FACILITATING LESBIAN, GAY, BISEXUAL, TRANSGENDERED AND INTERSEXED YOUTH-INCLUSIVE PRIMARY HEALTH CARE IN TSHWANE DISTRICT, GAUTENG PROVINCE, SOUTH AFRICA: A CONSTRUCTIVIST GROUNDED THEORY STUDY

by

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DEDICATION

This thesis is dedicated to the women that have touched my life in many different ways.

My late paternal grandmother Annah Mama Nkadimeng, whom I'm named after, my late mother Elizabeth Matoesi Nkadimeng, my late maternal grandmother Welhemina Thlanamile Kabeng, my late mother-in-law Florah Sefolosha whom my second daughter is named after, my late aunt Athania Nthamane Kabeng, whom my first daughter is named after, and my late best friend Valencia Boitumelo MolotsaneNkosi, my late 'sister' and friend Maureen Adelaide Masethe.

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DECLARATION

I certify that:

This thesis is, to the best of my knowledge and belief, original, except as acknowledged in the text, and that the material has not been submitted, either in whole or in part, for the purpose of acquiring a degree at this or any other university. I acknowledge that I have read and understood the University's rules, requirements, procedures and policy relating to my higher degree research award and to my thesis. I certify that I have complied with the rules, requirements, procedures and policy of the university (as they may be from time to time).

Signed,

Annah Sefolosha
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ABSTRACT

Introduction: Youth is a time when young people start to explore and discover their sexuality and sexual orientation and begin to identify themselves as either heterosexual or LGBTI. Most of those who identify as LGBTI are prone to a range of abuse, discrimination and victimisation; as well as health care inequalities. As a result, they experience poorer physical and mental health outcomes than the general population. The aim of the study was to develop a substantive theory focused on the basic social processes involved in facilitating LGBTI youth-inclusive PHC in Tshwane District, Gauteng Province, SA. The objectives included to explore and describe the experiences of LGBTI youth regarding health care they received in PHC clinics, to describe the experiences of nurses regarding caring for LGBTI youth in PHC clinics; and to explore and describe the basic social processes involved in facilitating LGBTI youth-inclusive PHC. A constructivist grounded theory was used. Interviews were held with an initial sample of seven LGBTI youth and five registered nurses working in PHC followed by theoretical sample of three LGBTI youth and three registered nurses, all from Tshwane District, Gauteng Province, South Africa. Constant comparative data analysis was done. Codes, categories, and the core category were conceptualised.

The substantive theory that emerged from this study explains three phases of facilitating LGBTI youth-inclusive care. Phase 1 involved recognising barrier to facilitating LGBTI youth-inclusive care, reflecting the main concerns of participants when they experienced value-laden tension and conflict. Phase 2 involved recognising the need to change values and attitudes, and Phase 3 involved applying strategies to promote nurse-patient interaction reflect strategies employed by the nurses as the main resolutions to resolve those value-laden tension and conflict. A substantive theory presents reflections on how nurses might facilitate care and support for LGBTI patients in PHC, and other similar health care practices.

Key words: LGBTI youth; primary health care; LGBTI youth-inclusive care and facilitating care

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INTRODUCTION AND BACKGROUND OF THE STUDY

1.1. INTRODUCTION

Youth is a time when young people explore and learn about their sexuality and identify themselves as either heterosexual, lesbian, gay, bisexual, transgendered, or intersexed homosexual (McCabe, Brewster & Tillman 2011:142; Saewyc 2011:257258). Lesbian, gay, bisexual, transgendered and intersexed (LGBTI) youth are prone to a wide range of physical, verbal, emotional and sexual abuse, discrimination, and victimisation (Kann, Olsen, McManus, Kinchen, Chyen, Harris, & Weschler 2011:2; Everett 2013:230; Meyer 2016:82), which increases their vulnerability to experiencing poorer physical and mental health outcomes than the general population (Coker, Austin & Schuster 2009:213; Saewyc 2011:262; Brewster & Tillman 2012:1168; Müller 2013:2; Knight, Shoveller, Carson & Contreras-Whitney 2014:662). For example, LGBTI youth appear to be prone to mental health risks, such as alcohol and substance abuse (Kann et al. 2011:2; Brewster & Tillman 2012:1168), smoking, depression, and suicide (Ash & Mackereth 2010:5), as well as sexually transmitted infections (STIs) (Riskind, Tornello, Younger & Patterson 2014:1959-1961, Everett 2013:223), including infection with the Human Immunodeficiency Virus (HIV) (Müller 2013:2; Mavhandu-Mudzusi & Sandy 2015:1054).

The World Health Organisation (WHO 1978:np) defines primary health care (PHC) as a “health care model which encompasses primary care, disease prevention, health promotion, population health, and community development within a holistic framework, with the aim of providing essential community-focused health care”. In most countries, PHC is regarded as the first entry point into the health system, and is geared towards health promotion, disease

prevention, early diagnosis and treatment of diseases, and referral to secondary and tertiary health care (Dookie & Singh 2012:2). In the United States of America (USA), LGBTI youth consult PHC first when they need health care. However, there are some barriers that prevent the PHC system from being able to respond to their health care needs adequately (Maza & Krehely 2010:2). For example, LGBTI youth are vulnerable to the effects of the lack of targeted health promotion information (Lambrese & Hunt 2013:225), and insensitivity to their health concerns by health care providers; and therefore, they experience neglect of their health care needs (Hoffman, Freeman & Swann 2009:227). Once the health care needs of one subset of the population are neglected, the members of that group become vulnerable to negative health outcomes (Eliason, Dibble & DeJoseph 2010:207).

The aim of this study is to develop a substantive theory focused on the basic social processes involved in facilitating LGBTI youth-inclusive PHC in Tshwane District, Gauteng Province, South Africa.

1.2. BACKGROUND TO THE PROBLEM STATEMENT

This section will provide an overview of LGBTI people and related health care within the global context, amongst Sub-Saharan countries, and finally within South Africa (SA) specifically.

