dismissed by healthcare providers. These experiences create a lasting impact, leading individuals to anticipate similar treatment in the future. This anticipation of bias causes many LGBTQ individuals to avoid primary care settings, where they might feel vulnerable or exposed, and instead turn to emergency departments for their healthcare needs. Emergency care is often seen as more impersonal, with less need to disclose personal details such as sexual orientation or gender identity, which reduces the fear of discrimination. They also found that LGBTQ individuals who have experienced negative interactions, such as being denied care, subjected to inappropriate questioning, or encountering hostile attitudes, are more likely to avoid regular healthcare services. These negative experiences contribute to a deep mistrust of the healthcare system, leading individuals to bypass primary care providers in favor of emergency departments. The episodic and urgent nature of emergency care is perceived as a way to receive treatment without enduring the discomfort and potential trauma associated with disclosing their LGBTQ identity in a more intimate, ongoing care setting. They also noted that the anonymity of EDs, where patients are less likely to see the same provider twice, makes them a more appealing option for LGBTQ individuals seeking to avoid stigma. In an emergency setting, the focus is primarily on immediate medical needs rather than personal history, which can be a relief for those who have previously faced discrimination or prejudice. However, this reliance on emergency care for non-emergent issues may come with significant drawbacks, including the lack of continuity of care and the potential for missed opportunities for preventive health interventions.

The pattern of avoiding primary care due to fear of bias and relying on emergency care may have profound implications for the health outcomes. It may lead to fragmented care, where underlying health issues may go unaddressed or are only managed in crisis situations. The lack of consistent, ongoing care contributes to higher rates of undiagnosed or poorly managed chronic conditions among LGBTQ individuals, exacerbating health disparities within this population.

Psychosocial factors such as higher rates of mental health issues also play a role. A study by Feinstein et al. (2020) reported that LGBTQ individuals, particularly those who are transgender or non-binary, experience elevated levels of psychological distress, which contributes to increased emergency room visits for mental health crises. Furthermore, Hsieh et al. (2021) noted that LGBTQ individuals are often in crisis situations due to acute episodes of stress and trauma, leading to higher emergency service utilisation.

On the contrary, significant portion of transgender/nonbinary patients avoid the ED, with rationales including past negative experiences and discrimination and a perceived lack of knowledge of providers and staff, and this may result in worse health outcomes compared nonsexual-and-gender-minority patients (Kruse et al., 2022). Kruse and colleagues found that a significant portion of these patients actively avoid the ED because they have encountered disrespect, misgendering, and a general lack of understanding of transgender and nonbinary health concerns in the past. These experiences contribute to a pervasive sense of mistrust toward healthcare providers, leading many to delay or forgo necessary care. This delay in seeking medical attention can result in the worsening of acute conditions that could have been managed effectively with timely intervention. According to their study, the avoidance of emergency care by transgender and nonbinary patients has significant implications for their health outcomes. Delays in receiving care can lead to the progression of otherwise manageable conditions, increasing the risk of complications and the need for more intensive treatments later on. Moreover, the cumulative stress of navigating a healthcare system perceived as hostile or unwelcoming can exacerbate mental health issues, which are already prevalent within the transgender and nonbinary communities. The disparity in health outcomes between transgender/nonbinary individuals and non-LGBTQ+ patients underscores the urgent need for improvements in the cultural competence of healthcare providers and the creation of more inclusive healthcare environments.

2.4.1.3 Specialist health service utilisation

Specialist healthcare services are crucial for addressing specific health conditions that require expert attention beyond the scope of primary care. These services may include areas such as cardiology, oncology, mental health, and endocrinology, among others. However, LGBTQ individuals face unique challenges in accessing specialist healthcare, which results in lower utilisation rates compared to heterosexual individuals (Kattari et al., 2020). kattari and colleagues identified several barriers that contribute to this disparity, including insurance limitations and a shortage of providers who are knowledgeable about the specific health needs of LGBTQ populations. Their study highlights that LGBTQ individuals, particularly those who are transgender or non-binary, may face insurance denials for gender-affirming treatments or other specialised services that are essential to their health and well-being and that, LGBTQ individuals are more likely to be uninsured or underinsured compared to their heterosexual counterparts, which further limits their access to specialist healthcare. The financial constraints imposed by inadequate insurance coverage can lead to delayed or forgone care, exacerbating health disparities in this population. The study also noted that availability of LGBTQ-competent specialty care varies significantly by region, with rural areas often lacking the necessary resources and providers. kattari and colleagues indicated that LGBTQ individuals living in rural or underserved areas are particularly disadvantaged when it comes to accessing specialist healthcare. These individuals may need to travel long distances to find knowledgeable providers, which can be both time-consuming and costly. Additionally, the lack of anonymity in smaller communities can deter LGBTQ individuals from seeking specialist care, particularly for sensitive issues such as sexual health or gender-affirming procedures, due to fears of stigma and discrimination (Kattari et al., 2020).

These barriers to specialist healthcare utilisation among LGBTQ individuals have serious implications for their health outcomes, for instance, without access to specialised care, LGBTQ individuals are at greater risk for untreated or poorly managed health conditions. For instance, inadequate access to mental health services can lead to higher rates of depression, anxiety, and suicidality in LGBTQ populations. Similarly, the lack of competent care in areas such as endocrinology or oncology can result in suboptimal treatment for conditions like hormone imbalances or cancer, which can have life-threatening consequences. These disparities contribute to the overall poorer health outcomes observed in LGBTQ populations compared to their heterosexual peers (Jennings et al., 2019).

To address these identified barriers, several strategies may have to be implemented to improve access to specialty care for LGBTQ individuals. Expanding insurance coverage to include LGBTQ-specific services, such as gender-affirming care, is a critical step in reducing financial barriers. Additionally, increasing the number of healthcare providers who are trained in LGBTQ health issues is essential for ensuring that specialty care is both accessible and competent. This can be achieved through the integration of LGBTQ health topics into medical education and continuing professional development programs. Furthermore, telemedicine and other digital health solutions can help bridge the geographic gap by providing remote access to specialized care for LGBTQ individuals in underserved areas.

Referrals to specialist care are often critical for the diagnosis and management of complex health conditions, yet LGBTQ individuals are less likely to be referred for these services. Morris et al. (2019) found that even when LGBTQ individuals present with similar or greater healthcare needs, they are disproportionately under-referred to specialists. This disparity in referral rates can be attributed to several factors, including implicit biases among healthcare providers and systemic issues within the healthcare system that disadvantage LGBTQ patients. The lack of referrals not only limits access to necessary care but also perpetuates a cycle of unmet health needs within the LGBTQ community. Stigma and discrimination within the healthcare system play a significant role in the lower referral rates for LGBTQ individuals. Morris and colleagues emphasised that healthcare providers may consciously or unconsciously allow their biases to influence clinical decisions, including the decision to refer a patient to a specialist. LGBTQ individuals who experience discrimination or feel unwelcome in healthcare settings may be less likely to advocate for themselves or to disclose pertinent health information, which can lead to missed opportunities for referrals. Furthermore, providers who hold stigmatising attitudes towards LGBTQ individuals may underestimate the seriousness of their health concerns or dismiss the need for specialty care, further contributing to the under-referral. Another critical barrier to specialty care referrals is the knowledge gap among healthcare providers regarding LGBTQ-specific health needs. Their study found that many providers lack the training and awareness necessary to recognise when a referral to a specialist is appropriate for LGBTQ patients. For example, a primary care provider who is unfamiliar with the healthcare needs of transgender patients may not recognize the importance of referring a patient for hormone therapy or gender-affirming surgery. Similarly, a provider who is unaware of the heightened risk of certain cancers among LGBTQ populations may fail to refer patients for necessary screenings. These knowledge gaps not only hinder the referral process but also contribute to the overall lower quality of care that LGBTQ individuals receive.

The lower rates of referrals for specialist care for LGBTQ individuals may have significant implications for their health outcomes. For instance without timely and appropriate referrals, LGBTQ patients are more likely to experience delays in diagnosis and treatment, leading to worse health outcomes. The lack of referrals for mental health services can exacerbate conditions such as depression and anxiety, which are already prevalent in LGBTQ populations. Similarly, the absence of referrals for specialized care in areas such as cardiology, oncology, or endocrinology can result in the progression of untreated conditions, increased morbidity, and, in some cases, higher mortality rates.

To address the disparities in referral rates and improve access to specialty care for LGBTQ individuals, several strategies may have to be implemented. There may be the need for healthcare providers to receive comprehensive training on LGBTQ health issues, including the importance of referrals for specialty care. This training could be integrated into medical education and continuing professional development programs to ensure that providers are equipped with the knowledge and skills necessary to serve LGBTQ patients effectively. Additionally, healthcare systems can implement policies that promote equity in referrals, such as standardized referral protocols that take into account the specific needs of LGBTQ patients.

Stigma remains a pervasive barrier to healthcare access for LGBTQ individuals, particularly when it comes to seeking specialty care for conditions that are heavily stigmatized, such as HIV. Stigma can manifest in various forms, including societal discrimination, internalized stigma, and anticipated stigma within healthcare settings, all of which deter LGBTQ individuals from seeking necessary care. Silveri et al., (2020) emphasised that the stigma surrounding certain health conditions, especially HIV, can significantly impact the willingness of LGBTQ individuals to engage with specialty care services. HIV-related stigma is a significant deterrent for LGBTQ individuals who require specialty care, particularly in the context of HIV treatment and prevention. Silveri and colleagues indicated that the fear of being judged or discriminated against based on their HIV status can lead LGBTQ individuals to avoid seeking care, even when they know they need it. This avoidance is often driven by concerns about privacy, confidentiality, and the potential for negative experiences with healthcare providers. For many LGBTQ individuals, particularly those who are already marginalised within society, the prospect of facing additional stigma in healthcare settings can be overwhelming, leading to delays in diagnosis, treatment, and the management of HIV. According to their study, Stigma does not exist in isolation but often intersects with other barriers to specialty care for LGBTQ individuals. They noted that LGBTQ individuals who face discrimination based on their sexual orientation or gender identity may be particularly vulnerable to the effects of HIV-related stigma. For example, a transgender woman living with HIV may experience compounded stigma due to both her gender identity and her HIV status, making her even less likely to seek out specialty care. Additionally, structural barriers such as poverty, lack of insurance, and geographic location can exacerbate the impact of stigma, further limiting access to essential HIV-related services.

The impact of stigma on the utilisation of specialty care has profound implications for the health outcomes of LGBTQ individuals, especially those living with HIV. The avoidance of HIVrelated specialty care due to stigma may lead to poorer health outcomes, including higher viral loads, increased risk of HIV transmission, and greater morbidity and mortality. The fear of stigma can also prevent LGBTQ individuals from accessing preventive services, such as PrEP (pre-exposure prophylaxis), that could significantly reduce their risk of contracting HIV. This cycle of stigma, avoidance, and poor health outcomes contributes to the persistent health disparities observed in LGBTQ populations, particularly in communities of color where HIV rates are disproportionately high (Silveri et al., 2020).

Additionally, Tamargo et al. (2017) noted that a lack of specialised care providers who are familiar with LGBTQ-specific health issues further exacerbates this disparity while a study by Lunn et al. (2023) found that LGBTQ individuals, particularly transgender individuals, often face insurance barriers that limit their access to necessary specialty care. This can result in delayed care and poorer health outcomes for conditions requiring specialised management.

2.4.2. HEALTHCARE NEEDS OF THE LGBTQ COMMUNITY

The healthcare needs of the LGBTQ community are complex and multifaceted, encompassing a wide range of physical, mental, social as well as cultural health issues that are often inadequately addressed within mainstream healthcare systems.

Despite the LGBTQ community has gained increasing prominence worldwide since the 1990s both in rights and social acceptance (Sekoni et al., 2022), ongoing stigmatisation, persecution, and discrimination continue to profoundly impact the health of LGBTQ individuals (Holt et al., 2023a; Kcomt, 2019). Various societal factors, including lack of protection from bullying, limited access to knowledgeable and culturally competent healthcare professionals, and legal restrictions on rights such as employment, marriage, and healthcare insurance, contribute to the health disparities experienced by LGBTQ populations (Fredriksen-Goldsen et al., 2019; Jennings et al., 2019).

Legal restrictions on rights such as employment, marriage, and healthcare insurance further compound the challenges faced by LGBTQ populations. Discriminatory laws and policies can perpetuate inequalities and limit access to essential resources and opportunities. For example, legal barriers to marriage equality may impact access to healthcare insurance and spousal benefits, while employment discrimination based on sexual orientation or gender identity can create economic instability and financial stress (Jennings et al., 2019; Pachankis et al., 2021; Silveri et al., 2022).

By promoting inclusivity, fostering supportive environments, and advocating for policy change, society can work towards ensuring that all individuals, regardless of sexual orientation or gender identity, have the opportunity to lead healthy and fulfilling lives.

2.4.2.1 Mental Healthcare needs

Research has consistently shown that the widespread prejudice and discrimination faced by LGBTQ individuals are linked to higher rates of mental health issues, including anxiety, depression, self-harm, risky sexual behaviour, suicide, and homelessness (Pachankis et al., 2021; Jennings et al., 2019). The constant threat of discrimination, rejection, and violence can create chronic stress and undermine feelings of safety and belonging. LGBTQ individuals may internalise these negative societal attitudes and struggle with feelings of shame or self-doubt, contributing to the development of anxiety and depression (Pachankis et al., 2021).

In a Georgia and South Carolina study titled Health needs and experiences of LGBTQ Population in Georgia and South Carolina,‖ it was found out that LGBTQ individuals report unmet mental health care needs at higher rates compared to their heterosexual counterparts (Stepleman et al., 2019). Coping with the stress of prejudice and discrimination can be overwhelming, and some individuals may resort to self-injurious behaviours as a maladaptive means of managing distress. LGBTQ youth, in particular, are at heightened risk for self-harm, as they may face additional challenges related to identity development, peer acceptance, and familial rejection (Pachankis et al., 2021).

Mental health is determined by an interplay between a host of factors which include social, economic, psychological, biological and environmental factors (Reeves et al., 2023). People who experience mental health problems are also at risk of developing other diseases because they are less likely to deploy health promoting and preventive measures or to seek treatment for emerging health issues (Reeves et al., 2023). One key aspect illuminated by this literature is the tendency for individuals with mental health issues to exhibit lower rates of engagement in health promoting activities. Factors such as decreased motivation, fatigue, cognitive impairments, and social withdrawal commonly associated with mental health conditions can hinder individuals' ability to adopt and maintain healthy lifestyle behaviours (Jennings et al., 2019). This may include aspects such as regular exercise, balanced nutrition, adequate sleep, and avoidance of harmful substances like tobacco and alcohol. Consequently, their overall physical health may suffer as a result of these lifestyle factors.

As a socially marginalised group, sexual and gender minority population are exposed to multiple social stressors which has been described as one of the factors undermining the physical and mental health of the population (Sekoni et al., 2022a).

A multistate population based data analysis of 518,986 individuals in the USA revealed a difference in the mental health of transgender and non-binary adults compared to the general population with the former more likely to complain of frequent mental distress (Reeves et al., 2023). In addition, a cross sectional study of 1309 transgender men and women in China, it was found that lifetime prevalence of suicidal ideation and attempted suicide was 56.4% and 16.1% respectively (sekoni, 2020). The same study also reveals that half of the participants in the 2018 _LGBT health in Britain‘ report experienced depression in the previous year; within the same time frame, an estimated 46% of transgender people and 31% of LGB people had suicidal ideation.

Concerns over mental health, particularly depression and anxiety as well as substance abuse are health concerns that disproportionately affect sexual minorities and are particularly pronounced among homosexual and bisexual individuals (Gonzales et al., 2021; Zeeman et al., 2019). Sexual orientation is also associated with chronic stress, with gay men showing lower levels of allostatic load compared to strictly heterosexual men, and bisexual men exhibiting significantly higher levels of allostatic load (Mayer et al., 2018).

In narrating this literature, it becomes apparent that addressing the link between mental health and physical health is crucial for promoting overall well-being. Integrated healthcare approaches that recognize and address the interconnectedness of mental and physical health are essential. This entails not only providing comprehensive mental health services but also integrating screenings and interventions for physical health conditions within mental health settings. Additionally, efforts to reduce stigma surrounding mental illness and improve access to healthcare services among the LGBTQ population are vital for ensuring that individuals experiencing mental health problems receive timely and appropriate care for both their mental and physical health needs. By addressing these barriers and promoting holistic approaches to healthcare within the LGBTQ population, we can mitigate the risk of individuals with mental health issues developing additional health complications and improve their overall quality of life.

2.4.2.2 Preventive and Sexual Healthcare needs

Sexual health disparities are evident among LGBTQ individuals, especially among gay and bisexual men and transgender women, who have higher rates of HIV and other sexually transmitted infections (Cahill et al., 2017; Holmes & Beach, 2020). Research indicates a higher prevalence of anogenital malignancies among men who have sex with men, underscoring the need for tailored healthcare interventions (Coleman et al., 2022). Anogenital malignancies, including anal, penile, and certain types of genital cancers, are of particular concern among MSM which could be attributed to several factors. Firstly, engaging in receptive anal intercourse is associated with a higher risk of contracting sexually transmitted infections (STIs) such as human papillomavirus (HPV), which is a significant risk factor for the development of anal cancer. Additionally, MSM may face unique barriers to accessing healthcare, including discrimination, stigma, and lack of culturally competent care, which can result in delays in diagnosis and treatment. Preventative healthcare service utilisation among LGBTQ individuals is lower, with lesbians, for instance, being less likely to engage in preventive services such as pap smears and clinical breast exams (Ogunbajo et al., 2018). This attitude towards preventive health services usually leads to delayed or avoided medical care resulting in potential missed cancer diagnoses and other health issues (Stepleman et al., 2019).