1.2.1. LGBTI PEOPLE AND THEIR HEALTH CARE GLOBALLY

Literature reveal a lack of consensus with regard to the methods of defining sexual orientation and sexuality and understanding of the LGBTI populations who experience sexuality and sexual orientation-related health inequalities (Pathela, Blank, Sell & Schillinger 2006:422-424; Saewyc 2011:257-258). Sexual attraction, sexual behavior, and sexual identity represent distinct dimensions of sexuality, particularly during youth years (Igartua, Thombs, Burgos & Montoro 2009:603; Society for Adolescent Health and Medicine (SAHM) 2013:507). Authors such as Moradi, Mohr, Worthington and Fassinger (2009:5) and Ridolfo, Miller and Maitland (2012: 113-124) are of the opinion

that concise conceptual definitions of sexual orientation are needed. Most researchers in sexuality have grouped together people with non-conforming sexual orientation (homosexuals i.e. gay, lesbians and bisexuals) and sexual identity (intersexed and transgendered) as LGBTI. They believe that the term is inclusive of the diversity among and within these groups, and that they experience similar dynamics and problems (Eady, Dobinson & Ross 2010:379). This study will focus on the LGBTI youth in the Tshwane District of Gauteng Province in South Africa.

Those people who identify themselves as LGBTI experience health inequalities (Pathela et al. 2006:422-424; Saewyc 2011:257-258), which traditionally emanated from the way people with non-conforming sexual orientation especially homosexual people were treated in the health care system (Hinchcliff, Gott & Galena 2005:346). During the 1970s, non-conforming sexual orientation like homosexuality was classified by the Diagnostic and Statistical Manual of Mental Disorders (DSM-II) (the American classification of mental disorders), as a mental disorder (Hinchcliff et al. 2005:346). Non-conforming sexual orientation is regarded as a pattern of emotional and/or sexual attractions primarily or exclusively to people of the same sex (Higgins, Sharek, McCann, Sheerin, Glacken, Breen & McCarron 2011:15). People who were regarded to have non-conforming sexual orientation like homosexuals were subjected to corrective therapies, which included coercive hormone replacements, electroconvulsive therapy, hypnosis, gender reassignment surgeries and psychotherapies on the part of mental health practitioners to reverse what was considered to be a *disorder* (Smith, Bartlett & King 2004:429). In 1973, homosexuality was declassified in the DSM-IV as a mental disorder (Johnson, Mimiaga & Bradford 2008:214) due to the fact that homosexual people did not all manifest with signs and symptoms of psychopathology (Hinchcliff et al. 2005:346).

Most countries in Europe and the USA have attempted to develop laws to eliminate discrimination against the LGBTI population (Ash & Mackereth

2010:5-6; Meyer 2016:82). However, health care providers are still contributing to the violation of the health and human rights of LGBTI youth. They are subject to prejudice, hostility and discrimination in the clinical settings (Adams, Dickinson & Asiasiga 2013:6; Rounds, McGrath & Walsh 2013:99), where as a result, they become vulnerable to health risks (Buchmueller & Carpenter 2010:491; Saewyc 2011:257; Müller 2013:2). Most LGBTI populations are found to utilise health care services less than the general population (Rispel, Metcalf, Cloete, Moorman & Reddy 2011:138; Cele, Sibiya & Sokhela 2015:5). They perceive that health care providers tend to treat them differently from the general population (Ash & Mackereth 2010:5) and that they generally do not understand their health needs (Coker et al. 2009:213).

1.2.2. LGBTI PEOPLE AND THEIR HEALTH CARE IN SUB-SAHARAN COUNTRIES

Information about LGBTI health in sub-Saharan countries is difficult to obtain, since most countries do not acknowledge the existence of the LGBTI populations (Ehlers, Zuyderduin & Oosthuizen 2001:849), and homosexuality has been criminalised in about 38 African countries (Thoreson & Cook 2011:5). For example, in Zimbabwe, homosexuality is considered immoral, criminal and deviant, and homosexual people are often condemned in public by religious and political leaders (Mabvurira, Motsi, Masuka & Chigondo 2012:218-223). For homosexual people, when they overtly express their non-conforming sexual orientation, they increase their vulnerability to being victims of discrimination or imprisonment. As a result, LGBTI people in most African countries do not disclose their sexual orientation (Thoreson & Cook 2011:5; Mabvurira et al. 2012:218-223; Mavhandu-Mudzusi 2014:710), thereby limiting their access to LGBTI professional support networks that could help them to cope with their challenges and health care needs (Thoreson & Cook 2011:5). A study of gay men in Malawi, Namibia, and Botswana in 2011, found that 18,5% of gay men were afraid to visit health care services, and 5,1% were denied health care by health care providers (Thoreson & Cook 2011:5). Ehlers et al. (2001:855) suggest that African countries like Botswana require an application

of a health and human rights framework in describing and gaining an understanding of the health needs of the LGBTI population.

1.2.3. LGBTI PEOPLE AND THEIR HEALTH CARE IN THE SOUTH AFRICAN CONTEXT

In 2011, SA was estimated to have a lesbian and gay population of 900 000 (Nell & Shapiro 2011:10) compared to the 51,8 million of the total population (Census 2011:14). In SA, there has been a national response to promote the rights to health care of the youth including LGBTI youth. Discrimination on the basis of sexual orientation has been outlawed by the SA Bill of Rights. Section 27(1a) of the Constitution (Act 108 of 1996:1255) states that all SA citizens have the right of access to health care (OUT LGBT Wellbeing 2007:2). Hence, SA has developed the Adolescent and Youth Health Policy (2012) and National Implementation Guidelines for Adolescents and Youth Friendly Health Services (2012-2016) guided by the National Youth Policy (2009-2014). These guidelines are aimed at preventing and responding to health problems of the youth including among others the LGBTI youth as a vulnerable population, and to address the barriers that prevent them from accessing health care services (OUT LGBT Wellbeing 2007:2).

In SA, non-profit organisations have established LGBTI PHC clinics, such as *OUT LGBT Wellbeing* in Tshwane, Gauteng Province, *Durban Lesbian and Gay Community and Health Centre* in Durban, KwaZulu-Natal Province and *Triangle Project* in Cape Town, Western Cape Province (OUT LGBT Wellbeing 2007:25-26). These clinics were established to promote access to targeted LGBTI health care services. The clinics provide LGBTI-friendly sexual and mental health services and encourage research and mainstreaming of health programmes to reduce the effects of heterosexism and homophobia on the LGBTI population (OUT LGBT Wellbeing 2007:2). The findings of the research conducted by *OUT LGBT Wellbeing* between 2004 and 2005 in the Gauteng and KwaZulu-Natal Provinces respectively revealed that the LGBTI population experienced homophobic attitudes when accessing general public health care,

with the main concern being the homophobic attitudes of health care providers. The LGBTI populations were being denied access to health care; receiving inappropriate treatment or inferior care from the health care providers (OUT LGBT Wellbeing 2007:2). SA has insufficient data with regard to LGBTI patients' satisfaction with the health care services (OUT LGBT Wellbeing 2007:7). Again, in SA, research on LGBTIs' health, practices and theoretical concerns of health care providers towards LGBTI people, have been largely neglected.

1.3. HEALTH CARE NEEDS OF LGBTI YOUTH

LGBTI youth share to some extent, the same developmental issues and the same health care needs (Röndahl 2009:2341; Eliason et al. 2011:1358; Brennan et al. 2012:96; Knight et al. 2014:665) as heterosexual youth (Hoffman et al. 2009: 222). However, LGBTI youth are prone to greater risks of their health and well-being due to stigma, victimisation and discrimination than their heterosexual counterparts (Dysart-Gale 2010:23; Hoffman et al. 2009:222). They experience higher rates of poor physical health and mental health problems such as low self-esteem, depression, anxiety, alcohol and substance abuse, and suicidal ideation than their heterosexual counterparts (McNair, Szalacha & Hughes 2011:40-41).

1.4. RATIONALE OF THE STUDY

In the USA, it is estimated that at least 10% of the population identifies as LGBTI. Factors such as age, race, socioeconomic status and geographical location significantly influence the experience of living as LGBTI individual in the USA (Dorsen 2015:1). For example, literature reveal that the LGBTI population experiences stigma, discrimination (Dysart-Gale 2010:23; Hoffman et al. 2009:222); and health inequalities as compared to their heterosexual counterparts (Pathela, Blank, Sell & Schillinger 2006:422-424; Saewyc 2011:257-258).The main reasons for these experiences are attributed to factors such as socioeconomic differences, negative attitudes of health care providers which contribute as barriers for LGBTI people to access health care

(Dorsen 2015:3). Most LGBTI individuals who are able to access health care, prefer not to disclose their sexual orientation to the health care providers and thus experience poor health outcomes and unmet health care needs (Dorsen 2015:3). Although there is a significant amount of related research conducted internationally, its applicability within the SA context and other developing countries is still questionable. The nature of the demographic and socio-cultural factors of these countries differ significantly from those of developed countries and might contribute as barriers for LGBTI youth to access health care like (Dorsen 2015:3) has articulated.

Despite research revealing that LGBTI people experience poor health outcomes and have special health care needs, in SA, research pertaining to their health care needs and how these needs should be addressed by nurses has been overlooked (OUT LGBTI Wellbeing 2007:7). There is limited research that is aimed at examining the nurses' attitudes towards LGBTI patients and the role that nurses could play in promoting access to health care by LGBTI population and meeting their health care needs (Dorsen 2015:3). PHC is the entry point for health services that effectively respond to the needs of LGBTI youth. Health care providers that are competent and effective with regard to LGBTI health care can provide an entry point for LGBTI youth into the health care system (Reitman, Austin, Belkind et al. 2013:506-510). At present, this is not the situation in SA. Without LGBTI youth-inclusive PHC facilities accessible to them, LGBTI youth do not have access to preventative health care services that PHC offers. It may be that they only consult health care providers when complications develop, and they have no other choice. Therefore, changing the attitudes of health care providers towards LGBTI people and promoting an LGBTI-inclusive health care setting is significant.

1.5. PROBLEM STATEMENT

LGBTI youth have negative experiences in the health care system (Ash & Mackereth 2010:5; Coker et al. 2009:213; Hoffman et al. 2009:227). Despite initiatives by other countries such as the USA, Canada and Europe to respond

to the rights to health care of LGBTI youth through implementation of LGBTI youth-inclusive policies and guidelines, health care providers often still express their embarrassment to treat these patients and often refuse to provide care to them (Ash & Mackereth 2010:5).

LGBTI people are considered to be the most underserved populations in nursing (Eliason et al. 2010:208; Dysart-Gale 2010:24) since nursing is considered to be heterosexist and conservative (Shattell & Chinn 2014:76). Nurses are not always equipped to effectively treat vulnerable LGBTI youth. Some nurses do not accommodate the diversity of LGBTI patients, thus rendering them invisible or nonexistence in PHC (Eliason et al. 2010:208; Brennan, Barnsteiner, De Leon Siantz, Cotter & Everette 2012:96). LGBTI issues and sexuality have been lacking in the nursing education curriculum (Eliason et al. 2010:208; Brennan et al. 2012:96). As a result, the nurses lack the knowledge and skills regarding how to adequately manage the health care needs of LGBTI youth (Ash & Mackereth 2010:5). Authors such as Eliason et al. (2010:208); Dysart-Gale (2010:24) and Shatell and Chinn (2014:77) have raised the concern that the nursing profession lags behind, when compared to other health and human disciplines in conducting research, developing theoretical frameworks, and practicing guidelines on LGBTI issues; as well as when influencing LGBTI-inclusive policies in health care. Therefore, theoretical frameworks and interventions that could address the challenges faced by the LGBTI population in health care ought to be developed. It is anticipated that these theoretical frameworks and interventions may enhance evidence-based practice and positively change the attitudes of health care providers towards LGBTI patients (Hoffman et al. 2009:228; Eliason et al. 2010:207).

Little is also known about how LGBTI youth interact with the health care system from their point of view. A study conducted by Hoffman et al. (2009:222-229) to determine the health care preferences of LGBTI youth in the USA revealed that the participants viewed LGBTI youth-inclusive health care as a setting, where health care providers are respectful and well educated

about LGBTI youth health concerns and problems. Furthermore, the results suggest that health care providers ought to have good interpersonal skills, be non-judgmental; and ought not to assume that all LGBTI people are at risk of HIV infection. Similar information regarding what LGBTI youth and nurses in PHC clinics in SA consider to be LGBTI youth-inclusive PHC do not exist, and no context-specific theory to guide nurses to deliver LGBTI youth-inclusive care is available. Thus, this study will attempt to develop substantive theory focused on the basic social processes involved in facilitating LGBTI youth-inclusive PHC in Tshwane District, of Gauteng Province in South Africa.