While it is evident in research that LGBTQ individuals report more unmet health needs and perceive less equitable access to social and medical services compared to heterosexual individuals (Cahill et al., 2017), interestingly Moore et al., (2023) in their study titled ―Investigating the Joint Effect of Allostatic Load among Lesbian, Gay, and Bisexual Adults with Risk of Cancer Mortality,‖ they found that LGBTQ individuals are less likely to seek or discuss health information with a doctor, suggesting a discrepancy in healthcare-seeking behaviour.

The concept of allostatic load, which refers to the cumulative physiological toll that chronic stressors have on the body, provides valuable insight into the health disparities experienced by LGBTQ individuals. Discrimination, stigma, and minority stress are pervasive stressors faced by many LGBTQ individuals, which can contribute to elevated levels of allostatic load. These chronic stressors not only impact mental health but can also have detrimental effects on physical health, including an increased risk of cancer mortality (Moore et al., 2023).

Taking a critical look at this literature, it becomes evident that addressing the disparities in preventive healthcare utilisation among LGBTQ individuals is essential for improving their overall health outcomes. This includes efforts to increase awareness and education about the importance of preventive screenings, as well as initiatives to create more inclusive and welcoming healthcare environments for the LGBTQ population (Coleman et al., 2022).

Healthcare providers should receive training on LGBTQ cultural competency to ensure that they can provide affirming and respectful care to all patients, regardless of sexual orientation or gender identity.

Additionally, targeted outreach and engagement strategies may be necessary to reach LGBTQ individuals who may be marginalised or underserved within traditional healthcare settings. By addressing these barriers and promoting equitable access to preventive healthcare services (Casey et al., 2019), we can work towards reducing health disparities and improving the health and well-being of

LGBTQ individuals.

2.4.2.3 Sensitive and culturally competent Healthcare needs

Stigmatised experiences within healthcare settings, including lack of cultural competency, misgendering, deadnaming, heteronormative assumptions, prejudice, and inadequate healthcare services, create a hostile environment for sexual minorities, impacting their healthcare access and quality of care (Stepleman et al., 2019; Coleman et al., 2022; Gyamerah et al., 2020 Kushwaha et al., 2017). Misgendering and deadnaming, where individuals are referred to by incorrect gender pronouns or former names, respectively, are common experiences that contribute to feelings of disrespect and deletion of LGBTQ identities within healthcare settings. Heteronormative assumptions, such as assuming all patients are heterosexual, can further marginalize LGBTQ individuals and inhibit open communication about their health needs and concerns (Coleman et al., 2022). Prejudice against LGBTQ individuals within healthcare environments can manifest in both overt discrimination and implicit bias. Implicit bias refers to the unconscious attitudes or stereotypes that healthcare providers may hold, which can negatively influence their interactions with LGBTQ patients. For instance, studies have shown that healthcare providers may unconsciously assume that LGBTQ patients engage in higher-risk behaviours, leading to biased clinical decisions (Casey et al., 2019). These biases can result in inadequate treatment or unnecessary tests, contributing to a lower quality of care for LGBTQ patients compared to their heterosexual counterparts. Moreover, inadequate healthcare services, including lack of LGBTQaffirming resources and limited access to gender-affirming care, exacerbate existing health disparities within the LGBTQ community (Stepleman et al., 2019).

Considering this literature, it is essential healthcare providers undergo training and education on LGBTQ cultural competency to foster an environment of respect, inclusivity, and sensitivity towards diverse sexual and gender identities (Gyamerah et al., 2020). Implementing policies and practices that promote inclusive language, affirming documentation practices, and nondiscriminatory care could be crucial for creating a welcoming and supportive healthcare environment for LGBTQ individuals.

2.4.3 FACILITATORS FOR LGBTQ HEALTHCARE UTILISATION

Effective healthcare for individuals who identify as gay, lesbian, bisexual, transgender, or questioning relies on creating welcoming clinical and program environments that promote open communication and ease in discussing issues related to sexual identity, behaviour, and conflicts (Coleman et al., 2022). These environments should be characterised by inclusivity, respect, and sensitivity to the diverse identities and experiences of LGBTQ+ individuals. Creating such environments fosters a sense of safety and acceptance, which is essential for building trust between patients and healthcare providers (Reeves et al., 2023).

Central to the concept of a welcoming clinical environment, is the promotion of open communication therefore, it is crucial for healthcare providers to create spaces where patients feel comfortable discussing issues related to their sexual identity, behaviour, and any conflicts or concerns they may have. Healthcare professionals and personnel should be trained in genderappropriate communication with LGBTQ patients and clients, with considerations such as nondiscrimination laws, inclusive intake forms, and visual cues (Coleman et al., 2022). In a study titled ―Barriers, Motivators, and Facilitators to Engagement in HIV Care Among HIV infected Ghanaian Men who have Sex with Men (MSM)‖ it is found that enrollment onto a National Health Insurance Scheme facilitates health service utilisation among the LGBTQ community (Ogunbajo, 2018). By enrolling in the NHIS, HIV-infected Ghanaian MSM are able to overcome financial barriers to accessing HIV care and treatment, which may contribute to better health outcomes and reduced HIV transmission rates within this community.

Moreover, the study suggests that NHIS enrollment may serve as a motivator for engagement in HIV care among HIV-infected MSM in Ghana. Knowing that they have access to affordable healthcare services through the NHIS may motivate individuals to seek HIV testing and treatment, thereby improving their overall health and well-being. About a third of participants in the same study also noted that socially supportive and nonjudgmental atmosphere experienced in the hospital setting made the care process easy and accessible.

Inclusive Healthcare Environments: Creating inclusive healthcare environments that affirm LGBTQ identities is a critical facilitator in improving health outcomes and access to care for LGBTQ individuals. A growing body of literature emphasises the importance of healthcare providers demonstrating cultural competence, using affirming language, and respecting patients' gender identities and sexual orientations (Bauer et al., 2017; Eliason et al., 2018).

Bauer and colleagues highlight that when healthcare environments are inclusive and affirming, LGBTQ individuals are significantly more likely to seek care. This inclusivity is not just about the physical environment but extends to the behaviours and attitudes of healthcare providers. Providers who are culturally competent—meaning they are knowledgeable about and sensitive to the unique needs and challenges faced by LGBTQ patients—create a space where patients feel safe and respected.

Eliason et al. (2018) further support this by showing that the use of affirming language and the recognition of diverse gender identities and sexual orientations play a crucial role in fostering trust between patients and healthcare providers. When patients perceive that their identities are respected and understood, they are more likely to engage in open communication, adhere to treatment plans, and return for follow-up care.

Both studies underscore the importance of healthcare providers receiving training in LGBTQ cultural competence. This training could include understanding the social determinants of health that disproportionately affect LGBTQ communities, such as discrimination, stigma, and violence, as well as practical skills in using inclusive language and practices. By doing so, healthcare providers can reduce the barriers to care that LGBTQ individuals often face and promote a more equitable healthcare system.

Policy and Legal Protections: Legal protections against discrimination based on sexual orientation and gender identity are essential facilitators of healthcare access for LGBTQ individuals. Research indicates that such protections are crucial in fostering a healthcare environment where LGBTQ individuals feel safe, respected, and more likely to seek care (Eliason et al., 2018).

Cahill et al. (2017) emphasise that legal policies designed to protect LGBTQ individuals from discrimination in healthcare settings significantly enhance their ability to access necessary medical services. These protections help mitigate the fear of discrimination, which has historically been a major barrier preventing LGBTQ individuals from seeking care. When individuals are assured that they will not face bias or unequal treatment based on their sexual orientation or gender identity, they are more likely to engage with healthcare providers and utilise healthcare services.

The study by Cahill and colleagues further suggests that anti-discrimination policies contribute to building trust between LGBTQ patients and healthcare providers. This trust is critical for effective patient-provider communication, adherence to medical advice, and continuity of care. The presence of legal protections reinforces the notion that healthcare settings are safe spaces for all individuals, regardless of their identity, which in turn leads to increased utilisation of healthcare services by the LGBTQ community.

Community Support and Resources: Community-based organisations (CBOs) play a pivotal role in bridging the gap between LGBTQ individuals and healthcare services. According to Grant et al. (2019), these organisations serve as safe spaces where LGBTQ individuals can receive support tailored to their specific needs. CBOs often offer a range of services, including health education, mental health support, and referral to LGBTQ-friendly healthcare providers. By doing so, they not only address immediate health concerns but also foster a sense of community and belonging, which is crucial for the overall well-being of LGBTQ individuals.

Moreover, these organisations often act as advocates for LGBTQ rights, working to eliminate systemic barriers within the healthcare system. Puckett et al. (2019) emphasised that advocacy efforts by CBOs have led to increased awareness and sensitivity among healthcare providers, which in turn has improved the quality of care available to LGBTQ individuals. This advocacy is essential in promoting a more inclusive healthcare environment, where LGBTQ patients can seek care without fear of discrimination or prejudice.

Provider Training and Competence: LGBTQ individuals often encounter healthcare providers who lack the necessary knowledge and skills to address their specific health needs. Sekoni et al. (2017) emphasise that without adequate training, healthcare providers may unintentionally contribute to the marginalization of LGBTQ patients by providing substandard or non-affirming care. This can result in LGBTQ individuals avoiding healthcare services altogether, exacerbating health disparities within this population.

Training on LGBTQ health issues is essential for equipping providers with the knowledge and tools to deliver care that is both competent and affirming. Cahill et al. (2017) argue that such training should include comprehensive education on sexual orientation and gender identity, as well as the social determinants of health that disproportionately affect LGBTQ individuals. By understanding these factors, providers can better address the unique health concerns of LGBTQ patients, such as higher rates of mental health issues, substance use, and sexually transmitted infections.

The literature indicates that healthcare providers who receive LGBTQ-specific training are more likely to offer care that is sensitive to the needs of LGBTQ patients. Sekoni et al. (2017) found that training programs that include content on sexual orientation and gender identity improve providers' cultural competence, allowing them to create a more welcoming and inclusive environment for LGBTQ patients. This, in turn, can lead to increased trust and communication between patients and providers, which is critical for effective healthcare delivery.

Cahill et al. (2017) further suggest that training can help providers recognise and mitigate their own biases, leading to more equitable care for LGBTQ individuals. When providers are educated about the unique challenges faced by LGBTQ populations, they are better able to advocate for their patients within the healthcare system, ensuring that LGBTQ individuals receive the care they need without fear of discrimination or judgment.

Access to Gender-Affirming Care: Gender-affirming healthcare services are vital for the physical and mental health of transgender and gender-nonconforming individuals. Kearns et al. (2021) argue that these services are essential for reducing gender dysphoria—a significant source of distress caused by the incongruence between an individual's gender identity and their assigned sex at birth. Access to hormone therapy and gender-affirming surgeries allows individuals to align their physical appearance with their gender identity, which can lead to improved mental health outcomes, including reduced rates of depression, anxiety, and suicidal ideation.

One of the primary facilitators of access to gender-affirming healthcare is the implementation of policies that ensure insurance coverage for these services. Kearns et al. (2021) emphasise that policies mandating insurance coverage for gender-affirming treatments have significantly expanded access for transgender and gender-nonconforming individuals. Prior to the introduction of such policies, many individuals were forced to pay out of pocket for these costly procedures, creating a substantial financial barrier to care.

Supportive policies not only alleviate financial burdens but also send a powerful message about the legitimacy and necessity of gender-affirming care. These policies often include antidiscrimination clauses that protect transgender individuals from being denied coverage or care based on their gender identity. By legally mandating coverage and protecting patients' rights, these policies play a crucial role in facilitating access to essential healthcare services.

Another critical facilitator of access to gender-affirming healthcare is the availability of knowledgeable and culturally competent healthcare providers. Kearns et al. (2021) indicated that providers who are well-informed about transgender health issues and gender-affirming treatments are key to improving healthcare outcomes for transgender and gender-nonconforming patients. These providers not only offer the necessary medical interventions but also provide care in a manner that respects and affirms the patients' gender identity.

2.4.4 BARRIERS TO HEALTHCARE UTILISATION AMONG THE LGBTQ COMMUNITY

In their study titled Standards of Care for the Health of Transgender and Gender Diverse People, Coleman et al., (2022) indicated access to high-quality healthcare for LGBTQ individuals is impeded by several significant barriers rooted in four major issues: (1) reluctance among some LGBTQ patients to disclose their sexual orientation or gender identity during medical care; (2) a lack of healthcare professionals trained in LGBTQ issues; (3) structural barriers such as limited health insurance coverage and restricted visitation and medical decisionmaking rights for LGBTQ individuals and their partners; and (4) the absence of culturally relevant prevention programs. These barriers collectively create substantial challenges that hinder LGBTQ individuals from accessing essential medical care (Coleman et al., 2022). The literature review under the overarching heading ―barriers to healthcare utilisation among the LGBTQ community‖ is structured around these four areas.

2.4.4.1 Reluctance to Disclose Sexual Orientation and Gender identity

Lesbians gays bisexuals transgender and queer patients often hesitate to reveal their sexual orientation or gender identity when seeking medical care due to concerns about confidentiality, fear of stigmatization, or previous experiences of discrimination (Coleman et al., 2022). LGBTQ individuals may fear receiving non-affirming or discriminatory care from healthcare providers who may not be knowledgeable or supportive of their identities. They may worry about facing judgment, rejection, or even hostility from healthcare professionals, which can deter them from being open about their sexual orientation or gender identity (Coleman et al., 2022).

Some healthcare providers may lack the cultural competency and training needed to effectively care for LGBTQ patients. This can result in insensitive or inappropriate behaviour, further reinforcing the apprehension LGBTQ individuals feel about disclosing their identities. Without assurance that their healthcare needs will be understood and respected, LGBTQ patients may choose to withhold this information to avoid potential mistreatment. This reluctance can impede effective medical care and treatment (Jennings et al., 2019). Internalised homophobia and fear of punishment upon disclosure of sexual orientation or gender identity also serve as barriers to seeking healthcare among LGBTQ individuals, particularly gay and bisexual men (Alencar Albuquerque et al., 2016). Internalised homophobia refers to the act of accepting societal stigma and negative beliefs about homosexuality or same-sex attraction by LGBTQ individuals themselves. It can manifest as feelings of shame, self-hatred, or discomfort with one's own sexual orientation or gender identity. Fear of punishment upon disclosure of sexual orientation or gender identity is closely related to this phenomenon and stems from concerns about potential negative consequences, such as rejection, discrimination, or violence, that may result from revealing one's LGBTQ identity. These individuals may delay seeking medical attention and turn to pharmacies first and seeking help from healthcare facilities only after initial attempts fail (Kushwaha et al., 2017). This may be driven by a perception that these settings offer a degree of anonymity and may not require disclosure of sexual orientation or gender identity. This delay in seeking care can result in missed opportunities for early intervention and treatment, potentially leading to poorer health outcomes.

2.4.4.2 Lack of Culturally Competent Healthcare Providers and Services

The effectiveness of disclosing sexual orientation or gender identity is contingent on healthcare providers being culturally competent and knowledgeable about LGBTQ issues. Unfortunately, professional schools and continuing education programs often lack the necessary training to improve healthcare providers' attitudes and awareness regarding LGBTQ individuals (Zeeman et al., 2019). This knowledge gap may result in insufficient professionals capable of providing LGBTQ patients with the care they need. According to Kattari et al., (2020), more than 35% of their transgender and gender variant sample had to travel more than 25 kilometers to find an experienced provider. The shortage poses a barrier to adequate care to LGBTQ individuals (Zeeman et al., 2019) Research has also found that better care outcomes are associated with greater disclosure and openness with healthcare professionals (Matsuzaka et al., 2021). However, the attitudes of both LGBTQ individuals and healthcare providers play a role in this decision, for example, LGBTQ patients are more likely to come out if they perceive their healthcare provider as accepting and open to discussing their unique health concerns (Coleman et al., 2022; Kcomt, 2019; Ocloo et al., 2021). Misgendering and deadnaming, where healthcare professionals use incorrect names or pronouns for transgender and gender diverse patients, represent significant barriers to care (Meyer et al., 2020). Misgendering and deadnaming invalidate the gender identity of transgender and gender diverse individuals by ignoring their self-identified names and pronouns. This can have profound psychological effects, especially where individuals are vulnerable and seeking support for their health needs, experiencing invalidation of their gender identity can further exacerbate existing stressors and barriers to care leading to discomfort, reluctance to seek further care, and biased treatment, even for common medical procedures (Apodaca et al., 2022). Perceived homophobia and heterosexism among healthcare providers can impact patient-provider interactions and access to care. These perceptions may influence the frequency of healthcare utilisation and the quality of care received (Ocloo et al., 2021)

The absence of LGBTQ-specific prevention programs to address issues such as assault victimization, substance misuse, and mental health among sexual minorities is a critical barrier to healthcare access (Ocloo et al., 2021). Outreach initiatives by healthcare providers to connect with LGBTQ populations and provide affirmative care options are limited, resulting in a lack of understanding among LGBTQ care-seekers about where to find culturally competent providers (Romanelli & Hudson, 2017).

2.4.4.3 Health Insurance and Financial Barriers

Structural barriers within healthcare systems include limitations in health insurance coverage for LGBTQ individuals, particularly in situations related to domestic partnerships. In the United States, only a limited number of organisations and legal systems offer insurance coverage to domestic partners, leaving unmarried partners of LGBTQ individuals with restricted access to healthcare coverage (Ocloo et al., 2021). Furthermore, LGBTQ individuals may encounter higher healthcare costs due to independently purchased insurance policies with higher outofpocket expenses (Ocloo et al., 2021). High unemployment rates, employment in low-paying jobs without benefits, and geographic factors also contribute to financial barriers in accessing healthcare (Conron et al., 2018). Geographic barriers, transportation costs, and a concentration of LGBTQ healthcare facilities in urban areas also contribute to healthcare disparities (Ogunbajo et al., 2018).