1.6. SIGNIFICANCE OF THE STUDY

This study is significant, as it seeks to bring new insights into the theory and practice that will facilitate LGBTI youth-inclusive PHC. Firstly, this research explored the experiences of LGBTI youth and nurses in PHC clinics as they interacted with each other within the PHC system in Tshwane District, Gauteng Province, SA. Secondly, this research was conducted using a grounded theory method by means of a qualitative approach, which remains rare within studies related to LGBTI health care. Grounded theory is suitable for this research as it is a method used specifically to explore and describe the basic social processes involved within human interactions, which in this study implies the LGBTI youth and nurses interaction within the PHC system. It is anticipated that the theory generated from this grounded theory study, will make a specific theoretical contribution, by providing a description of the basic social processes involved in the facilitating of LGBTI youth-inclusive PHC. It is also anticipated that the theory could be operationalised in PHC and other similar health care settings in SA, and other developing countries, and tested in future research. The theory could also assist in improving health care and health seeking behaviour among LGBTI youth.

1.7. RESEARCH QUESTIONS

The study was guided by the following two main research questions:

- How do nurses and LGBTI youth experience their interaction in PHC in Tshwane District, Gauteng Province, South Africa? and
- What are the basic social processes involved in facilitating LGBTI youth-inclusive PHC in Tshwane District, Gauteng Province, South Africa?

The researcher undertook a qualitative study using a constructivist grounded theory approach. Therefore, it was anticipated that the research questions could change as the research progresses, thus, this study did not make use of pre-determined sub-questions.

1.8. AIMS AND OBJECTIVES

The aim of this study was to develop substantive theory focused on the basic social processes involved in facilitating LGBTI youth-inclusive PHC in Tshwane District, Gauteng Province, South Africa.

The research objectives were to:

- Explore and describe the experiences of LGBTI youth regarding health care they received in PHC clinics.
- Explore and describe the experiences of nurses regarding caring for LGBTI youth in PHC clinics.
- Explore and describe the basic social processes involved in facilitating LGBTI youth-inclusive PHC.

1.9. CONCEPT CLARIFICATION

The concepts applicable to this study are defined as follows:

1.9.1. BISEXUAL PERSON

Bisexual people refer to a person whose fantasies and sexual attractions are to both men and women (Institute of Medicine (IOM) 2011:317). In this study, the term refers to male and female youth, who are self-identified as sexually attracted to people of the same as well as the opposite sex.

1.9.2. GAY MEN

Gay men refer to men whose fantasies and sexual attractions are toward other men (IOM 2011:317). In this study, the term referred to male youth who are self-identified as sexually attracted to other males.

1.9.3. HEALTH CARE NEEDS

Health care needs refer to particular health conditions that require interventions to prevent deterioration and to improve the health state of a particular patient or a group of patients (Hasman, Hope & Østerdal 2006:146). In this study, health care needs referred to any health condition that will require LGBTI individual or group to seek medical attention.

1.9.4. HEALTH CARE SERVICE

Health care service refers to any service that is aimed to the diagnosis, treatment and rehabilitation of sick people to improve their health and wellbeing (Mosadeghrad 2013:203). In this study, health care service implied the health care rendered to the LGBTI population. Therefore, the term health care and health care services were used interchangeably.

1.9.5. HEALTH NEEDS

Health needs refer to health condition or deterioration in health that requires attention of a health care service such as health promotion, treatment and/or rehabilitative care (WHO 1971:21). In this study, the term health needs referred to any physical, mental and emotional condition that requires health care. The term health care and health care needs were used interchangeably.

1.9.6. HOMOSEXUALITY

Homosexuality is an enduring pattern of emotional and/or sexual attractions primarily or exclusively to people of the same sex (Hershberger (2001) in D'Augelli & Patterson 2001:27). It also refers to a person's sense of identity based on those attractions, related behaviours, and membership in a community of others who share those attractions. This study focused on self-identified lesbian, gay and bisexual youth.

1.9.7. INTERSEX

Intersex refers to individuals born with ambiguous genital or reproductive anatomy (Johnson et al. 2008:216). In this study, the term referred to those individuals who cannot identify themselves as either men or women.

1.9.8. LESBIAN WOMEN

Lesbian women refer to women whose fantasies and sexual attractions are to other women (IOM 2011:317). In this study, the term referred to female youth who are self-identified to be sexually attracted to other females.

1.9.9. NURSE

Nurse refers to a person who has been trained and is licensed to practice the profession of nursing, of proving health promotion, diagnosis and treatment to the sick (Anderson, Anderson & Glanze 1994:1086). In this study, nurse referred to any all category of nurses working in Primary Health Care clinic. The terms nurse and health care provider were used interchangeably.

1.9.10. PRIMARY HEALTH CARE

Primary Health Care (PHC) is defined by the WHO (1978) as a "health care model which encompasses primary care, disease prevention, health promotion, population health, and community development within a holistic framework, with the aim of providing essential community-focused health care". In SA, PHC refers to the first entry point into the health care service. In this

study, PHC referred to the first health care service that LGBTI youth consult when they need preventative health care, health promotion or suffer from minor and chronic ailments, and includes health care services rendered at public sector and university-based PHC clinics in Tshwane district.

1.9.11. SUBSTANTIVE THEORY

Substantive theory refers to an emergent theory developed inductively from interpreting the data generated within the context of the phenomena that the theory represents. The purpose of substantive theory is to predict, explain and interpret phenomena and to enhance understanding and inform action (Bryant & Charmaz 2007b:610). Substantive theories are modifiable and transferrable and cannot be generalised, whereas more formal theories are less specific to a group and place and are therefore generalised (Glaser & Strauss 1967:32-35). Substantive theory in the context of this study relates to the concepts and statements that emerged from the findings of the study and focused on the basic processes involved in facilitating LGBTI youth-inclusive PHC.

1.9.12. TRANSGENDER

Transgender is an inclusive term used to describe people who have gender identities, expressions or behaviours that are not associated with their biological sex (Johns, Zimmerman & Bauermeister 2008:216). In this study, the term referred to people who identify more with another gender, i.e. women who identify themselves as men and men who identify themselves as women. They may be heterosexual, homosexual, bisexual or nonsexual.

1.9.13. YOUTH

The definition of the term youth remains inconsistent. The United Nations Youth (2008:2) acknowledges that different age ranges are used to define the youth in different states as determined by the demographic, financial, economic and sociocultural status of that state, and defines them as people between the ages of 15 and 24 years of age. The WHO (1989) uses the same age bracket in its definition. In SA, the *National Youth Policy* (2009-2014:12)

uses the age bracket of 14 to 35 years, the Census of 2011 uses the bracket of 14 to 34 years, and the *African Youth Charter* (2006:11) 15 to 35 years, when referring to youth. This study referred to the WHO definition as it is aligned with the definition in the *National Youth Policy* (2009-2014:12).