2.4.5 SUMMARY OF LITERATURE

In summary, the literature review highlights the systemic challenges faced by LGBTQ individuals, in healthcare. LGBTQ care-seekers often struggle to find culturally competent healthcare providers and LGBTQ-specific clinics, leading to higher rates of forgone care and lower satisfaction with treatment. This is compounded by prevalent prejudice within the healthcare system, resulting in negative health outcomes for this population (Holt et al., 2023a; Kcomt, 2019; Macapagal et al., 2016; Mizock et al., 2021). LGBTQ older adults also face significant barriers, such as fear of stigma and discrimination, overt homophobia or transphobia from healthcare professionals, and financial challenges due to a lack of health insurance. These factors contribute to their delayed or changed healthcare utilisation and worse health outcomes compared to their heterosexual peers (Conyers et al., 2023; Holt et al., 2023; Jennings et al., 2019). Queer-identifying individuals and those questioning their sexual orientation often receive limited research attention, leading to unnoticed health disparities. Additionally, LGBTQ individuals living in rural areas, those from racial and ethnic minority groups, and those with intersecting minority identities report decreased healthcare access and worse health status due to compounded discrimination and structural barriers (Newcomb et al., 2020; Scandurra et al., 2019). Despite increasing social acceptance, ongoing stigmatisation, legal restrictions, and discrimination significantly impact the health of LGBTQ individuals, particularly in areas like mental health and preventive care. Creating inclusive clinical environments, promoting open communication, and training healthcare providers in LGBTQ issues are essential to improving healthcare utilisation (Stepleman et al., 2019; Coleman et al., 2022; Ogunbajo et al., 2018). Barriers such as reluctance to disclose sexual orientation or gender identity, limited health insurance coverage, and the absence of LGBTQ-specific prevention programs further contribute to disparities in healthcare access. Understanding these unique healthcare experiences is crucial for achieving health equity, with efforts needed to address financial barriers, expand research, and enhance provider training (Coleman et al., 2022; Ogunbajo et al., 2018).

CHAPTER THREE

3.0 METHODS

3.1 Introduction

This chapter provides a description of the research methodology employed for the study. The research design, setting, target population, sample, sampling method, tool, and method of data collection and analysis are all explained in this chapter. This chapter also addressed the issue of data management as well as ethical considerations to ensure methodological rigor.

3.2 Philosophical underpinning of the study

The researcher understands that experiences of the LGBTQ community in health utilisation is a phenomenon that is open to multiple interpretations and meanings. Considering this, the interpretivist approach was employed.

According to Anderson et al. (2017), interpretivism holds that reality is not objective or singular, but rather subjective, socially constructed, and open to multiple interpretations. Ontologically, in the context of this study, the researcher recognised that the participants‘ experiences of healthcare utilisation are not objective truths but are influenced by their perceptions, interpretations, and cultural contexts. To understand the complex nature of these multifaceted experiences from the unique perspective of the LGBTQ individuals, the researcher adopted the interpretivist approach.

Epistemologically, interpretivism emphasises the importance of understanding the meanings and interpretations individuals attach to their experiences (Anderson et al., 2017). In this study, the researcher explored the LGBTQ community members' experiences through qualitative methods that allowed them to express their thoughts, feelings, and narratives. Through in-depth interviews, the researcher gathered rich, context-dependent data and gained insight into the diverse ways the LGBTQ community members make sense of their healthcare service interactions.

Axiologically, interpretivism acknowledges that the researcher's values and subjectivity play a role in shaping the research process and outcomes (Anderson et al., 2017). The researcher recognised and openly acknowledged his own perspectives, biases, and values, which influenced how he interpreted and presented the data. This transparency helped ensure that the findings are situated within the researcher's and participants' perspectives, rather than being presented as objective truths.

The interpretivist philosophical foundation for a qualitative study highlights the significance of understanding individuals' subjective experiences, varied realities, interactions, and contextual factors (Anderson et al., 2017). This approach, the researcher believes has allowed him to delve into the rich and varied narratives of LGBTQ individuals' interactions with healthcare services and has contributed to a deeper understanding of the challenges they face.

3.3 Research Design

Research design outlines the core strategies that researchers employ to address specific inquiries (Polit & Beck, 2010). To gain deeper insight into how the LGBTQ population accesses and utilizes health services, this study adopted a qualitative research design, utilizing an exploratory descriptive approach. Instead of focusing on the numbers which is typical of quantitative approaches, qualitative research design inquiry often used to characterise a phenomenon by looking at the feelings, behaviour, ideas, insight, experiences, and activities. Because the qualitative design is flexible, it enables the researcher to characterise the process in relation to its context rather than just outcomes (Sargeant, 2012)), the qualitative design became more appropriate in this study that sought to explore the experiences of LGBTQ community during their health care utilisation. Understanding people's and groups' subjective experiences of healthcare as well as interactions between participants and the healthcare environment is best done using a qualitative approach (Fossey, Harvey, McDermott, & Davidson, 2002). Polit & Hungler (1999) assert that the researcher gets the data directly from the individuals who are experiencing the issues therefore an in-depth insight of the LGBTQ health utilisation experiences was obtained using a qualitative approach. A qualitative method worked well because it focused more on the individual meanings of the experiences and the research was conducted in a natural setting. The qualitative method also yielded more thorough results because of its thick descriptive nature.

The exploratory descriptive approach was deemed more appropriate than other research approaches for this study because it allows for a detailed and flexible examination of a relatively under-researched and sensitive phenomenon. Unlike experimental or purely descriptive quantitative designs that focus on measurable variables and predefined outcomes, the exploratory descriptive approach provides the opportunity to gain deep, contextual, and nuanced insights directly from participants who have lived the experience.

3.3 Research Setting

This study was conducted in the Accra Metropolis, which is the largest population size Metropolis in Ghana (GSS, 2021; Konlan et al., 2022). It also has all the levels of health facilities, including primary, secondary, and tertiary as well as private and government facilities for health service delivery (GSS, 2021). Accra Metropolis is an urban area within the Greater Accra Region and has a total area of about 20.4Km2 with a population 284,124 of inhabitants (GSS, 2021). It is bounded to the North by Ga West, to the West, by Ga South to the south, by the Gulf of Guinea and to the East by La Dadekotopon. Majority of the population are females (50.9%) and the remaining are males (49.1%). A great majority (62.5%) of the population is aged between 15 and 64 years, and only 3.5% forms age 65 and above, with those aged below 15 years forming 31.3% (GSS, 2021). There are different ethnic groups of which Akans form the main ethnic group (39.8%), followed by Ga-Dangme (29.7%) and Ewe (18%).

The Ga people – the indigenous people of the Greater Accra Region, however, represent the largest single sub-ethnic grouping, accounting for 18.9%. The largest religious groups are Christians, which make up 83% of the population, Muslims make up 10.2% of the population, and 4.6%identify as having no religion (GSS 2021).

According to the local government structure, Accra Metropolis is divided into eleven (11) sub-metropolitan areas as follows: Ablekuma Central, Ayawaso West-Wuogon, Ablekuma North, Ablekuma South, Okaikoi South, AshieduKeteke, Ayawaso Central, Ayawaso East, La, Okaikoi North, and OsuKlottey. Some economic activities include manufacturing, farming, fishing, real estate, quarrying, electrical, construction, wholesale trade, financial intermediation, service, retail trade, hotel, restaurant services, gas and water manufacturing, transportation, storage, communication, education, public administration, health, and other social services. The Accra Metropolis houses the government of Ghana administrative businesses as well as international business activities and other private organisations. The metropolis also has a lot of public and private schools. In terms of health facilities, there are a total of 28 government hospitals including Greater Accra Regional Hospital, 60 private hospitals, 130 health centers, and Korle-Bu Teaching Hospital (KBTH) which is a major referral center (GSS, 2021).

The selection of the Accra Metropolis as the study's setting stemmed from its urban diversity, varied healthcare infrastructure, and heterogeneous population. These attributes are deemed crucial by the researcher, and had a positive influence on the study's outcomes. Moreover, the decision was also substantiated by a nationwide behavioural epidemiological survey targeting men who have sex with men (MSM) in Ghana. 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 4,187 to 20,822 individuals (Ogunbajo et al., 2018). It was based on these considerations that the Accra Metropolis was deliberately chosen as the study's setting.

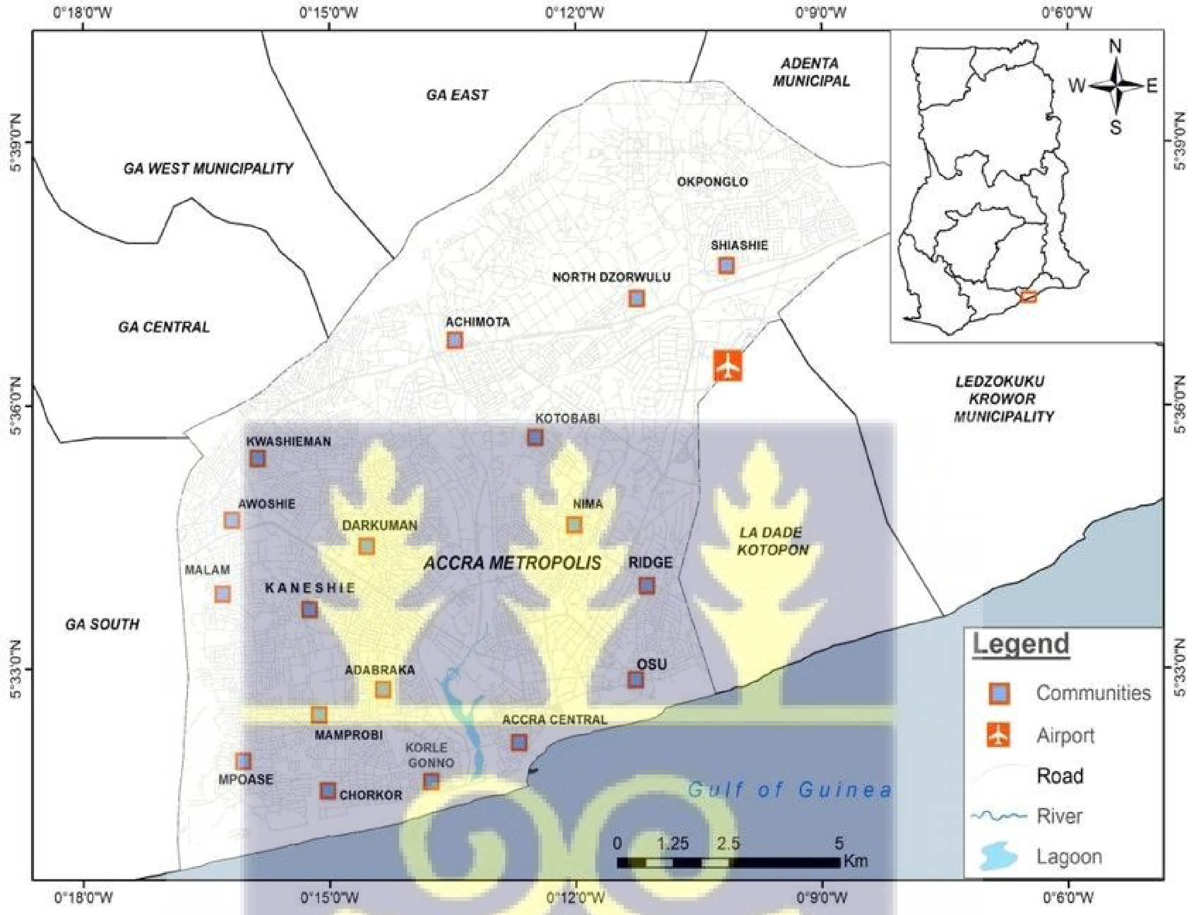

Figure 2.0 map of Greater Accra Metropolis

Source (Fagariba, & Song, 2016)

3.4 Target Population

According to Moen & Middelthon, (2015)), the target population is a group of people from whom the researcher intends to make inferences after the study is complete. These people are seen to have the knowledge to offer important information. The target population for this study consists of LGBTQ community members who reside in the Accra metropolis, and who have utilised healthcare services within the Accra metropolis. This population includes individuals across a spectrum of sexual orientations and gender identities, such as lesbian, gay, bisexual, transgender, and queer. Participants are sought across diverse age groups, socioeconomic backgrounds, and educational levels, to capture a comprehensive range of experiences within healthcare settings in Accra.

3.5 Inclusion Criteria

1. The study included only participants who reside in the Accra Metropolis.

2. The study included participants who identified as members of the LGBTQ+ community, encompassing but not limited to lesbian, gay, bisexual, transgender, queer/questioning individuals, as well as other related gender and sexual identities."

3. Participants were adults, typically, aged 18 and above, and provided verbal informed consent before participating in the study.

4..Participants included LGBTQ individuals who sought healthcare services or attempted accessing healthcare services in the Accra Metropolis.

3.6 Exclusion Criteria

1. LGBTQ individuals with hearing and speech impairment were excluded in the study. This was to ensure accurate data collection since the researcher did not engage the services of sign language interpretators.

2. LGBTQ individuals with mental illness or history of mental illness were also excluded from the study. This was done to ensure accurate data since mental illness-related confounding

factors and other complexities could affect their responses or understanding of healthcare experiences

3. LGBTQ Individuals who reside in Accra Metropolis but have not sought healthcare services or attempted accessing healthcare services in the Accra Metropolis were not included. This was to ensure that the data pertains specifically to those who have interacted with the healthcare system. Including individuals who have not used healthcare services might dilute the findings and lead to data that is not directly relevant to the study‘s objectives.

4. Nurses and Doctors who are members of the LGBTQ community were excluded. This is because their inclusion could introduce bias, as their professional roles might affect their experiences of healthcare utilisation.

3.7 Sample Size and Sampling Technique

The sample size for this study was determined by data saturation. In qualitative research, data saturation refers to the point at which no new information, themes, or insights emerge from additional data collection (Fusch & Ness, 2015).The researcher continued to recruit and interview participants until at a point when no new data or information was emerging from the interviews.

The researcher adopted exponential non-discriminative snowball sampling technique in the participant recruiting process because the target population is a hidden population with limited visibility and very difficult to access. With the snowballing approach, this invisible population was easily accessed. The researcher first identified relevant existing LGBTQ groups and clubs operating within the Accra Metropolis. The researcher then reached out and engaged with the leadership, who are well-connected within these clubs and groups. These individuals provided valuable insights into potential participants who were willing to share their experiences with the researcher. The leadership of these groups then provided the researcher with the contact numbers of these potential participants who were then contacted for consent and interview. Additionally, the researcher also collaborated with friends who are healthcare professionals and working in clinics that were known for being LGBTQ-friendly. These providers served as intermediaries that helped the researcher identified and approached participants who have utilised their services. The initial recruited participant who happens to be a client with complication who sought healthcare in one of the LGBTQ friendly health facilities then also suggested and provided the researcher with phone numbers of other individuals who were suitable for the study. This approach helped uncover hard-to-reach participants and created a more interconnected network of participants. It is the exponential non-discriminative snowball sampling technique that helped the researcher to reach out and interviewed this hard-to-reach population.

3.8 Data Collection tool and Procedure

The researcher employed both face-to-face and phone interviews to gather data on the healthcare utilisation experiences of the LGBTQ population in the Accra metropolis. A piloted semi-structured interview guide (appendix 2) was used for data collection. One LGBTQ individual who matched the inclusion criteria was used for piloting the interview guide. This helped in identifying flaws within the interview guide and addressed them before the main interview. The piloting also gave the researcher the opportunity to sharpen his interviewing skills and techniques before the main interview. The piloting was conducted on one LGBTQ individuals from one of the communities within the Accra Metropolis. 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 two-month, from April to June, 2024. The semi-structured interview format was chosen for its flexibility, allowing participants to express themselves freely, while the use of probes by the researcher facilitated deeper exploration of different perspectives. The Andersen health utilisation model and the study's objectives served as a reference in creating the semi-structured interview guide. After identifying participants using the snowball sampling methods described earlier, the researcher then gave each participant the opportunity either to be interviewed via phone or face to face. By employing either phone or face-to-face interviews, the researcher ensured a well-rounded data collection process that accommodated the diverse preferences and needs of LGBTQ participants. All the participants except one felt more comfortable sharing their experiences over the phone and so fourteen (14) interviews were all conducted via phone while one (1) interview was by face to face lasting forty five (45) minutes to one hour (1hr) on the average. Creating opportunity for either of these approaches (face-to-face interview and phone interview) helped the researcher capture a broader range of perspectives and experiences within the LGBTQ community freely. This flexible approach also helped to increase the willingness to participate. This also led to more open and honest responses, especially for sensitive topics which went a long way to increase the credibility of the data.

The data collection tool consisted of two sections: Section A and Section 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 participants' healthcare utilisation experiences in depth.

The inclusion of demographic data in Section A was crucial, particularly given the study‘s adoption of Andersen's health utilisation model as a guiding framework. The model emphasises the importance of predisposing, enabling, and need-based factors in influencing healthcare access and utilisation. Collecting demographic information allowed the researcher to identify and analyse key predisposing factors such as age, sex, educational level, gender identity, sexual orientation and occupation that may affect participants' healthcare-seeking behaviour and experiences. This facilitated a more comprehensive understanding of how these variables interact with other components of the model in influencing healthcare utiliation experiences within the Accra metropolis.

A proposal for the study was submitted for ethical approval from Noguchi Memorial Institute for Medical Research (NMIMR), University of Ghana.

Consent was also sought from participants verbally (for the phone interview) and in-person (for the face-to-face interview) and the entire interview process was explained for participants to understand before data collection began. All interviews were audio recorded with the consent and permission of the participants.

3.9 Data management

Data management is the process of storing data and making it simple to retrieve or access for analysis (Miles & Huberman, 1994). The researcher separated Section A (demographics) from Section B of the interview guide and assigned unique identifiers or pseudonyms (e.g., Cm1 for Community Member 1, Cm2 for Community Member 2, etc.) to participants to maintain their anonymity. The researcher also avoided using any personally identifiable information in the analysis or reporting of the findings. To ensure data security, all digital data, including audio recordings, transcriptions, coding files, and analysis outputs were stored and backed-up using soft wears. All files are stored and will be protected for five years following the study, at which point they will be destroyed.

3.10. Data Analysis

The data was analysed simultaneously with data collection. The study adopted Braun and Clarke‘s (2020) reflexive thematic analysis approach. This approach is a systematic, iterative process that allows researchers to explore and understand the richness of their data and involves the following steps;

- **Familiarisation with the data**: Researchers immerse themselves in the data to become familiar with it by repeatedly reading the data and taking note of important ideas.
- **Generating initial codes**: Researchers systematically code interesting features of the data in a way that captures the essence of what each data segment is about.
- **Searching for themes**: Researchers look for broader patterns or themes in the codes.
- **Reviewing themes**: Researchers refine and define themes, ensuring they accurately reflect the data.
- **Defining and naming themes**: Researchers create clear definitions and names for each theme.
- **Writing up**: Researchers write up the analysis, providing illustrative examples from the data.
- **Reflexivity**: Throughout the analysis, researchers reflect on how their own background, experiences, and assumptions may influence the analysis.

. The researcher read the transcribed data several times and familiarised himself with the data and made sure the data conformed to what is audiotaped. The researcher then proceeded to code the data, creating initial codes that captured significant portions of information within the content. The researcher 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 scrutinised 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 research report. Throughout the analytical journey, the researcher remained vigilant about his own biases, assumptions, and positions. Acknowledging and reflecting on these factors ensured transparency and credibility of the analysis

3.11 Methodological Rigor

In qualitative research, rigor is used to determine whether the information gathered from the participants actually represent the participant's experiences and can be trusted (Lincoln & Guba, 2016). This study adopted the criteria for trustworthiness defined by Lincoln and Guba (2016). Lincoln and Guba suggest the use of credibility, transferability, dependability, and confirmability to achieve trustworthiness in qualitative studies.

Credibility

Assessing the degree to which the research findings from the data accurately reflect reality and are representative of the participants' is known as the credibility process (Lincoln & Guba, 2016). To establish credibility, the researcher ensured prolonged participation during interviews by probing and conducting member checks. Through member verification, the researcher routinely confirmed the participants' data accurately reflect their opinions. To guarantee that the data are interpreted correctly, all the field notes and data were discussed with the supervisors. Prior to conducting the next interview, the researcher transcribed and coded the transcript of each one. The researcher also carried out a pilot study on one participant before the main study was conducted to ensure the interview guide was fit for purpose.

Transferability

Transferability is the degree to which research findings can be used in other settings (Polit & Hungler, 1999; Lincoln & Guba, 2016). The researcher guaranteed this by using snowball sampling to recruit the participants. The researcher also provided a deep description of the research environment, methods, and participant characteristics, such as gender identity, sexual orientation, religion, marital status, and age. The researcher also ensured that the sample size for the study was determined by data saturation. The clearly defined procedure and methodology adopted by the researcher makes it feasible and easy for this study to be replicated or applied in similar settings and situations.

Dependability

Dependability is the consistency of the methods and techniques the researcher employed to conduct the research. Therefore, it is crucial to ask all participants the identical question in order to ensure consistency when collecting data. Lincoln & Guba (2016); Polit & Hungler (1999). To ensure this, the researcher employed the use of same interview guide, tape recorder, and analysis techniques to guarantee reliability. Additionally, the researcher went over all the interview-related documents with the supervisors, and all the criticisms of the processes and techniques helped to improve the gathering of data in subsequent interviews. The researcher also ensured a detailed description of the research design as well as an explicit audit trail. The researcher also ensured accuracy in his coding during the data analysis

Confirmability

When the research findings are consistent with participant experiences rather than the researcher's own, confirmability is ensured (Polit & Hungler, 1999; Lincoln & Guba, 2016). In order to prevent meaning from being interpreted incorrectly, the researcher made sure he quickly transcribed the information from the participants. The researcher also provided a sufficient audit trail, which included audiotapes, interview transcripts, documentation on emerging themes and categories, comments from the member check, personal notes from the interview, and interpretation, including a draft of the final report. The audit trail makes it easy for the data to easily be verified.

The researcher examined the beliefs, values and experiences of participants and did self-reflection on his beliefs, values and experiences in the same manner. The researcher‘s beliefs and values were made clear and considered so as to help the researcher avoid biases. The researcher also ensured data reduction and accurate data analysis and processing of notes. This will allow independent auditors to cross check the researcher’s reasoning about the data.

3.12 Ethical Consideration

The researcher obtained ethical clearance (appendis 3) from Institutional Review Board (IRB) of Noguchi

Memorial Institute for Medical Research, University of Ghana, Legon with protocol number NMIMR-IRB CPN 059/23-24 (appendis 3).

The researcher first identified relevant existing LGBTQ groups and clubs operating within the Accra Metropolis. The researcher then reached out and engaged with the leadership, who are well-connected within these clubs and groups. These individuals provided valuable insights into potential participants who were willing to share their experiences with the researcher. In other to access more participants, the researcher also collaborated with friends who are healthcare professionals and working in clinics that were known for being LGBTQ-friendly. These providers served as intermediaries that helped the researcher identified and approached participants who have utilised their services. Participants who preferred phone interview provided verbal informed consent while those who were comfortable with the face-to-face interview were given a written informed consent form (appendix 1) to sign before the commencement of data collection. The participants were also told that their participation in the research is voluntary and that they could withdraw at any time they wish to do so. The participants were assured that they would not face any harm when they take part in the study. The participants were informed that there may not be any direct benefits, but their views could help them and others to know what they want from the health facilities and staff. This could also help the health personnel to provide the necessary care that the LGBTQ population requires.

The participants' identities were protected by using pseudonyms to ensure anonymity and confidentiality. Each participant's views were respected during the study. Every information from the participants was also well protected and stored. The information was locked in a cabinet and the key is handled by the researcher.

CHAPTER FOUR

4.0 PRESENTATION OF FINDINGS AND ANALYSIS

4.1 Introduction

This chapter presents the study's findings. The first part deals with the socio-demographic data of the participants, while the second part describes the various themes generated to answer the research questions, taking into account Braun and Clarks' (2020) reflexive thematic analysis approach as a guiding authority.

4.2 Demographic Characteristics of Participants

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. All the fifteen (15) participants were single. Twelve (12) of the participants who took part in the study were Christians while the three (3) were Muslims. With regards to their educational background, all the fifteen participants had a minimum education up to the 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, eight (8) of the participants were employed (driving, fashion designing, research assistant, program officer, graphic designing, bakery attendant, Information Technology, and teaching), one (1) participant was a national service personnel while three (3) were school dropouts; 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: Socio-demographic characteristic of 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
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
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

4.3 Organisation of themes

Based on the constructs of the theoretical framework and the study objectives, and with the adoption of Braun and Clarke‘s (2020) reflexive thematic analysis approach, six (6) themes in all and eighteen (18) subthemes were generated. The major themes that were generated from the interviews were; Patterns of healthcare utilisation, Health challenges, Facilitators of healthcare utilisation, Barriers to healthcare utilisation, recommendations for improved healthcare access, and Community members life experiences.

Table 2: Details of all the themes and subthemes

S/N	THEMES	SUBTHEMES
1	Patterns of healthcare utilisation	a. Primary healthcare utilistion b. Emergency healthcare utilisation c. Specialist healthcare utilisation
2	Health challenges of community members	a. Sexual transmitted infections b. Mental health challenges
3	Facilitators of healthcare utilisation	a. Community-friendly health services b. Affordable and accessible services c. Provider awareness of community member status
4	Barriers to healthcare utilisation	**a.** Negative provider attitude **b.** financial constraints **c.** Behavioural cues of community members **d.** Nondisclosure of community status **e.** stigmatisationStigma among health providers
5	Community members‘ Life experiences.	a. Life in the family b. Life within the community c. Public life
6	Recommendations for improved healthcare access	a. Provider education b. Inclusive care

THEME ONE: PATTERNS OF HEALTHCARE UTILISATION BY THE LGBTQ COMMUNITY

Participants shared their personal experiences and perspectives on the general healthcare landscape for the LGBTQ community. A critical analysis of these nuanced shared experiences and perspectives of the participants culminated in the generation of three subthemes focusing on three critical dimensions: primary healthcare utilisation, emergency healthcare utilisation, and specialist healthcare utilisation taking into accounts the different subgroupings under the overall LGBTQ umbrella

Understanding the trends in primary healthcare utilisation as shared by participants is essential, as it reflects the level of accessibility to health services and preventive care that are crucial for promoting overall well-being. Additionally, the analysis of the shared experiences and perspective on emergency healthcare utilisation sheds light on the immediate and often acute healthcare needs faced by LGBTQ individuals, which the data shows how it often exacerbated by stigma and discrimination. Finally, participant's experiences and perspectives on specialist healthcare utilisation revealed the importance of tailored medical services, particularly in areas such as mental health, sexual health, and gender-affirming care.

Sub-theme A: Primary healthcare utilisation by the LGBTQ community

Primary Healthcare (PHC) utilisation is essential for preventive care, health promotion and ongoing health management. It serves as the first point of contact for individuals within the healthcare system. It is a critical component of preventive care, health promotion, and management of chronic conditions. Participants shared their experiences and perspectives on utilisation of these services and some of the factors influencing the patronage or other wise of these services including but not limited to challenges with accessibility and the perceived quality of care. Access to general practitioners and routine medical services forms the foundation of good health outcomes, yet LGBTQ individuals often face barriers such as discrimination, lack of LGBTQ-competent care, and limited access to inclusive healthcare environments. This analysis sheds light on the experiences of participants from the different LGBTQ subgroupings, such as transgender, gays, and bisexuals, and how these different subgroupings engage with primary care services and the factors influencing their utilisation patterns.

For instance a participant who identifies as bisexual expressed how sometimes he has to bypass a health center closer to him and go straight to the hospital because the health providers there seems not to know what they are doing, He stated:

> *"Sometimes the nurses there don"t seem to know what they are doing, and I end up going to the hospital instead."* (CM 15 bisexual).

A participant who identifies as transgender narrates how the lack of LGBTQ-competent care results in feelings of rejection and frustration, sometimes leading to delayed or avoided healthcare. He explains:

> *"I don't really go for routine check-ups unless it's absolutely necessary. As a trans, every visit feels like I'm preparing for battle. I've had health workers ask unnecessary questions about my gender, and some of them even seem curious in a way that feels invasive. It's exhausting to feel like I'm educating my doctor instead of receiving care."* (CM 1 transgender)

Another participant sharing his experiences raised the issue of limited availability of resources in some primary health facilities. He stated how the primary health facilities sometimes lack the required medications and they will have to seek healthcare from other healthcare levels. He indicated:

"They often don't have the medication I need, so I have to go elsewhere." (CM 14 bisexual) These concerns may be reflecting that while PHC is intended to be the first line of care, inefficiencies in service provision may push patients towards other healthcare levels.

Another participant also indicated how a feeling of being judged or discriminated by healthcare providers can sometimes make LGBTQ community members either delay or avoid routine check- ups or visits. He shared:

> *"….finding health providers who don't judge me for being gay has been tough. I've had doctors ask questions about my sexual activity that felt more like an interrogation. Once, when I went in for an STI screening, the doctor gave me a lecture about being „responsible" even though I was just doing the right thing by getting tested regularly. It is experiences like this which make me hesitant to visit the doctor unless it's becomes necessary. I wish more doctors understood that we're just like anyone else seeking care." (*CM 13 Gay*)*

Furthermore, a participant who identifies as bisexual recounted how misconceptions about sexual health and inappropriate assumptions create an unwelcoming environment, ultimately discouraging healthcare-seeking behavior and fostering mistrust in primary healthcare services. He recounts:

> *"I had a really bad experience with health workers a few years ago. I was at the facility for a check-up, and when the topic of my sexual health came up, the doctor immediately made assumptions about me being promiscuous. They started questioning my HIV status without me even mentioning it. I really felt bad. Now, If I'm feeling sick or need a test, I often have difficulty going to the hospital because I don't want to face those kinds of things." (*CM 6 Bisexual)

Sub-theme B: Emergency healthcare utilisation by the LGBTQ community

Emergency healthcare services (EHS) are utilised during critical and life-threatening situations. Emergency care departments (ECD) provide immediate care for acute and severe conditions. Emergency healthcare can also be a critical point of contact for those who may not have consistent access to other forms of care. In this study, the use of emergency services was often tied to the severity of illness or injury and often marked by mistreatment, subtle biases, and delays in care due to a lack of cultural competence among healthcare providers. One participant who identifies as transgender indicated how she only goes to hospital when it is critical which could be suggesting that emergency healthcare is seen as a last resort for the LGBTQ community, particularly when primary healthcare services are not equipped to handle more serious conditions.

She stated:

> *"I don't usually go to the hospital unless it's an emergency." (*CM 1 transgender)

Another participant also narrated how a friend of his avoided hospital because of bad past experience and was only rushed to the hospital when it became critical. He recounted:

> *" 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" (*CM 4 bisexual*)*

A participant also shared his experience and demonstrated how focusing on gender, rather than immediate medical needs by some health professionals sometimes result in substandard care, increasing both anxiety and potential health risks in emergency settings. He recounts:

> *"I had a severe asthma attack last year and had to go to the emergency room. I was barely able to breathe, and yet, one of the first things they asked was about my gender identity. It was humiliating because it felt like that information was more important than treating my emergency. I could see the confusion on their faces when they got to know I was a community member. It delayed my care, and I felt like they didn't take my condition as seriously because of my affiliation with the community." (*CM 15 Bisexual*)*

Sub-theme C: Specialist healthcare utilisation by the LGBTQ community

Specialist healthcare (SHC) services, such as mental health care, endocrinology, gender-affirming care, and HIV-related services, play an essential role in meeting the specific healthcare needs of LGBTQ individuals. The LGBTQ population may require access to specialist services that address conditions disproportionately affecting them, such as HIV/AIDS, gender-affirming care, and mental health support. Participants shared their individual experiences as well as their perspectives on how barriers such as cost, lack of LGBTQ competent specialists, and geographic inaccessibility often limit their utilisation of these services. The narratives from participants captured the frustrations the LGBTQ community members face when seeking specialist care, particularly when it comes to mental health issues and HIV treatment as well as gender affirming therapies. Many healthcare systems are not equipped to handle LGBTQ health issues forcing individuals to navigate a system that often pushes them toward binary medical models, leaving them without adequate support.

For instance a participant narrated how important LGBTQ-competent HIV care is and how many individuals face stigma and judgment when seeking treatment for HIV, which can result in delayed or inconsistent care. His narration showed that access to a trusted specialist can make a significant difference in long-term health outcomes.

He explains:

> *"I've been on HIV treatment for almost three years, and while I'm grateful that the medication is effective, finding an HIV specialist who understands me as a gay man wasn't easy. Early on, I dealt with doctors who seemed uncomfortable talking about my sexual health or even made me feel like I was being judged for contracting HIV in the first place. I eventually found a specialist who I trust, but it took years. The lack of competent health providers in HIV care makes it difficult for people like me to get the help we need without feeling stigmatised."* (CM 11 Gay)

Another participant who identifies as a bisexual explains the difficulties bisexual individuals face in receiving appropriate care from specialists who make judgmental assumptions. She indicated how these uncomfortable or inappropriate interactions create barriers to accessing necessary sexual health services, contributing to avoidance of care. She explains:

> *"I needed to see a gynecologist for sexual health services, but I had a hard time finding one who didn't assume I was either straight or didn't ask invasive questions about my relationships. One doctor made a comment about how I just needed to settle down with a man,' which made me feel uncomfortable. It's hard to find specialists who don't make those kinds of assumptions or comments. I've had to change doctors several times just to feel comfortable in their office." (*CM 14 Bisexual)

A participant also narrated how his colleagues have difficulty accessing gender-affirming services in Ghana

> *"Getting access to gender-affirming surgery is a long and frustrating process. My friends had to travel out of the country because it is not easy accessing such services here" (*CM 3 Bisexual*).*

One participant also noted the fact that the issue of mental illness is a big challenge within the LGBTQ community yet people don't seek help because of stigma and lack of mental health resources to take care of them. He stated:

> *"Mental health is a big issue in our community, but many people don't seek help because of the stigma and lack of resources." (*CM 12 gay*)*

THEME TWO: HEALTH CHALLENGES OF LGBTQ COMMUNITY MEMBERS

Under this theme, participants shared their personal experiences as well as their perspectives and these were structured around two key areas ie sexually transmitted infections (STI), and mental health challenges. STIs such as gonorrhea, HIV, herpes, anal warts, and genital warts as well as mental health issues including suicidal ideations, suicide, depression, and substance abuse were all highlighted by participants. Thus, the subthemes sexually transmitted infections (STIs) and mental health issues under the overarching theme healthcare challenges of LGBTQ community members were examined.

Sub-theme A: Sexually Transmitted Infections (STIs)

Upon a thorough and critical analysis of participants shared experiences and perspectives, the results showed majority of the health challenges that compelled community members to seek healthcare were basically STIs including gonorrhea, HIV, herpes infection, anal warts and genital warts. For instance, in sharing his first time experience of contracting an STI, a participant who identifies as a bisexual recounted:

> *"My first time I had a sexually transmitted infection, I didn't know what it was and I was so scared I thought that was the end of my life and do you know one funny thing? I even spoke about it with a female colleague of mine at work, that was gonorrhea then, so I didn't know the symptoms and I didn't know what it was, so automatically my mind went afar so I became so down, like I became so shattered yes because if my family finds out now what do I tell them?"* (CM 10 bisexual)

In probing a 27 year old participant on a specific STI she has ever visited the hospital with, this participant who identifies as a lesbian remarked;

> *"For myself, gonorrhea once, I had gonorrhea once" (CM 7 lesbian*)

While another participant when a similar follow up question was asked on infections that he ever sought healthcare for, he noted:

> *"Most of them are STDs, HIV, gonorrhea and other stuff" (CM 3 bisexual)*

A participant also narrated how he accompanied his friend to the hospital for the friend to treat his anal warts condition. This is an excerpt of what he narrated:

> *" 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"(CM 4 bisexual)*

Indeed the analysis revealed with copious evidence that majority of the participants in one way or the other sought healthcare from the health facilities mostly to treat STIs. Another participant in responding to a question regarding diseases he ever went to hospital with, the participant had this to say:

> *" I personally haven"t had a lot of STIs because I am very careful but most often it is either warts or herpes or gonorrhea because this are the most transmitted ones, so the warts, herpes and gonorrhea" (CM 12 gay)*

Sub-theme B: Mental health challenges

The analysis also revealed that mental health issues are another critical health challenge affecting community members and some end up taking away their lives because of nonexistence of supportive systems in place to help such individuals.