1.9.14. YOUTH-INCLUSIVE PHC

The term **youth-inclusive PHC** is also referred to as *Adolescents and Youth Friendly Health Services*. It refers to the health care that is sensitive to the health care needs of adolescents and youth (National Implementation Guidelines for Adolescents and Youth Friendly Heath Services 2012-2016). In this study, PHC implies a sensitive and effective response to the specific health care needs of the youth including LGBTI youth.

1.10. ASSUMPTIONS OF THE STUDY

In this section, the assumptions and theoretical framework applicable to the study are discussed as follows:

1.10.1. PARADIGMATIC ASSUMPTIONS

According to Denzin and Lincoln (2005:3) as well as Creswell (2009:6), a paradigm is defined as basic set of beliefs that guide actions, and is also referred to as worldview. A worldview implies “an individual’s accepted knowledge, including values and assumptions, provide a ‘filter’ for perception of all phenomena” (Grover & Glazier 1986:235). This study was guided by five paradigmatic assumptions that led to the researcher’s choice of qualitative research, viz.: ontological, epistemological, axiological, rhetorical, and methodological assumptions, which were briefly discussed in the next section and comprehensively discussed in Chapter 3.

1.10.1.1. ONTOLOGICAL ASSUMPTIONS

Ontology refers to the nature of social reality as well as the study of being, i.e. how humans view the world (Crotty 1998:10). The researcher assumed in this study a relativist ontological position in researching and understanding reality.

Relativist ontology assumes that there are multiple ways of discovering realities (Mills, Bonner & Francis 2006:2). In this study, the researcher used a grounded methodology to discover the nature of reality. Constructivist grounded theory signifies that even though reality exists, and can be discovered through inquiry, it is never perfectly apprehensible, as it is influenced by thoughts, interpretations and meanings (Hallberg 2006:146).

1.10.1.2. EPISTEMOLOGICAL ASSUMPTIONS

Epistemology is concerned with how knowledge is generated and communicated, in other words "what it means to know" (Holloway & Wheeler 2010:21). In this study, the researcher assumed a constructivist epistemology. Crotty (2003:42) defines constructionism as "the view that all is knowledge and therefore all meaningful reality as such is contingent upon human practices, being constructed in and out of interaction between human beings and their world and developed and transmitted within an essentially social context." Constructivists assume that there is a subjective relationship between the researcher and the participants that contributes to a comprehensive understanding of the studied phenomenon (Mills et al. 2006:2). The researcher asserts that in this study, knowledge is constructed during interaction between the researcher, participants and their world, developed and transmitted within an essentially social context. Thus, meaning is not to be discovered, but constructed.

1.10.1.3. AXIOLOGICAL ASSUMPTIONS

Axiological assumptions inquire about the way in which the values of the researcher can influence what is to be studied, and are based on a branch of philosophy dealing with values, and those of ethics, aesthetics, and/or religion. Axiological assumptions depict that, the findings of qualitative research are influenced in one way or the other by the researcher's values. Hence, the researcher becomes immersed in what is being studied.

1.10.1.4. RHETORICAL ASSUMPTIONS

Rhetorical assumptions examine the language and the writing approach of the researcher. Rhetorical assumptions use metaphors and personal and literal language based on definitions that evolve during a study, rather than being defined by the researcher (Creswell 2007:16-19).

1.10.1.5. METHODOLOGICAL ASSUMPTIONS

Methodology is “the strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of the methods to the desired outcomes” (Crotty 2003:3). The methodology that was employed in this study was constructivist grounded theory methodology. The goal of grounded theory research is to develop a theory (Bowen 2006:13) through an interactive process of integrative analysis and comparison of data (Charmaz 2005:510; Coyne & Cowley 2006:508; Moghaddam 2006:53). The method must attempt to answer the conceptual question, “What are the basic social processes that underlies the phenomenon of interest?” (Reed & Runquist 2007:119). The researcher attempted to answer the question by making use of constructivist grounded theory research methodology. Basic social processes in this study refer to the processes of facilitating LGBTI-youth inclusive PHC, and were the core category around which the grounded theory was developed. The researcher referred to grounded theory and constructivist grounded theory in this study, because some of the descriptions that were referred to were anchored in grounded theory research, and others only in constructivist grounded theory. Methodological assumptions will be further discussed in Chapter 3.

1.11. THEORETICAL FRAMEWORK FOR THE RESEARCH

Crotty (2003:7) defines a theoretical framework as the theoretical stance informing the methodology, and provides a context for the process to be followed, its logic, and criteria. The ontology of this study is concerned with meanings and interpretations between the participants; and the epistemological stance is constructivist in nature, using constructivist grounded

theory methodology. Thus, symbolic interactionism is considered to be the theoretical framework underpinning this constructivist grounded theory research. Both symbolic interactionism and grounded theory focus on the studying of social processes (Bryant & Charmaz 2007b:21). Symbolic interactionism, according to Blumer, is based on the following three tenets:

a) Humans act towards things on the basis of the meaning they attach to them;
b) The meaning of things is derived from the social interaction with others; and
c) The meanings are modified through an interpretive process (Blumer 1969:2; Plummer & Young 2010:310).

Symbolic interactionism depicts that through social interaction people learn the meanings of how others interpret their actions and interactions. Klunklin and Greenwood (2006:34) assert that interaction within the self and with others allows people to understand a situation and make choices by deciding whether to change, adapt or maintain their course of actions. This is relevant to this study, where LGBTI youth and nurses working in PHC are viewed as social actors in their own right. Their language, actions and the meanings they attached to these, were attended to. This was done in order to explore and describe how nurses and LGBTI youth experience their interaction in PHC, and to explore and describe the basic social process involved in facilitating LGBTI youth-inclusive PHC, Tshwane District, Gauteng Province, South Africa.

1.12. DELIMITATION OF THE STUDY

This study was delimited to public sector PHC and university-based PHC clinics in the Tshwane District, Gauteng Province, SA. Tshwane is a densely populated urbanised region which has a total population of 2,9 million people (Gauteng, Tshwane District Profile 2010-2011:2-3) of which 569 422 comprises of youth between the age of 15 and 34 years of age, who form the majority of the population (Census 2011:21). The target population was self-identified LGBTI youth and nurses in the public sector and university-based PHC clinics in Tshwane District.

1.13. METHODOLOGY OF THE RESEARCH

The study was qualitative in design, using a constructivist grounded theory approach in order to develop a substantive theory focused on facilitating LGBTI youth-inclusive PHC in Tshwane District of Gauteng Province in SA.