One participant expressed a concern on how majority of his colleagues suffer from mental health issues including suicidal ideations as a result of pressure from family and society. He also expressed concerns about how some of them also engage in smoking marijuana and indulge in alcoholism.

This was what he said:

> "*Yes, so most of the community members they suffer mental health issues, there are a lot of people who through this have committed suicide and other things, because some were pressured to go and marry they were not ready, so pressure from the home because they are getting old they need to marry and they are not ready for it, and like everyone is attacking them and out of that they couldn't get proper Phycologist and Counselors to speak to, so they just ended their lives….others also engage in smoking marijuana and taking alcohol to help them think better but rather they turned out to destroy their lives and it gave them kidney diseases and cancer and many more" (CM 4 bisexual)*

One participant also noted:

> *"Mental health is a big issue in our community, but many people don't seek help because of the stigma and lack of resources." (CM 12 gay)*

Another participant who identifies as a bisexual and doubles as a peer educator in the community also had this to say:

> *"The problem with this our work is the mental health issue, as I'm talking with you now I'm taking care of one of us at home, and my family is beginning to have problem with me….and the problem is that he wants to kill himself." (CM 3 bisexual)*

THEME THREE: FACILITATORS OF HEALTHCARE UTILISATION

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. Capturing the voices and experiences of participants, they recounted factors such as community friendly facilities, community friendly services, community friendly providers, affordable services, accessible services, quality care, health insurance use and acceptance as well as being opened to 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.

Sub-theme A: Community-friendly health services

Through a critical analysis of participants' narratives and shared experiences, issues surrounding privacy, anonymity, confidentiality, inclusivity, positive provider attitude, 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 rather preferred facilities far away from where he stays in other 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 the 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 who also appreciated facilities without explicit signs indicating their purpose 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 emphasising 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. Participant had this to say:

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

> *".....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 every body'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 on 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 International Health Care Centre IHCC……. 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)*

Sub-theme B: 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 subsidised cost were shared by participants and indicated how all these factors go a long way to ease healthcare utilisation 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 including 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 10gay)*

Another also stated he patronises certain facilities because of the fact that 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 11gay)

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 patronising 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 subsidise the cost, it is not cheap and is not expensive too, it is moderate" (CM 2 gay)

Sub-theme C: Provider awareness of community member status

Effective communication between patients and healthcare providers is crucial for accurate diagnosis, treatment, and ongoing care. Openness and willingness to disclose relevant health information to the health provider including gender identity or sexual orientation are critical ingredients of effective healthcare. A detailed examination of the results under this subtheme 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 up. 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 to 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 may be 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 continue 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 and was talking to them and then I opened up to them and it was a bit okay, I wanted them 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)

THEME FOUR: BARRIERS TO HEALTHCARE UTILISATION

Participants expressed diverse experiences and perspectives on factors that hinder their healthcare utilisation. A deeper reflection and analysis of the shared experiences and perspectives resulted into the generation of five subthemes. These include; negative provider attitude, financial constraints, behavioural cues of community members, nondisclosure of community member status and stigmatisation among health providers.

Sub-theme A: 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 judgemental attitude of health providers.

For instance, a participant who identifies as a bisexual recounts 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 to 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 utilisation, 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)

*A*nd one also noted:

".yes is one of the greatest thing, the stigma and perceptions and especially in this 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)

Sub-theme B: 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 behaviour and ultimately healthcare utilisation. 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 lack of 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 (NHI) 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 utilisation. 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)*

Sub-theme C: Behavioural cues of community members

Behavioural 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 behavioural cues by healthcare providers can negatively influence the quality of care received. The analysis uncovered the impact of appearance and other behavioural 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 breaded 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 work place 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 famine 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 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)*

Sub-theme D: Nondisclosure of community status

This analysis uncovered a lot of evidences of nondisclosure among community members as shared by participants. For instance a participant out rightly 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 it is difficult 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)*

Sub-theme E: Stigma among health providers

This analysis revealed diverse instances of stigmatisation and discrimination against community members. For instance a participant narrated how he was stigmatised 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 famine 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 utilisation, 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 it's 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 other 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)*

THEME FIVE: RECOMMENDATIONS FOR IMPROVED HEALTHCARE ACCESS

Participants consistently emphasised myriad of barriers that frequently hindered their healthcare and in light of this, made recommendations that were structured around two major areas, provider education and inclusive care.

Majority of the participants indicated that addressing these areas, healthcare systems can better meet the unique needs of LGBTQ individuals.

Sub-theme A: Provider education

The analysis revealed majority of the participants consistently emphasised the need for health providers to be educated on inclusive care practices and approaches. Voices were captured consistently echoing the need for community appropriate communication, provider acceptance of community members, and ensuring privacy and confidentiality in care. For instance, a participant suggested:

> *"okay I think the root cause of all this problems is the brain drain, that is to say that the Nurses and the doctors in the health facilities, especially the government facilities they must be trained. I say they must be trained, I think the Ghana Health Service or the Ghana AIDS Commission can lead this, and they must be trained in inclusive health policies, they should be made to*

understand that there are people like this existing in the population, so that when they get to the hospital they don't automatically assume that the partner is a female, do you get what I am saying?" (CM 2 gay)

A participant also suggested the need for education and sensitisation on the issues of confidentiality and nonjudgemental care. He stated:

"so they need a lot of education and sensitisation, that I am a doctor, I am a Nurse I know my work and my work comes with confidentiality and other persons should understand this and then they should also understand they are not there to judge people, they are there to provide services to make their clients better, yeah so if they are educated they are sensitised on this things, I think it would help and one thing too I also think should be necessary is sometimes, this health centres they should provide key service providers who will specialize in specific I will say infections or something related to the community" (CM 4 bisexual)

Another participant also recommended the need for provider sensitisation on community friendliness and respect for human rights. He indicated:

"well I think the best thing is to make doctors and nurses understand the situation and understand what people feel and they should enjoy their rights no matter their sexuality and no matter wherever they belong they should get their rights anywhere and then probably set an organisation that will go round every facility to talk to them about they being friendly to the community, you don't have to be part of the community, just be friendly to the community to help the community." (CM 6 bisexual)

Sub-theme B: Inclusive and community friendly care

Participants expressed the need to create an inclusive healthcare environment. Recommendations from community members included, ensuring equality and nondiscrimination, ensuring that healthcare settings are welcoming and affirming, ensuring representation of LGBTQ staff and visible support within healthcare facilities.

This is how three participants presented their recommendations regarding representation of LGBTQ staff in health facilities. One said:

"I think more community members should be employed since they understand their community more, so more community members should be employed, yeah that is what I would suggest." (CM 1 transgender)

Another also suggested:

"At least we should have one community member at the hospital, you know you can't tell the Doctor everything, some Doctors when you tell them your problems that is when they will be criticising you and be saying a lot of things before looking for a medicine for you, so I think we should give each hospital or the unit one community member or someone who understands us." (CM 5 lesbian)

The third participant also suggested:

"Oh okay, well like I said before, I think we should have so many community health related facilities, and the health workers have to be community members or people who are allies or people who are very open minded in that regard, that is one of the things that I will recommend and I think that we should try and come to the aid of people who need help in a very confidential and non-risk attached to it, so that a lot of community members will feel like okay if I visit this particular health facility they will know that I am in a place where I can comfortably disclose whatever condition that it will be, or whatever it is that is bothering me, because I know there are situations where people visit the health facility but they will not disclose entire what is wrong with them because they feel they will ask questions that they will be uncomfortable or afraid to do so, so I think that is two things I can recommend." (Cm 8 gay)

One participant also indicated there is no need for special room for LGBTQ health care. What is required is nondiscriminatory care. Here is what the participant said:

"After telling you it shouldn't create any space for you to start discriminating, just treat me or just give me the attention I want but I don't think we will need any special room or whatever it will rather create a lot of attention." (CM 12 gay)

A participant also suggested that:

"Yeah I wish the Nurses won't ask the community members about their sexuality and the Nurses won't look down on them and I wish they can treat everybody equally so that no one will get any bad experience from the facility." (CM 3 bisexual)

A participant also recommended:

"Okay so one, I think we should have community friendly healthcare centres in prioritised regions here in Ghana…. and also we need to re-orient the minds of this healthcare service providers to understand the field they are in." (CM 4 bisexual)

One also suggested:

> *"So like we have a doctor from the community, a nurse like when you are going to Madina Polyclinic you also have a center.. .. Like you won't go like you are going to a normal hospital like you are going there straight, like creating centers for them in the hospitals, that this center is for this people and you are in the community and you feel that you are save, like Mamobi Polyclinic you are going to this department, I hope you get me …So they should create departments, like centres in the hospitals, they should have people from the community who will assist them when they are going to seek health care." (CM 9 bisexual)*

A participant also recommended virtual and anonymous health services. Participant had this to say:

> *" 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)*

A female participant also recommended:

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

THEME SIX: COMMUNITY MEMBERS' LIFE EXPERIENCES

Quite apart from participants' narratives regarding their healthcare utilisation experiences, majority of the participants consistently shared their general life experiences during the interview session. They recounted their experiences within their respective families, within the LGBTQ community, and their experiences with the general public. Thus, the subthemes; life in the family, life within the community, and public life‖ were generated under the overarching theme community members' life experience.‖

Sub-theme A: Life in the family

Participants recounted the diverse family dynamics they encounter within their individual families including challenges with family acceptance, threats of rejection, and the various ways in which community members navigate familial expectations and pressures. For instance a participant explained how the parents will be disappointed in him if the find out that he is into this, however they might not disown him. He explained:

> *"if my parents should find out what like I am actually into, like I don't know what they will do, they wouldn't disown me, I know they wouldn't I know for a fact but the truth is they will be disappointed, for me my elder brother knows, he is a Nurse so he knows, he is okay with that, he is only cautioning me to be cautious of the people I engage with because of the prevalence of STIs and other diseases." (CM 2 gay)*

Another participant who identifies as a gay also explained how he is the only boy among his father's children and some of his siblings do not approve of his community membership because they expect him to marry and produce children to continue their family lineage. He said:

> *"because now that my sister who doesn't want me to be so, because we are only four siblings three girls and myself, so they don't understand the fact that their only brother is going to be so. That one won't be entertained, because they believe they will get married and their father's name will be changed and then I have to make family to bear my Daddy's name, so they won't understand." (CM 13 gay)*

He equally narrated how the mother loves him and he has to keep telling lies to maintain that relationship anytime the mother asked him who his girlfriend is? This is what he said:

> *"...but because of my Mum I didn't want to disappoint my Mum and all of that, and my Mum too she always ask me so who is your girlfriend now, who is she, so who is that and me when I talk to her she listens and I will be like she knows the situation in which we are now and me I want to make money before I think of marriage and all of that, so sometimes if my aunties say eii so you Won't come and show us our in-law and all of that, she will just say you guys should leave my son alone, he is making money if he makes money you people will see her" (CM 13 gay)*

A participant also narrated how the mother was in support of his LGBTQ membership and even pierced his ears for him. He stated:

> *"..because my mother was supporting what I was doing, and sees me as her daughter she is even the one who pierced my ears for me." (CM 11 gay)*

Sub-theme B: Life within the community

The analysis revealed how the LGBTQ community itself serves as a vital source of support, identity, and solidarity. The analysis also highlighted the interactions and relationships within the LGBTQ community itself. The analysis also discovered the significance of community organisations, social networks, and communal events in providing safe spaces for self-expression and mutual support.

For instance a participant shared how supportive organisations help community members access health service with ease. He stated:

> *"Okay so we have community base organisations that are into easier health assessment for community members, so they can give you contacts of facilities where they have trained Nurses and you can just go and talk to them and they will help you." (CM 12 gay)*

Another participant also revealed how community based NGOs even organise workshops for community members even though patronage is always low because of fear of stigma. He said:

> *"Yeah it is something that is being done, but majority of the members don't attend the workshops all because they know that if I come and this person sees me, maybe they will go and say that I am also part of the community, I don't know if you get what I am saying?" (CM 2 gay)*

A participant also noted how they even have community members who are peer educators specifically for community members but some of the community members are not aware; He noted:

> *"For the health service some of them don't know that we have peer educators for community members, community members don't know so they go to the hospital on their own, that one they charge you according to your problem." (CM 3 bisexual)*

A participant's shared experience showed how there is mutual support and solidarity within the community especially in time of need. He recounted how he was taken care of by a colleague in his house for about one week when he was seriously sick and only had to go back to his parents when his parents got disturbed and were worried. He recounted:

> *"I can say it was just like a week, because my family were disturbing him to tell them where I was, and they started threatening him and were calling my number too, so I even had to switch off my phone, so my phone was off for about a week and since my family were all disturbed and worried about where I could be, I decided to go back home even though I had not recovered" (CM 10 bisexual)*

Sub-theme C: Public life

Participants expressed how navigating public life as an LGBTQ community member presents its own set of challenges. The analysis examined the diverse experiences of LGBTQ people in the broader society as they encounter varying degrees of acceptance, discrimination, and visibility. A participant who identifies as a transgender man expresses her disquiet about how police arrested her and her colleagues and collected their money for identifying as transgender. She recounted:

> *"I think somewhere last two years, my friends and I were arrested by some police officers, for identifying as trans, so they arrested us and took money from us which was defamation and crime, why are they taking money from us for being who we are and they have stolen our money from us, so that is it." (CM 1 transgender)*

Another participant who identifies as a bisexual also shared how he encountered homophobic threats from someone online through his dating App.. He said:

> *"….and he said that he is a homophobic and he is against this one and he want to catch this people around Adenta so that is why he introduced himself on the App and he is tracking them and they will beat you, that is what he said and I got shocked and even afraid for my life at that time, that was early last month he sent a picture and I also sent mine and he said that he knew me and he will let people beat me, what I am doing is it good? why should I myself like that, he is a homophobic and he swear he is tracking some guys around and then beat people who are into this so I was afraid and I am having a friend who told me to be careful, he sent me a video where they caught a community member and they were beating him naked, so for now I am*

really afraid even when I am doing, I am doing it low like even now I am not on any App, I am not on any dating App I am meeting the people that I know that is what I am doing now, I am not on any App." (CM 9 bisexual)

Another participant, who identifies as gay, shared his fear of stigma, which has made him hesitant to attend church. He expressed concern that pastors might prophesy about his sexual orientation, revealing his identity to others. He explained:

"So at a point because of what I am doing, I am scared to go to church because maybe a Prophet will see something…a Prophet will be like young boy come, why are you doing this and that and the person will reveal what I am doing to the public and all of that, so I was scared to go to church, so at a point my Mum didn't understand the reason let's go to church I will say she should take the lead I will come, then I won't come, she should take the lead I will come, then I won't come and I prayed over it severally but then it is what it is, and then I gathered some courage I started going to church and anytime I am being called by a Prophet or something no Prophet has ever made mention about it before, they talk about something else and all of that so I started becoming comfortable and all of that." (CM 13 gay)

A participant also explained how he is very discrete and mindful of his environment because the Ghanaian society is intolerant and hostile towards the community members. He explained how a community member was beaten in a trotro just for how he talks. He explained:

"I don't even know where to start from, you see, African society specifically Ghanaian society we are very hostile towards this thing, we are intolerant, in fact we don't even want to have a room for discussion for it because we are being brain washed to understand that it is a foreign import, it is not a foreign import, it is not something that is being forced on us, it has been with us since time immemorial and even before the colonizers who are now being accused of introducing this came, but for me, I am being discrete as possible and I am taking charge of my own security, I am being mindful of my environment, I know how to behave wherever I find myself, because there is an instance where someone has been beaten in trotro just because of how the person talks." (CM 2 gay)

One also noted:

I think 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)

Whiles one also expressed his disquiet about community members who are stigmatised and bullied in schools, homes and even hospitals. Some are even denied food, and kicked out of their homes. He narrated:

"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 bi-sexual that is why, yeah so I have not experienced bullying before but some people go through bullying at schools, homes even some of them their own family members kick them out from their house, they don't give them food they don't give them place to sleep and they will be on the street struggling for their lives, that thing is not good, is not very good." (CM 3 bisexual)

A participant also narrated how he always gets scared anytime parliament is deliberating on the LGBTQ private member's bill currently in parliament. He stated:

"I am afraid, I am very, very afraid whenever I see parliament having issues over this and they are putting pressure and I think law is law so if they pass it and it becomes a law, I don't think the community can do something to protect us." (CM 9 bisexual)

4.4 SUMMARY OF THE FINDINGS

Using Braun and Clarke's (2020) reflexive thematic analysis approach, the study generated six main themes and eighteen subthemes from the data. A total of fifteen participants, predominantly male and aged between 22 and 30, took part in the research. They identified as bisexual, gay, lesbian, or transgender and came from diverse backgrounds in terms of occupation, religion, and educational status, including employed individuals, students, and school dropouts.

The findings revealed distinct patterns in healthcare utilisation among LGBTQ individuals, particularly in relation to primary, emergency, and specialist healthcare services. Participants reported a tendency to avoid or delay accessing primary healthcare, largely due to experiences or fears of discrimination and the absence of LGBTQ-competent healthcare providers. As a result, many resorted to emergency care only when absolutely necessary. However, emergency healthcare services were also reported to be problematic, often involving mistreatment, delayed care, and hostile attitudes from healthcare professionals.

Although specialist healthcare services—particularly for mental health, HIV care, and gender-affirming treatments—were seen as crucial and highly valued, participants encountered significant barriers to access. These included limited availability, geographical inaccessibility, and judgmental assumptions made by some healthcare providers, which discouraged continued engagement with care.