1.13.1. RESEARCH DESIGN

This section will briefly discuss the research design, further details will be discussed in Chapter 3.

According to Charmaz (2006:104), grounded theory research is an emerging methodology. The aim of grounded theory is to generate substantive theories that explain the basic social processes or actions through analysis of data from participants who have experienced them. Grounded theory is an inductive research approach and the substantive theory that developed from this study was *grounded* in data from the field (Glaser 1978:93), thus available literature was not considered until the theory began to emerge (Charmaz 2006:182). The point of departure in grounded theory is to understand the contexts, meanings and processes involved in the phenomenon being studied (Charmaz 2006:182). The phenomenon being studied in this research is LGBTI youth-inclusive PHC, which provides an understanding of how participants experience their interaction in PHC and the basic social processes involved in facilitating LGBTI youth-inclusive PHC. Grounded theory approach is appropriate for areas about which little theoretical or factual knowledge is available. In SA, little formal research regarding how LGBTI youth-inclusive PHC ought to be run has been conducted. This study was therefore conducted in the research tradition of constructivist grounded theory. Constructivist grounded theory begins with the exploring of experiences and describing how members construct them. Thus, the interpretation of the studied phenomenon is in itself is recognised as a construction on its own (Charmaz 2006:187).

1.14. CONTEXT OF THE STUDY

This study was conducted at selected public sector and university-based PHC clinics in Tshwane District, Gauteng Province, SA. According to Gauteng, Tshwane District Profile (2010-2011), Tshwane District has 39 PHC clinics, which are provided and managed by Gauteng Provincial Government and 26 PHC clinics, which are provided and managed by Tshwane Municipality, and three PHC clinics, which are provided by non-governmental organisations, aided by the Gauteng Provincial Government. In addition, Tshwane District has eight Community Health Centres (CHC), which render among other services PHC services, and are provided and managed by the Gauteng Provincial Government. According to South African Association of Campus Health Service, Tshwane District has five universities, namely the University of Pretoria, Sefako Makgatho Health Science University, University of South Africa, and Tshwane University of Technology (www.saachs.ac.za). These universities have university-based PHC clinics on all their campuses, which render PHC services to students, who are mostly youth.

1.15. STUDY POPULATION AND SAMPLE

This study comprised two accessible target populations, i.e. self-identified LGBTI youth and nurses in public sector and university-based PHC clinics in Tshwane District. The sample constituted of self-identified LGBTI youth residing in Tshwane during the time of study and had experience of using public or university-based PHC clinics in Tshwane District. The study also comprised of nurses working in the public sector and university-based PHC clinics in Tshwane District. The researcher limited the study to public sector PHC clinics that are in close proximity to the universities, since university-based PHC clinics refer their students to those nearby public sector PHC clinics. Thus, the clinics that were selected were public sector PHC clinics in Mamelodi and Central Pretoria, and university-based PHC clinics of the Tshwane University of Technology and the University of Pretoria.

In constructivist grounded theory, two sampling methods are applicable, namely initial sampling and theoretical sampling (Charmaz 2006:96-100; Coyne & Coyle 2006:507). According to Burns and Grove (2005:40), population refers to “all the elements (individuals, objects or substances) that meet certain criteria for inclusion in a given universe”. This study comprised of two populations sets, i.e. self-identified LGBTI youth and nurses in public sector and university-based PHC clinics. Burns and Grove (2005:40) define sample as a subset of a target population that contains all the characteristics of the target population. Tshwane has a total population of 3 152 162 (City of Tshwane 2016/21 IDP 2016:30), of which 35% comprises of youth between the age of 15 and 24 years, who form the majority of the population (City of Tshwane 2016/21 IDP:40). In this study, the sample constituted self-identified LGBTI youth residing in Tshwane during the time of study, who had experience of using public and/or university-based PHC services in Tshwane District and nurses working in the public sector and university-based PHC clinics in Tshwane District, Gauteng Province, SA.

1.15.1. SAMPLING METHOD

Initial sampling was guided by the research question (Charmaz 2006:96-100) and sensitising concepts of the study (Watling & Lingard 2012:856). The researcher used a purposive sampling method to select the primary sources of data that were likely to provide rich information that was relevant to answer the research question (Watling & Lingard 2012:856). Theoretical sampling implies that the researcher sourced further data until the codes were saturated and elaborated upon; and fully integrated into the emerging theory (Boychuk-Duchscher & Morgan 2004:610). The two types of sampling are discussed as follows:

1.15.1.1. INITIAL SAMPLING

During initial sampling, the researcher used a purposive sampling method to select the primary sources of data that were likely to provide rich information relevant to the research questions (Watling & Lingard 2012:856). In this study,

the clinics that were selected were public sector PHC clinics in Mamelodi and Central Pretoria, and university-based PHC clinics of the Tshwane University of Technology and the University of Pretoria. It was not possible to pre-determine the number of participants that were going to participate in this grounded theory research (Hallberg 2006:144). However, to guide the research, the initial sample comprised seven LGBTI youth and five nurses. The researcher asserted that the initial interviews provided reasonable insight and a considerable amount of data from which relevant concepts for theoretical sampling emerged (Charmaz 2006:97). The researcher asserted that the initial interviews were sufficient to gain an overview of the basic social processes involved in facilitating LGBTI youth-inclusive PHC.

a) Recruitment strategy for initial sampling of LGBTI youth

Recruitment of the participants took place at public sector and university-based PHC clinics and LGBTI social network groups.

To recruit LGBTI youth participants, the main criteria for inclusion was LGBTI youth:

- between the ages of 18 and 34 years;
- residing in the Tshwane District at the time of the study;
- self-identified as either gay, lesbian, bisexual, transgendered or intersexed youth; and
- who had experience of using public sector and/or university-based PHC clinics in Tshwane District.

Recruitment of the participants took place at public sector and university-based PHC clinics and social network groups. Authorisation and assistance from the managers and clinic nurses to identify and refer prospective LBGTI youth and nurse participants was obtained. In order to select the best possible sample for this study, the researcher collaborated with the nurses in the clinics to assist in recruiting the most suitable participants. The nurses briefed those potential participants who met the inclusion criteria about the study, emphasising the

aim and value thereof. The nurses then provided potential participants with the researcher's contact details and left it to the discretion of individuals who had interest in participating to contact her. Once the participants had contacted the researcher, the interview was arranged at a suitable date and time for both parties.

Furthermore, the researcher collaborated with the coordinator of the LGBTI social network group at one of the university-based PHC, who assisted in recruiting prospective participants. The coordinator assisted by briefing the potential participants who met the inclusion criteria about the study, emphasising the aim and value thereof, and requested their permission to provide the researcher with their contact details. The coordinator provided the researcher with the name list and contact details of potential participants who were willing to participate in the study. Thereafter, the researcher contacted potential participants to arrange the first meeting with them. The aim of the meeting was to brief each potential participant about the study and to establish rapport. The researcher then provided potential participants with her contact details, and left the discretion up to the individuals who were interested in participating in the study to contact her. Once the participants contacted the researcher, the interview was arranged at a suitable date and time for both parties. Again, snowballing method was used to select potential participants by requesting LGBTI participants to assist in identifying and referring other LGBTI participants from their social network groups.

b) Recruitment of nurses

In order to obtain multiple perspectives, which will add insight, richness and depth to the phenomenon under study, the main inclusion criteria to purposively select nurse participants was nurses of all categories:

- working in the selected public sector and university-based PHC clinics;
- who have provided care to LGBTI patients; and
- who have more than two years' experience in the PHC clinics.

1.15.1.2. THEORETICAL SAMPLING

Theoretical sampling is a strategic, specific, and systematic process to ensure that data is collected for the construction and verification of tentative ideas and for the purpose of explaining data to build a theory (Charmaz 2006:102). Different sources of data are used as informed by the emerging theory, until theoretical saturation is achieved (Hallberg 2006:144). In this study, the theoretical sample comprised of three LGBTI youth and three nurses, who were interviewed as informed by the emerging theory and until theoretical saturation was achieved. Saturation implies that the categories and the relationships between the categories that will form the concepts of the theory have been finalised (Watling & Lingard 2012:856).

1.16. DATA COLLECTION

Though grounded theory is a qualitative design, it is not similar to other qualitative methods in the sense that it is a flexible method, with no fixed steps, allowing data collection and data analysis to occur concurrently (Watling & Lingard 2012:852). However, in this study, data collection and data analysis were discussed under separate headings. The researcher obtained data through interviews, guided by the research question and followed by probing questions. Field notes were written during and immediately after the interviews (refer to Addendum N). As the study progressed, the interview guide became more focused, as the researcher concentrated on gathering more information regarding the emerging categories (Coyne & Cowley 2006:508).

The researcher concurrently collected data and analysed it by continually comparing concepts with each other, a method that Glaser and Strauss (1967:105-115) refer to as constant comparative data analysis method. Constant comparative data analysis was conducted to conceptualise the data; as well as to validate the conceptualised data against the original and new data with the aim of developing codes, categories and eventually the theory (Klunklin & Greenwood 2006:35; Charmaz 2005:508).

The process of on-going data collection and comparison with codes and categories was the key process in developing the substantive theory that describes the basic social processes involved in facilitating LGBTI youth-inclusive PHC. The process of data collection was terminated once theoretical saturation was reached. Memos were also kept throughout in order to keep track of the data analysis process and to provide material for the theory construction (refer to Addendum J). All discussions between the researcher and the participants were audio recorded, with the permission of the participants, and then transcribed verbatim (refer to Addendum K for one of the transcripts).

1.16.1. THE INTERVIEW PROCESS

The way the interview was conducted was determined specifically by the philosophical perspective underpinning the research paradigm. An understanding of the phenomenon being studied is dependent upon a dynamic human interaction between the participant and the researcher (Coyne & Cowley 2006:508). The main research questions that guided the interview process were: “How do nurses and LGBTI youth experience their interaction in PHC in Tshwane District, Gauteng Province, SA?” and “What are the basic social processes involved in facilitating LGBTI youth-inclusive PHC in Tshwane District, Gauteng Province, SA?” The probing questions appear in Addendum A and Table 1 and were used as applicable. Not all the questions were asked of every LGBTI youth and nurse participant and questions were not necessarily used in the order that they appear in the addendum.

Table 1: Order of probing questions of the LGBTI and nurses' interview guide

Order of questions	Participants	Probing questions
Short facesheet	Nurses	Do you think that it is important to know the sexual orientation of the youth who consult you for health problems?
		In your opinion, what are the health care needs of LGBTI youth?
	LGBTI youth	Have you disclosed your sexual orientation to a nurse in PHC clinic?
Informational	Nurses	Why do you think it is important to know the sexual orientation of the youth seeking health service at your clinic?
		What questions will you ask to determine the sexual orientation of youth seeking health service at your PHC clinic?
		What makes your health care unique when compared to that of your heterosexual counterparts?
	LGBTI youth	What was the nurse's reaction towards you?
		What could the nurse have done to enhance the positive experiences that you have experienced?
		What could the nurse have done to mitigate the negative experiences that you have experienced?
		What concerns or problems will you feel at ease to discuss with the nurse in PHC clinics and why?
		What concerns or problems will you feel uneasy to discuss with the nurse in PHC clinics and why?
Reflective	Nurses	Describe your beliefs and values with regard to LGBTI youth?
		How does your beliefs and values with regard to homosexuality affect the way you respond to the health care needs of LGBTI youth?
		What has your experience been like when rendering health care to LGBTI youth?
		Please describe what you consider to have been positive experiences when rendering health care to LGBTI youth.
	LGBTI youth	Tell me about how your experience was when consulting the nurse with your health problem?
		What has it been like?
		Please describe the events and thoughts that influenced your feelings?
		Please describe what you consider positive experiences you've encountered when seeking health care services at PHC clinics.
		Please describe what you consider negative or unfavourable experiences you've encountered when seeking health care services at the PHC clinics.
Feeling	Nurses	How did you feel about disclosing your sexual orientation to the nurse?
		How did you feel about rendering health care to LGBTI youth?
	LGBTI youth	How did you feel about the nurse's response to the disclosure of your sexual orientation?
		How did you feel about the health service you have received from the nurse?
Ending	Nurses	What could you do to enhance the positive experiences that arose during your encounter with LGBTI youth?
		What knowledge and skills could make nurses competent in delivering LGBTI youth-inclusive PHC?
		What support and resources are required to improve the competencies of nurses rendering health care to LGBTI youth?
	LGBTI youth	What do you think health care that accommodates the health care needs of LGBTI youth-inclusive should be like?

NB Table 1 is not a questionnaire. The questions were only used when necessary and not in a specific order. The researcher only used the questions when the participants found it difficult to describe their perspectives about LGBTI youth-inclusive PHC.