A notable health concern highlighted by the participants was the high prevalence of sexually transmitted infections (STIs) such as gonorrhea, HIV, and anal warts. While many sought treatment for these conditions, they often did so with considerable hesitation due to stigma and negative attitudes from healthcare providers. In addition to physical health concerns, mental health emerged as a critical issue. Participants reported struggles with depression, suicidal thoughts, and substance use, often linked to family rejection, societal pressure, and isolation. The lack of LGBTQ-sensitive mental health services meant that many psychological challenges remained unaddressed.

Throughout the study, participants expressed concerns about discriminatory attitudes from healthcare providers, financial limitations, and the fear of stigma, all of which significantly impacted their willingness and ability to seek care. Many deliberately avoided disclosing their sexual orientation or gender identity during healthcare visits, fearing that such disclosures would lead to poorer quality of care, judgment, or invasive questioning. These experiences contributed to a broader mistrust in the healthcare system, particularly in primary and emergency care settings.

Despite these challenges, participants emphasized the importance of accessible, inclusive, and affordable healthcare services. The presence of LGBTQ-friendly providers—those who demonstrated cultural competence, respect, and understanding of diverse identities—was seen as key to improving healthcare utilisation. Participants also underscored the need for specialist mental health and HIV services delivered in non-judgmental, supportive environments.

Finally, the study revealed that LGBTQ individuals face significant societal pressure and discrimination not only in healthcare settings but also within their families, communities, and public spaces. These pressures exacerbate mental health challenges and further hinder access to necessary care.

Based on these findings, the study recommends increasing provider education to enhance cultural competence, implementing more inclusive care practices, and expanding access to mental health and specialised services tailored to LGBTQ needs. Such measures are critical to improving health outcomes and reducing the stigma and systemic barriers that continue to affect LGBTQ individuals' access to equitable healthcare.

CHAPTER FIVE

5.0 DISCUSSION OF FINDINGS

5.1 Introduction

This chapter discusses the study findings in relation to relevant literature that was reviewed. The discussion was organised according to the main themes and subthemes that were presented in chapter four. The areas discussed are patterns of healthcare utilisation, health challenges of the LGBTQ community, facilitators of healthcare utilisation, barriers to healthcare utilisation, recommendations for improved healthcare access and LGBTQ community members‘ life experiences.

5.2 PATTERNS OF HEALTHCARE UTILISATION

The study reveals that LGBTQ individuals face considerable barriers to engaging with primary healthcare (PHC) services, often due to discrimination, limited accessibility, lack of quality care and lack of LGBTQ-competent care by health providers. The findings indicate that these barriers discourage routine healthcare utilisation and push LGBTQ individuals, especially those with additional marginalisation, toward emergency care, where they encounter less inclusive treatment. Participants reported feelings of rejection and frustration when providers lack awareness of LGBTQ-specific needs. This finding of the study aligns with studies by Marti-Pastor et al. (2022) and Shaver et al. (2018), which highlighted LGBTQ patients' negative experiences in PHC and avoidance of routine care due to providers‘ limited cultural competence and discrimination

The limited engagement with PHC has several adverse health implications for LGBTQ individuals. For instance, the avoidance of routine care could lead to untreated chronic conditions, preventable health crises as well as delayed diagnosis which could go a long way to increase the economic and health cost of care. This avoidance of PHC care could also risk higher morbidity and mortality rates within the LGBTQ community.

These findings of the study therefore point to a need for systemic changes in healthcare policies and practices to foster an inclusive environment for LGBTQ individuals. For instance a mandatory LGBTQ cultural competency training for healthcare providers could be essential in medical and nursing education. These training programs should focus on reducing biases, educating providers about LGBTQ-specific health concerns, and equipping them to offer gender-affirming care sensitively.

With regard to emergency healthcare utilisation by the LGBTQ community, diverging perspectives were noted in the literature, such as Kruse et al. (2022), which found that some transgender and non-binary individuals actively avoid emergency care due to concerns about misgendering, discrimination and disrespect from health providers. This contrasts with some participants' accounts, which indicate that, despite the potential for disrespect and biases, The LGBTQ community utilised emergency services more especially in critical moments, as the anonymity of emergency settings often alleviates fears of judgment and discrimination.

The relative high patronage of emergency care services among the LGBTQ population shows a certain pattern of healthcare engagement, ie only when conditions become critical. The findings could be attributed to the low patronage of PHC by the LGBTQ community members which could lead to late diagnosis and complications compelling them to seek healthcare in emergency departments only in critical conditions. There is therefore the urgent need to address the challenges within the primary healthcare system in other to avert this trend.

Addressing the issue of limited accessibility, lack of provider competence, and discrimination may require outreach and inclusivity efforts. Health systems should engage in targeted outreach to LGBTQ communities to build awareness of inclusive healthcare options. LGBTQ-friendly signage and standardised procedures for collecting gender and sexual orientation data could further enhance patients' comfort and encourage disclosure, improving patient-provider communication and care outcomes.

Additionally, telehealth options for specialist LGBTQ care could also be of help. Expanding telehealth for LGBTQ-specific needs can improve access to specialised services, particularly in underserved areas where LGBTQ-competent providers are limited. This approach aligns with findings from Morris et al. (2019), suggesting telehealth as a viable solution to bridge accessibility gaps in LGBTQ healthcare.

While this study affirms many established findings regarding the healthcare utilisation patterns of LGBTQ individuals, it also provides nuanced insights that complicate or diverge from previous research. For example, while Marti-Pastor et al. (2022) and Shaver et al. (2018) emphasize broad avoidance of routine care due to discrimination, this study reveals that some LGBTQ individuals still engage with emergency care despite similar concerns, particularly due to the perceived anonymity and immediacy of such settings. This contrasts with findings from Kruse et al. (2022), where transgender and non-binary individuals reportedly avoided emergency care altogether due to the potential for misgendering and disrespect. This divergence suggests that healthcare-seeking behaviour is not monolithic across the LGBTQ spectrum, and may be shaped by intersecting factors such as socioeconomic status, geographic location, urgency of care needs, or prior trauma.

5.3 HEALTH CHALLENGES OF COMMUNITY MEMBERS

The findings of this study reveal several challenges faced by participants during the utilisation of healthcare services within the Accra Metropolis. These challenges included high rate of STIs and mental health challenges including substance abuse and suicidal attempt. The study revealed that majority of LGBTQ community members sought healthcare primarily for the treatment of STIs such as gonorrhea, HIV, herpes, anal warts, and genital warts. The study further revealed that the STI prevalence was comparatively higher among the bisexuals as all the bisexuals reported incidence of one STI or the other. These findings align with existing literature, which indicates higher prevalence of STIs among LGBTQ individuals, particularly among gay and bisexual men and transgender women (Cahill et al., 2017; Holmes & Beach, 2020). The higher prevalence could be attributed to the lack of targeted sexual health education and resources specifically addressing the needs of the LGBTQ community especially in a country where this population is marginalised and not accepted. The comparatively higher prevalence of STIs among bisexuals could also be attributed to the fact that bisexual individuals may have sexual partners of different genders, which can increase their risk of exposure to STIs if safer sex practices are not consistently adhered to. The high prevalence of STIs among LGBTQ individuals, particularly bisexuals, has significant health implications. Increased STI rates can lead to a range of health issues, including long-term complications such as infertility, chronic pain, and increased susceptibility to other infections (e.g., cancers). The burden of these health issues can be exacerbated by stigma and discrimination, which may discourage individuals from seeking timely medical care and adhering to treatment regimens (Holt et al., 2023; Kcomt, 2019). This finding could be a wakeup call for targeted interventions and policy changes to address the STI disparities among LGBTQ individuals. Key policy implications could include enhanced sexual health education, increased access to healthcare service, stigma reduction initiatives, and policy on integration of services.

Notably, all the three cases of anal and genital warts discovered by the study were reported exclusively by only gay participants. The reporting of anal and genital warts exclusively among gay participants is consistent with findings from previous studies that found higher rates of certain STIs, including HPV-related conditions, among men who have sex with men (MSM) ((Holmes & Beach, 2020; Mayer et al., 2018). Anal intercourse, which is more common among gay men, is said to be associated with a higher risk of HPV transmission. The fragile mucosal lining of the anus makes it more susceptible to tears and micro abrasions, facilitating the entry of the virus. This could therefore be a wake-up call for the need to promote HPV vaccination, regular screenings for STIs, and educational campaigns about the importance of preventive care.

The higher prevalence of anal and genital warts among gay men has significant health implications. HPV-related conditions can lead to complications such as chronic pain, psychological distress, increased risk of anal cancer, penile and oropharyngeal cancers, (Coleman et al., 2022). To mitigate the high prevalence of HPV-related conditions among the LGBTQ population, enhanced HPV vaccination programs are crucial. Policies should focus on increasing vaccination coverage among gay men and other high-risk groups. A study by Holmes & Beach, (2020) emphasised the need for targeted vaccination campaigns and accessibility improvements to ensure that MSM receive the HPV vaccine. Policies should also support regular screening and early detection of HPV-related conditions. Coleman and colleagues in 2022 suggested that routine anal cancer screening for high-risk populations, including MSM, can help identify precancerous lesions early and prevent cancer development. Expanding access to such screening services can improve health outcomes and reduce the burden of HPV-related diseases.

In this current study, mental health issues also emerged as another critical finding within the LGBTQ community including substance abuse, suicide, and suicidal ideations. This finding agrees with previous studies that indicated that LGBTQ individuals experience higher rates of mental health issues due to ongoing stigmatisation, discrimination, and minority stress

(Fredriksen-Goldsen et al., 2019; Jennings et al., 2019; Pachankis et al., 2021; Silveri et al., 2022). This finding could be linked to the constant societal and familial pressures for community members to conform to societal expectations as well as the lack of societal and family acceptance, undermining the feelings of safety and belonging leading to substance abuse, depression and consequently suicidal ideations and other mental health problems. It could as well be attributed to lack of targeted supportive mental health services.

The mental health challenges faced by LGBTQ individuals, including substance abuse and suicidal ideation, have profound health implications for their overall quality of life. These issues can lead to chronic health conditions, decreased life satisfaction, and reduced ability to function effectively in daily life. To address the mental health needs of LGBTQ individuals, there is a critical need for improved mental health services. Policies should focus on enhancing access to mental health care that is specifically tailored to the needs of LGBTQ individuals. This includes increasing the availability of culturally competent mental health professionals and integrating LGBTQ-specific issues into mental health training programs. Public health campaigns should focus on raising awareness about mental health issues within the LGBTQ community and promoting the availability of mental health resources. Educational campaigns can help reduce stigma and encourage individuals to seek help before issues escalate.

5.4 FACILITATORS OF HEALTHCARE UTILISATION

The study found that Facilities that ensured confidentiality and do not explicitly indicate their purpose were preferred. It also revealed 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. (2022), 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. (2023), 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 are supporting the need for discretion in healthcare settings including the need to create welcoming clinical environments as recommended by Reeves et al. (2023).

The preference for confidentiality and discretion in healthcare settings has significant health implications for LGBTQ individuals. 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 (Mayer et al., 2018). 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.

The findings of this study have several policy implications. First, healthcare policies should prioritise the creation of welcoming and inclusive environments that protect patient confidentiality. 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. Additionally, policies should encourage the development of LGBTQ specific training for healthcare providers to ensure that care is delivered competently and sensitively.

A study titled; Barriers, Motivators, and Facilitators to Engagement in HIV Care Among HIV infected Ghanaian Men who have Sex with Men (MSM) conducted by Ogunbajo (2018), 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 Ogunbajo, (2018) corroborates with the findings of this current study where participants consistently emphasised 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 subsidised and free services for STIs and community related infections in most of the community friendly facilities especial when an individual is taken to the facility by a peer educator.

Taking into accounts the findings of this study, one can hypothesise that, by offering subsidised 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. 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.

Another important discovery of this study was the fact that 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 Coleman et al., (2018) on Standards of Care for the Health of Transgender and Gender Diverse People.These findings also align with the studies that emphasise the importance of creating spaces where LGBTQ individuals feel comfortable discussing their sexual identity and health concerns (Reeves et al., 2023). The positive impact of provider awareness and understanding of LGBTQ-specific health needs is also noted in the study by Coleman et al. (2022), 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 utilisation. This finding contrasts with existing literature that highlights the potential for discrimination and stigma faced by lesbians in healthcare settings (Acquah et al., 2023). This finding could be as a result 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. 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 health challenges uncovered in this study particularly the high prevalence of STIs and mental health concerns are consistent with global literature on LGBTQ health disparities. However, the data also reveal context-specific dynamics that warrant deeper reflection. For instance, while studies from high-income countries like the U.S. and parts of Europe have documented rising STI rates among gay and bisexual men (Mayer et al., 2018; Holmes & Beach, 2020), many of these contexts have simultaneously scaled up access to LGBTQ-friendly sexual health education, PrEP programs, HPV vaccination, and routine STI screening services. In contrast, within the Ghanaian context and by extension, many African settings where LGBTQ identities remain criminalised or heavily stigmatized such targeted interventions are largely absent (Jennings et al., 2019).

Moreover, while global studies (Fredriksen-Goldsen et al., 2019; Pachankis et al., 2021) link LGBTQ mental health challenges to minority stress and discrimination, these stressors appear to be further compounded in the Ghanaian context by widespread social, religious, and legal rejection. Unlike countries with legal recognition and civil rights protections for LGBTQ people, Ghana offers little institutional or psychosocial buffer, leading to intensified experiences of alienation, family estrangement, and internalised stigma all of which are contributing factors to the substance abuse and suicidality reported in this study.

5.5 BARRIERS TO HEALTHCARE UTILISATION

The study recorded significant cases of judgmental, discriminatory, and other attributes of negative provider attitude towards community members by health providers in their quest to seek healthcare leading to feelings of dismissal and disrespect. This agrees with existing studies (Coleman et al. 2022; Kcomt, 2019), that noted that reluctance to seek healthcare by the LGBTQ community 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 utilisation 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. The implications of negative provider attitudes on health outcomes could even be more significant. 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.

Furthermore, the mistrust generated by negative provider attitudes can lead to a broader disengagement with the healthcare system. 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. 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.

Ensuring that health facilities enforce strict anti-discrimination policies in facilities, clearly outlining the consequences of discriminatory behaviour and providing a framework for reporting and addressing such incidents will go a long way to reduce the incidence of negative provider attitude.

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 (Conron et al., 2018; Ocloo et al., 2021), 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 utilisation 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. This can result in higher rates of chronic diseases and preventable conditions within the LGBTQ community. 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.

Moreover, financial barriers can lead to a reliance on emergency care and other less effective alternative care rather than preventive services, which is both costlier 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 contributes to worse health outcomes for individuals.

The study further revealed that behavioural 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 (Kcomt, 2019;) that indicated how LGBTQ individuals with visible tattoos and piercings often encounter biased assumptions regarding their health behaviours 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.

Given the above revelation, it is reasonable for one to make the assertion that there exists a knowledge gap that requires 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. A participant explicitly noted, I don‘t disclose myself because I know that here in Ghana is illegal. 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. This is consistent with Coleman et al. (2022) who noted that reluctance to disclose sexual orientation or gender identity can impede effective medical care. The health implications of nondisclosure could be more profound. 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.

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 decriminalisation of LGBTQ identities and behaviours, which would reduce the fear of legal repercussions and encourage individuals to disclose their status when seeking care. Decriminalisation could also contribute to reducing societal stigma, making it easier for LGBTQ individuals to access healthcare services without fear of mistreatment. 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.

Additionally, policies should support the establishment of LGBTQ-friendly clinics and healthcare services, particularly in regions where discrimination and stigma are prevalent. These specialised 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.

Barriers including stigmatisation and prejudice from healthcare providers were pervasive, leading many participants to avoid healthcare services altogether. This finding is consistent with previous studies that have highlighted the impact of stigma on healthcare access for LGBTQ individuals (Meyer et al., 2020). The participants' narratives provide concrete examples of how stigma manifests in healthcare settings.

The health implications of stigmatisation and prejudice in healthcare settings could be profound. For instance, the psychological impact of stigma can exacerbate mental health issues, leading to higher rates of anxiety, depression, and suicidal ideation among LGBTQ individuals. When healthcare providers exhibit prejudice, it can reduce trust in the healthcare system, leading to disengagement and reluctance to seek help even in emergencies. This mistrust is particularly damaging in the context of HIV/AIDS care, where early detection and consistent treatment are crucial for managing the condition and preventing its spread.

Critically examining the findings within a broader global context reveals both commonalities and distinctions in the barriers faced by LGBTQ individuals in accessing healthcare. The themes of provider discrimination, financial barriers, fear of disclosure, and stigma are widely documented in global literature (Kcomt, 2019; Meyer et al., 2020). However, this study adds nuance by highlighting how these barriers are intensified in socio-legal contexts like Ghana, where homosexuality remains criminalised and socially stigmatised. In contrast, studies from more inclusive contexts such as Canada, the Netherlands, or parts of the U.S.—have shown that legal protection and anti-discrimination policies significantly reduce healthcare avoidance and improve LGBTQ health outcomes (Conron et al., 2018; Cahill et al., 2017).

5.6 RECOMMENDATIONS FOR IMPROVED HEALTHCARE ACCESS

One of the most consistent recommendations from participants in this study was the need for enhanced education and training for healthcare providers on LGBTQ health issues. This resonates with findings from previous studies (Cahill et al., 2017; Sekoni et al., 2017), which highlight the positive impact that well-informed and culturally competent healthcare providers can have on the healthcare experiences of LGBTQ individuals. Participants in this study emphasised that healthcare providers often lack the knowledge required to effectively address the unique healthcare needs of LGBTQ patients. They noted instances where healthcare providers exhibited discomfort or a lack of understanding regarding LGBTQ identities, resulting in suboptimal care, delays in treatment, or outright avoidance of healthcare services by LGBTQ individuals.

The importance of training healthcare providers to understand that LGBTQ individuals are a significant part of the population they serve cannot be overstated. Participants in this study expressed the need for healthcare providers to recognise the diversity within the LGBTQ community and to offer personalised care that respects individual experiences and needs. This aligns with the findings of Cahill et al. (2017), who argue that comprehensive LGBTQ health training should include content on sexual orientation, gender identity, and the unique health risks faced by LGBTQ individuals. Similarly, Sekoni et al. (2017) emphasised the importance of ongoing education and the integration of LGBTQ health topics into medical curricula to prepare future healthcare providers.

Furthermore, participants in this study highlighted the importance of training providers not only in medical care but also in creating a welcoming and affirming environment for LGBTQ patients. This suggests that training should not be limited to clinical skills but should also encompass communication strategies, the use of inclusive language, and the importance of respecting patients' gender pronouns and identities. Healthcare providers who are trained in these areas are more likely to foster trust and build strong patient-provider relationships, which are essential for improving health outcomes among LGBTQ individuals.

Participants in this study also called for the creation of more inclusive healthcare environments, a recommendation that is consistent with existing literature (Coleman et al., 2022; Reeves et al., 2023). An inclusive healthcare environment is one in which LGBTQ individuals feel safe, respected, and supported. Participants noted that such environments are critical for open communication, which is essential for accurately diagnosing and treating LGBTQ individuals. They expressed that without an inclusive and affirming setting, many LGBTQ individuals are reluctant to disclose their sexual orientation, gender identity, or health concerns related to these identities. This reluctance can lead to a range of negative health outcomes, including missed screenings, delayed diagnoses, and inadequate treatment.

The concept of an inclusive environment goes beyond mere tolerance; it requires proactive measures from healthcare providers and institutions to ensure that LGBTQ individuals feel welcomed and understood. Participants in this study stressed the importance of visible signs of inclusivity, such as LGBTQ-friendly signage, gender-neutral bathrooms, and the use of inclusive forms and documentation. Such measures not only signal to LGBTQ individuals that they are safe in the healthcare setting but also promote an atmosphere of respect and dignity. This is supported by Reeves et al. (2023), who argue that inclusive environments foster trust and improve the overall quality of care for LGBTQ patients. Coleman et al. (2022) further highlight the importance of such environments in promoting positive patient-provider interactions, which are crucial for addressing sensitive health issues that LGBTQ individuals may face.

The creation of inclusive environments also involves policy changes at the institutional level. Participants in this study recommended that healthcare institutions adopt inclusive health policies that explicitly protect LGBTQ individuals from discrimination. These policies should be visible and enforced, ensuring that LGBTQ patients are treated with the same level of care and respect as any other patient. This aligns with recommendations from Coleman et al. (2022), who advocate for institutional policies that promote inclusivity and prevent bias or discrimination within healthcare settings.

Both the need for provider education and the creation of inclusive environments have direct implications for health outcomes among LGBTQ individuals. Without competent, affirming care, LGBTQ individuals are at greater risk for poor health outcomes, including untreated mental health issues, unaddressed chronic conditions, and preventable diseases. This study‘s findings, in alignment with the literature, suggest that healthcare providers who are knowledgeable about LGBTQ health issues are better equipped to offer appropriate screenings, treatments, and referrals. For example, LGBTQ individuals may face higher risks for certain conditions, such as HIV, depression, and substance abuse, which require targeted interventions. Providers who understand these risks and are trained to address them are more likely to offer effective care, thereby improving health outcomes for LGBTQ patients.

Similarly, inclusive environments contribute to better health outcomes by promoting open communication and trust. When LGBTQ individuals feel safe and respected in a healthcare setting, they are more likely to seek care when needed and to disclose important health information, such as their sexual behavior or gender identity, that may be relevant to their treatment. This can lead to earlier interventions, more accurate diagnoses, and more comprehensive care, ultimately reducing health disparities faced by LGBTQ individuals.

The findings of this study align with a broader consensus in the literature that improving healthcare access for LGBTQ individuals requires a multifaceted approach. Health provider education and training, along with the creation of inclusive healthcare environments, are critical components of this effort. By addressing the gaps in provider knowledge and creating spaces where LGBTQ individuals feel safe and respected, healthcare institutions can significantly improve both the quality of care and health outcomes for this population. These findings highlight the urgent need for systemic changes within the healthcare system, particularly in terms of policy, education, and practice, to ensure that LGBTQ individuals receive the competent, affirming care they deserve.

The recommendations put forward in this study provide a framework for improving healthcare access and outcomes for LGBTQ individuals, offering insights that can inform future research, policy development, and clinical practice.

5.7 COMMUNITY MEMBERS' LIFE EXPERIENCES

The study uncovered a diverse spectrum of family dynamics within the LGBTQ community, ranging from full acceptance to conditional support and outright rejection. Many participants shared experiences of conditional acceptance from family members, where support was often contingent upon secrecy or adherence to traditional family roles. Many faced challenges with family expectations and pressures, particularly relating to marriage and lineage. This revelation of the study is in alignment with existing literature (Conyers et al., 2023; Sekoni et al., 2022) which supports these findings, indicating that LGBTQ individuals globally face similar challenges within their families. These Studies have also shown that family acceptance can significantly impact mental health and wellbeing, while rejection or conditional acceptance can lead to adverse outcomes, including depression, anxiety, and increased risk of suicidal ideation and suicide.

The health implications of family rejection are significant. Chronic stress, often as a result of family rejection, can trigger mental health disorders such as anxiety and depression. Additionally, the stress associated with navigating family rejection or conditional acceptance can lead to adverse health outcomes beyond mental health, including cardiovascular disease and substance abuse. The link between family dynamics and health outcomes underscores the urgent need for interventions aimed at fostering family acceptance of LGBTQ individuals. Family-based interventions and public health campaigns focused on education about LGBTQ identities could be critical in mitigating these negative health outcomes by promoting acceptance and understanding within families.

In contrast to the challenges faced within family settings, the LGBTQ community itself serves as a vital source of support, solidarity, and resilience. The study found that community-based organisations including NGOs and peer educators play an instrumental role in providing LGBTQ individuals with access to healthcare, social services, and safe spaces for self-expression.

However, the fear of stigma and exposure was cited as a deterrent to fully engaging with these community resources, despite their critical role in providing support.

This finding aligns with previous studies, which emphasised the importance of community networks in promoting the well-being of LGBTQ individuals. Studies by Conron et al. (2018) and Zeeman et al. (2019) highlighted how LGBTQ support groups and community organisations facilitate access to essential services, such as healthcare, legal assistance, and mental health resources. These community-based networks provide a refuge from the discrimination and stigma often encountered in mainstream society, helping LGBTQ individuals to navigate health systems and access culturally competent care without fear of exposure or mistreatment.

The health implications of community support are significant, particularly in reducing health disparities among LGBTQ individuals. Participants in this study consistently emphasised the role of peer educators and community organisations in connecting them to healthcare services that are knowledgeable and affirming of their needs. This connection is vital in contexts where mainstream healthcare services are often inaccessible or unwelcoming to LGBTQ individuals due to stigma, discrimination, or a lack of provider competence in LGBTQ health issues. By bridging the gap between the LGBTQ community and healthcare providers, these organisations help to mitigate the negative health impacts of societal discrimination, such as delayed care, unmet health needs, and increased vulnerability to mental and physical health challenges.

The ability of community-based organisations to reduce health disparities cannot be overstated. In environments where LGBTQ individuals may avoid mainstream healthcare due to fear of mistreatment, these organisations provide a lifeline, offering trusted sources of information and advocacy. The role of community support networks in facilitating access to healthcare is particularly important in ensuring that LGBTQ individuals receive timely and appropriate care, thus improving health outcomes and reducing the overall burden of health disparities in the LGBTQ community.

The study also revealed significant challenges faced by LGBTQ individuals in public life, including widespread discrimination, violence, and stigmatisation. Participants reported experiences of police harassment, threats from homophobic individuals, and fear of exposure in both online and physical spaces, particularly religious and public settings. These findings are consistent with the broader body of literature on the experiences of LGBTQ individuals, who often face societal intolerance and systemic discrimination (Izugbara et al., 2020; Ogunbajo et al., 2018).

The pervasive nature of discrimination against LGBTQ individuals is a significant contributor to health disparities within this community. Experiences of violence and harassment can lead to severe mental health challenges, including post-traumatic stress disorder (PTSD), depression, and anxiety. Studies have shown that LGBTQ individuals are disproportionately affected by mental health issues, often exacerbated by the societal stigma and lack of legal protections that compound their vulnerability (Ramsey et al., 2022; Reeves et al., 2023). This study found similar patterns, with participants highlighting how constant fear of exposure, particularly in public spaces, contributes to feelings of isolation, stress, and anxiety.

The health implications of societal discrimination are profound. LGBTQ individuals who face discrimination and violence in public life are more likely to experience chronic stress, which can manifest in both mental and physical health conditions. The lack of legal protections for LGBTQ individuals in many societies further exacerbates this issue, as participants in this study reported fear of reporting incidents of harassment or violence to authorities due to potential backlash or further victimisation. This contributes to a cycle of vulnerability, where LGBTQ individuals are left with few avenues for recourse or protection, further deepening their health disparities.

The findings from this study underscore the need for comprehensive legal reforms and public health interventions that address the systemic discrimination faced by LGBTQ individuals. Legal protections, anti-discrimination laws, and societal education campaigns are critical to creating an environment where LGBTQ individuals can live without fear of violence or harassment. Additionally, healthcare systems must be equipped to address the unique health challenges resulting from societal discrimination, offering mental health support and trauma-informed care that recognises the impact of public life on LGBTQ individuals'well-being.

The findings from this study reveal the complex and multifaceted experiences of LGBTQ individuals, shaped by family dynamics, community support, and public life challenges. The mental and physical health of LGBTQ individuals is significantly influenced by their interactions with family, community, and society at large. While family rejection or conditional acceptance poses significant mental health risks, community-based support networks provide a critical buffer against these challenges by facilitating access to healthcare and safe spaces for self-expression. However, societal discrimination and public life challenges continue to pose substantial barriers to the well-being of LGBTQ individuals, contributing to widespread health disparities.

These findings highlight the importance of a holistic approach to improving the health and wellbeing of LGBTQ individuals, one that addresses the family, community, and societal factors that shape their experiences. Public health interventions, legal protections, and community-based support systems are essential to creating an environment where LGBTQ individuals can thrive without fear of discrimination, violence, or exclusion.

5.8 EVALUATION OF ANDERSON’S HEALTH UTILISATION MODEL

The study's findings provide a nuanced understanding of healthcare utilisation among LGBTQ community members in the Accra Metropolis, with notable consistencies and some inconsistencies with Anderson's health utilisation (AHU) model. The AHU model typically identifies three main constructs influencing healthcare utilisation: predisposing factors, enabling factors, and need factors. These constructs served as a useful framework for framing the objectives of this study and analysing how LGBTQ individuals in the Accra Metropolis navigate healthcare services.

5.8.1 Consistencies of the study findings with AHU Model:

Predisposing Factors: The model emphasises demographic characteristics such as age, gender, religion, occupation and educational level, which were consistent with the study's findings as these characteristics were all captured by the study and some of them were discovered to have influence their healthcare utilisation. All participants were within the youth age bracket (22-30 years), and either affiliated to Christianity or Islam, all had a minimum education up to the JHS level with highest educational level being tertiary. Majority of them even though employed but in low paying jobs, which influenced their healthcare experiences, particularly in relation to financial accessibility.

Enabling Factors: The findings of the study aligned with the enabling factors of the AHU model, which include the availability of healthcare services, financial resources, and social support. The preference for facilities that ensured confidentiality, privacy, and anonymity is consistent with the model's emphasis on the importance of accessible and accommodating healthcare services. Additionally, the role of NGOs, ally agencies, and peer educators as facilitators of healthcare utilisation underscores the importance of external and social support systems in enabling access to healthcare.

Need Factors: The study revealed that LGBTQ individuals primarily sought healthcare for treating STIs and addressing mental health issues, which aligns with the need factors of the AHU model. The model posits that perceived and evaluated needs, such as health status and symptoms, drive healthcare utilisation. Thus, the findings of the study that highlighted that high prevalence of STIs and mental health issues were the main reasons for which the LGBTQ population sought health care, is consistent with this construct.

5.8.2 Inconsistencies of the study findings with AHU Model:

Behavioural Cues: The AHU model does not explicitly address the role of behavioural cues, such as dressing, tattoos, and grooming styles, which the study identified as significant factors attracting negative attention from healthcare providers. This suggests that the AHU model may not fully account for the stigmatisation and discrimination experienced by LGBTQ individuals based on their appearance and identity expressions.

Barriers beyond Financial and Structural Issues: While the AHU model includes financial barriers as an impediment to healthcare access, the study found that negative provider attitudes, discrimination, and stigma were equally critical barriers. The model does not explicitly highlight these interpersonal and social dynamics, indicating a gap in its application to marginalised groups like the LGBTQ community.

5.8.3 Emergent Themes and subthemes

The study also identified themes and subthemes not explicitly covered by the AHU model and the objectives of the study ie recommendations for improved healthcare access and public life experiences by the LGBTQ community. The study also identified subthemes not explicitly covered by AHU model as well as the objectives of the study such as the role of the LGBTQ community in providing mutual support and the impact of external threats like police harassment and familial rejection. These findings suggest that while the AHU model provides a useful framework for understanding healthcare utilisation, it may need to be expanded to fully capture the unique experiences and challenges faced by LGBTQ individuals in accessing healthcare.

In summary, while the constructs of Anderson's Healthcare Utilisation model are largely consistent with the findings of the study, particularly regarding predisposing, enabling, and need factors, the model does not fully account for the social stigmatisation, discrimination, and unique support systems within the community itself that influence healthcare access and utilisation among the LGBTQ members.

CHAPTER SIX

6.0 SUMMARY, IMPLICATIONS, LIMITATIONS, CONCLUSION AND RECOMMENDATIONS

6.1 INTRODUCTION

This chapter summarises the study and elaborates on the implication of the study for nursing practice, research, nursing education and policy. The limitations of the study have also been clearly stated and the chapter ends with recommendations based on the key findings of the study.

6.2 SUMMARY

The study explored the experiences of LGBTQ community members during utilisation of healthcare services in the Accra Metropolis**.** The study was guided by the Anderson‘s healthcare utilisation (AHU) model. A qualitative exploratory approach and purposive sampling technique were adopted to carry out the study and recruit participants respectively. The study involved fifteen (15) participants that lived and accessed health services within the Accra

Metropolis. In-depth phone and face to face interviews were conducted using semi-structured interview guide. Interviews were audiotaped with the permission of the participants, transcribed and analysed concurrently. Data analysis was guided by the principles of Braun and Clarke‛s (2020) reflexive thematic analysis approach. The analysis took into consideration the constructs of the AHU model as a guide. Four out of the six main themes that were generated were consistent with the AHU model. The fifth and sixth themes were generated as a result of the hybrid coding approach adopted. The themes include; trend of healthcare utilisation, health challenges of community members, facilitators of healthcare utilisation, barriers to healthcare utilisation, community members‛ life experiences and recommendations for improved healthcare access. There were a total of eighteen (18) subthemes.

The study revealed that all the participants fell within the youth age brackets (22 to 30 years). The participants included twelve (12) Christians and three (3) Muslims. The study revealed that majority of LGBTQ community members sought healthcare primarily for the treatment of STIs such as gonorrhea, HIV, herpes, anal warts, and genital warts. This revelation further highlighted how some community members are ignorant about the signs and symptoms of STIs. Mental health issues also emerged as another critical finding within the LGBTQ community. Concerns were expressed about the prevalence of mental health problems such as substance abuse, suicidal ideation and suicide stemming from societal and familial pressures as well as lack of supportive mental health services.

With regards to facilitators of healthcare utilisation, the study found that Facilities that ensured confidentiality, privacy and anonymity were preferred by community members. This current study further discovered how free health services and subsidised services rendered to community members by NGOs and other ally agencies were facilitating healthcare utilisation among community members. The study also highlighted the services of peer educators as a critical facilitator of healthcare utilisation. It also revealed that Participants who were open and disclosed their sexual orientation or gender identity status to healthcare providers reported better healthcare experiences and outcomes.

Barriers like negative provider attitudes including discrimination, stigma, prejudice, and provider biases were also discovered by the study as factors that hinder and discouraged healthcare utilisation by the LGBTQ community.

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/renew as well as unemployment and employment in low-paying jobs were frequently cited by participants.

Behavioural cues including visible identifiers such as dressing, tattoos, and piercings and grooming styles were also revealed by the study as factors that often attracted negative attention from healthcare providers. All participants who identified as bisexuals reported cases of STI infections such as gonorrhea, herpes, and HIV, indicating a significant health concern within this subgroup. The study also found anal and genital warts to be more prevalent among the gay subgroup of the LGBTQ community as all cases of anal and genital warts were exclusively reported by only gay participants. Three out of the five gays reported cases of anal and genital warts.

The study revealed that, all the lesbians who participated in the study did not report any incidence of negative healthcare encounter or experience. They only cited incidence of good treatment and satisfactory services at their chosen health facilities. Other findings that emerged from the study but were not initially part of the objectives of the study ranged from police arrest and harassment for identifying as LGBTQ to threats and violence from homophobic individuals. A participant expressed fear of attending church due to potential prophetic revelation by men of God. Participants recounted challenges with family acceptance and the pressure to conform to family expectations.

The study discovered that the LGBTQ community itself serves as a source of support and solidarity for members, with participants recounting instances of being cared for by fellow community members during times of need or sickness.

6.3 IMPLICATIONS

The findings of this study reveal significant barriers and facilitators to healthcare utilisation as well as healthcare needs among LGBTQ community members in the Accra Metropolis, which have several implications for nursing practice, nursing research, nursing education and policy.

6.3.1 Nursing Practice

The study established lack of culturally competent and inclusive care among health providers. It is therefore imperative that nurses develop a deeper understanding and sensitivity towards the unique healthcare needs of LGBTQ individuals. Training in culturally competent care that includes modules on LGBTQ health issues, non-discrimination, and confidentiality is essential. Emphasis must be placed on maintaining confidentiality and privacy to encourage LGBTQ individuals to seek healthcare without fear of stigma or discrimination. Establishing protocols to ensure these aspects can foster a more inclusive healthcare environment.

Given the worrying shared perspectives on the prevalence of mental health issues among LGBTQ individuals, nurses should be equipped to identify and provide appropriate mental health support, including referrals to mental health professionals when necessary.

Integrating trained peer educators from the LGBTQ community into healthcare teams can improve the comfort levels of LGBTQ patients and enhance healthcare delivery.

6.3.2 Nursing research

Research should focus on developing and testing interventions aimed at reducing the identified barriers. This could include programs designed to improve provider attitudes, enhance financial accessibility, and encourage disclosure of community member status. A research study on the effectiveness of specific interventions aimed at reducing stigma and improving healthcare access for LGBTQ individuals is necessary to develop evidence-based practices.

Further research into the health disparities within the subgroups under the wider LGBTQ umbrella, especially bisexuals and gay individuals, will provide insights into targeted healthcare interventions to bridge the existing health disparities.

A study specifically looking at the healthcare experiences of lesbians with healthcare utilisation will help establish a comprehensive findings regarding their healthcare experiences as the population of lesbians in the current study may be too limited (two participants) to establish the facts. Studies could also be conducted on understudied subgroups including the queer or questioning populations as current literature on these LGBTQ subgroups is limited.

6.3.3 Nursing education

Medical and nursing curricula should include comprehensive modules on LGBTQ health, emphasising the unique healthcare needs, cultural competence, and the importance of nondiscriminatory practices. Incorporating simulation training that includes scenarios involving

LGBTQ patients can help both medical and nursing students develop practical skills in providing inclusive care.

Providing continuing education opportunities for practicing medical officers and nurses on LGBTQ health issues will ensure that they remain informed about the latest best practices and research findings.

6.3.4 Implications for policy

Developing, and enforcing policies that protect LGBTQ individuals from discrimination in healthcare settings is critical. Developing and mandating training programs for all healthcare providers on LGBTQ health issues like non-discrimination, and cultural competence. Making sure that health insurance policies cover necessary treatments for LGBTQ individuals including mental health services and STI treatments, without discriminatory exclusions will go a long way to bridge these health disparities.

6.4 CONCLUSION

In conclusion, this study which examined the experiences of LGBTQ community members during the utilisation of healthcare services within the Accra Metropolis established significant findings. The study's adoption of Anderson‘s healthcare utilisation (AHU) model and a qualitative exploratory approach has provided a nuanced understanding of the various facilitators and barriers affecting healthcare access for this marginalised group.

Key findings revealed that the LGBTQ community primarily seeks healthcare for STIs and mental health issues. Facilities ensuring confidentiality, privacy, and anonymity, along with free or subsidised services provided by NGOs, emerged as critical facilitators of healthcare utilisation. Conversely, barriers such as negative provider attitudes, financial constraints, and behavioural cues attracting negative attention were significant impediments. The study underscores the necessity for improved culturally competent care among healthcare providers, highlighting the importance of training in LGBTQ health issues, non-discrimination, and confidentiality. Moreover, the integration of peer educators into healthcare teams was identified as a valuable strategy to enhance comfort and healthcare delivery for LGBTQ patients. Implications for nursing practice, research, education, and policy were thoroughly discussed.

In general, this study has shed light on the healthcare challenges faced by the LGBTQ community in the Accra Metropolis and offered practical recommendations for improving healthcare access and outcomes for this vulnerable population. The findings serve as a call to action for healthcare providers, researchers, educators, and policymakers to work collaboratively towards creating a more inclusive and equitable healthcare environment for LGBTQ individuals.

6.5 LIMITATIONS

This study focuses specifically on the Accra Metropolis, an urban area which may not be fully representative of the experiences of LGBTQ individuals in rural areas. The dynamics of healthcare and LGBTQ acceptance may vary significantly across different geographical locations. While the study aimed to understand comprehensively the health utilization experiences of LGBTQ community members, it did not capture the perspective of healthcare providers, policymakers, and other stakeholders. Their input could provide a more holistic view of the challenges and potential solutions

6.6 RECOMMENDATIONS

Based on the findings of the study, the following recommendations were made:

6.6.1 Ministry of health and Ghana health services

The Ministry of Health (MOH) and Ghana Health Service (GHS) should:

- Develop and implement comprehensive policies that promote inclusive and non-discriminatory healthcare practices for LGBTQ individuals.
- Allocate dedicated funding for:
    - Training healthcare providers on LGBTQ health issues.
    - Establishing LGBTQ-friendly healthcare facilities.
- Integrate LGBTQ health topics into the curricula of all health training institutions to ensure future healthcare providers are adequately prepared.
- Establish programs to include LGBTQ peer educators within healthcare teams to improve communication, trust, and support for LGBTQ patients.
- Implement strict confidentiality protocols to ensure the privacy and safety of LGBTQ individuals seeking healthcare.
- Create monitoring and evaluation frameworks to assess and ensure healthcare facilities comply with non-discrimination and inclusive care policies.

6.6.2 Ministry of gender, children and social protection

The Ministry of Gender, Children and Social Protection should:

Conduct advocacy campaigns to raise awareness about the rights and healthcare needs of LGBTQ individuals.

Develop support services for LGBTQ individuals facing familial and societal discrimination, including counselling and legal aid.

6.6.3 Nursing and Midwifery researchers.

Nursing researchers could also:

Engage in collaborative research with LGBTQ organisations to identify and address the specific health needs of the community.

Prioritise research on mental health issues within the LGBTQ community and develop intervention strategies based on findings.

Actively disseminate research findings to policymakers, healthcare providers, and the LGBTQ community to inform practice and policy changes.

Focus on developing and testing interventions aimed at reducing the identified barriers. This could include programs designed to improve provider attitudes, enhance financial accessibility, and encourage disclosure of community status or research on the effectiveness of specific interventions aimed at reducing stigma and improving healthcare access for LGBTQ individuals is necessary to develop evidence-based practices.

Research into the health disparities within the subgroups under the wider LGBTQ umbrella, especially bisexuals and gay individuals. This will provide insights into targeted healthcare interventions to bridge the existing health disparities.

Conduct study specifically looking at the healthcare experiences of lesbians with healthcare utilisation. This will help establish a comprehensive findings regarding their healthcare experiences as the population of lesbians in the current study may be too limited (two participants) to establish the facts. Studies could also be conducted on understudied subgroups including the queer or questioning populations as current literature on these LGBTQ subgroups is limited.

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APPENDICES

Appendix 1: Consent form

Title: Exploration of LGBTQ community members' experiences with utilisation of healthcare services in the Accra Metropolis.

Principal Investigator: Anuga Donald Womonia

Address: University of Ghana Legon, P.O Box LG 43,

General Information about Research

The proposed study seeks to explore the LGBTQ community members' experiences with utilisation of healthcare services in the Accra Metropolis. Data will be collected through semi structured interviews either in-person or via phone and it is estimated to last between 45-60 minutes under audio recording with the permission of the participants. Participants will be educated on their right to withdraw from the study even after consenting without any consequences. They will also be told to feel free in declining to answer questions they consider very sensitive or seek clarification about anything regarding the study

Possible Risks and Discomforts

Participants to this study will be treated with respect regardless of their rank, age, or religious affiliations because they won't be pushed to say anything they don't want to say.

Due to the ongoing discourse regarding criminalisation of LGBTQ activities in Ghana, and the fear that people may begin to take the law into their own hands to cause harm to LGBTQ individuals, the researcher will ensure that throughout the study, participants' safety and comfort will be given utmost attention by conducting interviews in safe settings and at safe times according to the preference of the participants.

This is to avoid any possible harassment or assault by any unscrupulous persons who may want to cause harm to these individuals.

The researcher will also engage the services of a clinical psychologist bearing in mind the emotional consequences the interviews may trigger in the course of the study. This will ensure that there is an expert to intervene in case of any emotional breakdown of any of the participants.

Possible Benefits

Participants in this study may not have any immediate and direct benefit. However, in the long term, the results from this study could help streamline the health delivery system and address any existing disparities.

Confidentiality

During the interview process, the anonymity of the participant will be protected, and any additional personal information that could allow for participant identification will be excluded.

To protect privacy and confidentiality, all interviews will take place in appropriate settings, and participants will be made to know participation is voluntary, and they have the right to withdraw from participation anytime they feel uncomfortable continuing with the process.

Compensation

Snacks will be provided to them after the interview section. They will also be given a token of fifty Ghana cedis for either transport or credit depending on whether it is phone interview or face-to-face interview that is conducted

Additional Cost

There is no any foreseeable cost that participants may incur by virtue of their participation in this study.

Voluntary Participation and Right to Leave the Research

Participation is voluntary, and participants have the right to withdraw from participation anytime they feel uncomfortable continuing with the process.

Termination of Participation by the Researcher

Where it is found that false information has been provided by a participant to the researcher especially regarding your LGBTQ membership, participation will be terminated without prior consent.

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title“ Exploration of LGBTQ community members’ experiences with utilisation of healthcare services in the Accra Metropolis.” has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

____

Date Name and signature of witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

____

Date Name Signature of Person Who Obtained Consent

Appendix 2: Interview guide

DATA COLLECTION INSTRUMENT

TOPIC: Exploration of LGBTQ community members’ experiences with utilisation of healthcare services in the Accra Metropolis

SECTION A

INTRODUCTION AND DEMOGRAPHIC DATA
Age
Gender identity
Sexual orientation
Educational level
Occupation

SECTION B

MAIN INTERVIEW SESSION

OBJECTIVE 1: HEALTHCARE UTILISATION PATTERNS

1. How often do you seek healthcare services?

Probes:
- Are there any specific health concerns or conditions that lead to more frequent healthcare visits?
- Have there been any changes in your healthcare utilisation patterns over time?
- Are there specific types of healthcare services you use more frequently? Please explain.

2.Please share with me your experiences with healthcare services in the Accra Metropolis?

Probes:
- What types of healthcare services have you used recently?
- Please provide an example of a recent healthcare visit, including the reason for the visit and the

outcome?

OBJECTIVE 2: HEALTHCARE NEEDS

3. Kindly share with me your primary healthcare needs or reasons for seeking healthcare services?
Probes:
- Describe the most common health issues or concerns that lead you to seek healthcare services?
- Are there specific LGBTQ-related healthcare needs that you feel are not adequately addressed? Kindly explain.

4.Tell me about any specific healthcare concerns that are unique to the LGBTQ community.
Probes:
- Are there any challenges related to sexual orientation or gender identity that affect your healthcare needs? Please explain.
- How do you manage or address these unique healthcare concerns?

5. How do you prioritise your healthcare needs?
Probes:
- Are there certain healthcare needs that take precedence over others? Why?
- What factors influence your decision to seek healthcare for specific needs?

OBJECTIVE 3: FACTORS FACILITATING HEALTHCARE UTILISATION

6. In your opinion what qualities or practices make a healthcare facility or provider LGBTQ-friendly?
Probes:
- Share with me an example of a positive interaction with a healthcare provider?
- Are there LGBTQ-friendly healthcare facilities or providers that you are aware of in this area? If yes, please describe your experiences

7. Do you feel comfortable discussing your sexual orientation and gender identity with healthcare Providers? Why or why not?
Probes:
- Have you encountered healthcare providers who were receptive to discussing these topics?
- What factors influence your comfort level in disclosing this information during healthcare visits?

OBJECTIVE 4: BARRIERS TO HEALTHCARE UTILISATION

8. Kindly share with me challenges you encounter when accessing healthcare services.
Probes:
- How have these negative experiences affected your willingness to seek healthcare services?

9. What is your opinion regarding cost of healthcare as a community member?
Probes:

Are there financial or logistical barriers, such as cost or transportation, which hinder your access to healthcare?

- Can you elaborate on the financial challenges you face in accessing healthcare services? How do these affect your decisions?
- Are there specific instances where transportation was a significant barrier? How?

Appendix 3: Ethical approval

UNIVERSITY OF GHANA

NOGUCHI MEMORIAL INSTITUTE
FOR MEDICAL RESEARCH (NMIMR)
COLLEGE OF HEALTH SCIENCES
INSTITUTIONAL REVIEW BOARD

6th December 2023

ETHICAL CLEARANCE

FEDERALWIDE ASSURANCE FWA 00001824 **IRB 00001276**

NMIMR-IRB CPN 059/23-24 **IORG 0000908**

On 6th December 2023, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) conducted an expedited review and approved your protocol titled:

TITLE OF PROTOCOL	:	**Exploration of LGBTQ community members' experience with utilisation of healthcare services in the Accra Metropolis**
PRINCIPAL INVESTIGATOR	:	**Donald Womonia Anuga, MPhil Cand.**

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

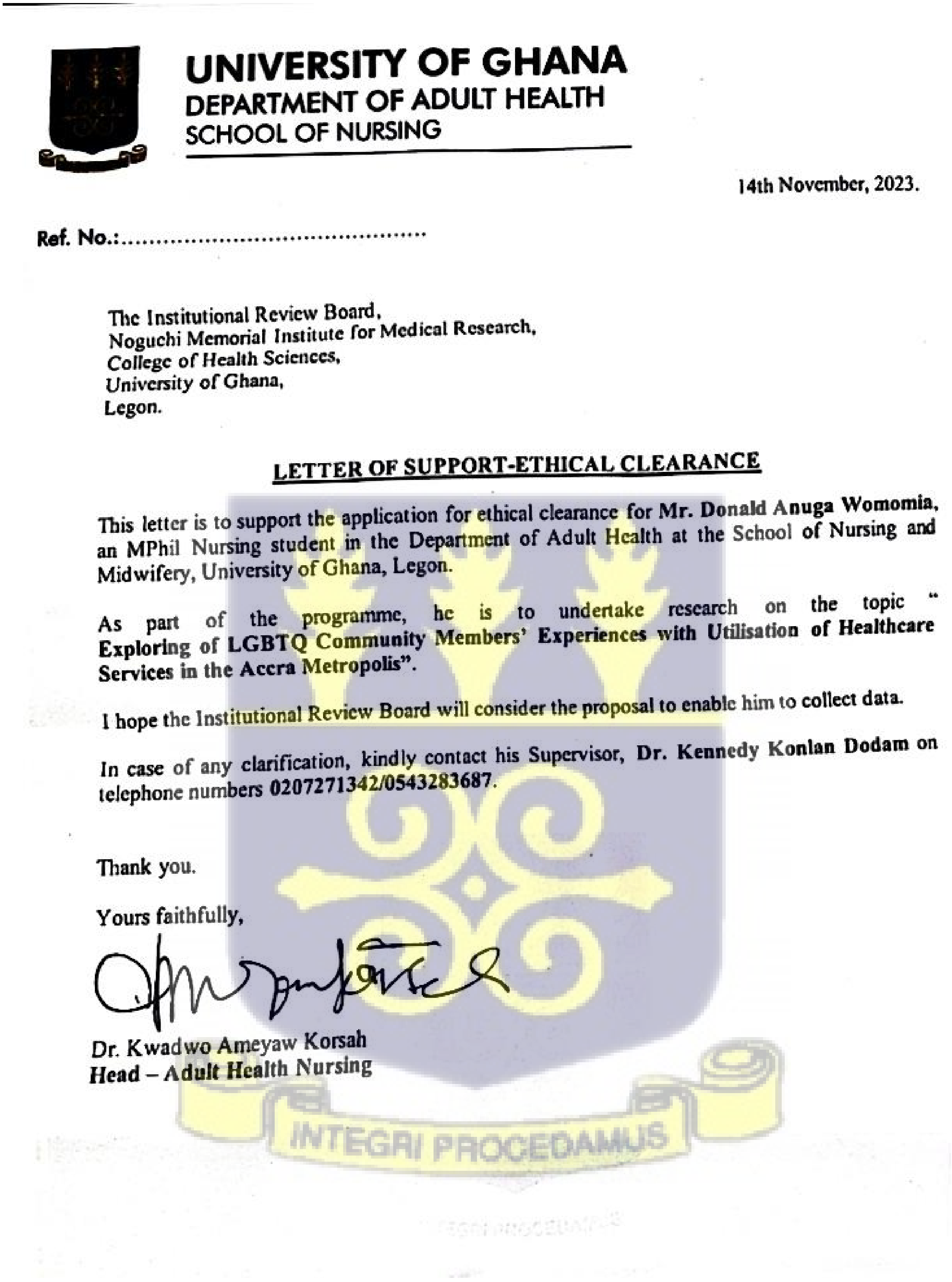
This certificate is valid till 5th December 2024. You are to submit annual reports for continuing review.

Signature of Chair: ....
Dr. Abraham Hodgson
(NMIMR – IRB CHAIR)

P. O. Box LG 581, Legon, Accra, Ghana | Tel: +233 (0) 302-2916438
Email: nirb@noguchi.ug.edu.gh | www.noguchimedres.org | www.ug.edu.gh

UG

Appendix 4. Letter of introduction



UNIVERSITY OF GHANA
DEPARTMENT OF ADULT HEALTH
SCHOOL OF NURSING

14th November, 2023.

Ref. No.:..

The Institutional Review Board,
Noguchi Memorial Institute for Medical Research,
College of Health Sciences,
University of Ghana,
Legon.

LETTER OF SUPPORT-ETHICAL CLEARANCE

This letter is to support the application for ethical clearance for **Mr. Donald Anuga Womomia**, an MPhil Nursing student in the Department of Adult Health at the School of Nursing and Midwifery, University of Ghana, Legon.

As part of the programme, he is to undertake research on the topic "**Exploring of LGBTQ Community Members' Experiences with Utilisation of Healthcare Services in the Accra Metropolis**".

I hope the Institutional Review Board will consider the proposal to enable him to collect data.

In case of any clarification, kindly contact his Supervisor, **Dr. Kennedy Konlan Dodam** on telephone numbers **0207271342/0543283687**.

Thank you.

Yours faithfully,

Dr. Kwadwo Ameyaw Korsah
Head – Adult Health Nursing