The following questions were initially used to obtain data from the LGBTI youth:

- What has your experience been like when seeking health services at the PHC clinics?
- What factors would enable you to feel at ease to seek health services at the PHC clinics?
- What factors could prevent you from seeking health services at the PHC clinics?
- What do you think LGBTI youth-inclusive PHC should be like?

The following questions were initially used to obtain data from the nurses:

- What has your experience been like when providing health care to LGBTI youth?
- What qualities should nurses providing health care to LGBTI youth have?
- How could nurses working in PHC clinics address the health care needs of LGBTI youth?
- What could enable nurses in PHC clinics to provide LGBTI youth-inclusive PHC?
- What do you think LGBTI youth-inclusive PHC should be like?

Data collection started once permission had been obtained from the health services authorities (see Addendum B and C), Research Ethics Committee of the University of Pretoria (see Addendum D), Research Ethics Committees of the Tshwane University of Technology (see Addendum E) and the Directors/Managers of the university-based PHC clinics where the study was conducted (see Addendum F and G). Informed consent had been obtained from the LGBTI youth participants (see Addendum H) and the nurse participants (see Addendum I).

1.17. DATA ANALYSIS

Once data has been generated, the researcher conducted constant comparative data analysis. Three types of coding were employed, namely open coding, axial coding, and selective coding (Hallberg 2006:143).

1.17.1. OPEN CODING

Strauss and Corbin (1990:61) define 'open coding' as ''the process of breaking down, examining, comparing, conceptualizing and categorizing data'' [sic]. Raw data was conceptualised with the aim of organising and developing codes, categories and concepts and eventually theories (Klunklin & Greenwood 2006:35). Transcripts were screened line-by-line to find words and phrases with similar meaning in order to produce initial codes (Poteat, German & Kerrigan 2013:25) using ATLAS.ti *7* software programme (see Addendum M for codes that emerged). Codes were examined and re-examined for overlap, and then collapsed into categories. Data was grouped together into categories and was given the same conceptual label.

1.17.2. AXIAL CODING

While open coding divides the data into categories, axial coding organised related categories and reintegrated them by making connections between a category and its sub-categories (Moghaddam 2006:58). During axial coding, using theoretical sampling, the researcher further sought new participants to collect data as categories emerged from earlier stages of data analysis. Where and when necessary, individual participants were re-interviewed to clarify, elaborate and verify information about the initial interviews in order to develop, expand, or challenge the emerging theory.

1.17.3. SELECTIVE CODING

Selective coding involves the integration of the categories in order to form an initial theoretical framework. The codes and categories were further explored by reviewing the coded statements (Mehmetoglu & Altinay 2006:12-33), giving attention to perceiving and understanding interrelationships. Memos were used

to assist in the process of creating order and making sense of the data and the data analysis process.

1.17.4. TRANSITION FROM EMERGING TO EMERGED THEORY

Once the theory has emerged from the data, it is appropriate to consider how existing theories might relate or differ from the emergent theory (Watling & Lingard 2012:855; McGhee, Marland & Atkinson 2007:341). The researcher conducted a comprehensive literature review to refine the theory once the theory has emerged. This process assisted the researcher to link the study with the existing body of knowledge in the subject area. The substantive theory was developed and critiqued to substantiate the claims that the emerging theory would make a contribution towards the facilitation of a LGBTI youth-inclusive PHC.

1.18. RIGOUR

In this study, the risk of biased interpretation, which results when the researcher becomes too involved in the process (Backman & Kyngàs 1999:148), was counteracted through reflexivity. Reflexivity (which addresses how the researcher-participant interactions influences the research process), and relationality (which addresses power and trust relationships between participants and researchers), has the potential to increase the validity of the findings in grounded theory studies (Hall & Callery 2001:258). Reflexivity emphasises that the researcher should be able to identify the effect of the 'self' in these relationships. The effect of the 'self' on the research process, and more specifically the outcome of the research have to be noted. Through reflexivity and control over relationality, the process of theory development becomes more transparent (Hall & Callery 2001:257). The writing of a reflective journal (refer Addendum L), an important tool for reflection on the research process (Bringer, Johnson & Brackenridge 2006:247), was used by the researcher.

The four criteria prescribed by Charmaz (2006:182) for evaluating grounded theory, namely, **credibility, originality, resonance**, and **usefulness,** will subsequently be discussed, as applied to this study.

1.18.1. CREDIBILITY

The depth and range of data collection ought to be sufficient to support the argument that the theory that emerges is logical, and linked clearly to the data. For this study, data was collected until theoretical saturation occurred. The researcher also transcribed the audio-recorded interviews verbatim so that the product of analysis could be compared with the primary data. The researcher adapted the set of probing questions, for the verification of the categories, concepts and emerging theory. The constant comparison of data and categories provided a further data source for analysis and justification of the emergent theory (Charmaz 2006:182). Since it was the aim of this study to make unique and specific contributions to the existing body of knowledge, available literature was not considered until the theory began to emerge (Charmaz 2006:182).

1.18.2. ORIGINALITY

Originality implies that the research should offer new insights, and fresh conceptual understandings (Watling & Lingard 2012:855). The researcher acknowledged that the findings of the research could have been influenced by the researcher's interpretations and understandings. However, the researcher demonstrated that the findings of the research were 'constructed truths' firmly grounded in the data, by substantiating the categories that emerged with quotations from the participants. Therefore, the researcher affirms that the concepts developed in this study were original and grounded in the data (Glaser 1978:37-41), and that they offered new insight into the basic social processes involved in facilitating LGBTI youth-inclusive PHC.

1.18.3. RESONANCE

Resonance implies that the grounded theory makes sense to the participants and captures the essence and fullness of their experiences (Watling & Lingard 2012:855). The researcher continued collecting data and continued with the constant comparison process until the categories were saturated. It is anticipated that the theory that developed from this study will provide nurses with a deeper insight into the basic social processes involved in facilitating LGBTI youth-inclusive PHC.

1.18.4. USEFULNESS

Usefulness implies interpretations that can be used in day-to-day situations by individuals who have interest in the phenomenon under study (Watling & Lingard 2012:855). The researcher provided detailed information about the sample and setting characteristics of the study so that people who want to adopt and use the substantive theory that emerged from the study can decide whether or not this could be applicable to their context. Therefore the usefulness of the substantive theory of this study depends on the reader's ability to interpret its applicability in similar settings, i.e. other settings that provide LGBTI youth health care.

1.19. LIMITATION OF THE STUDY

The study was limited to selected clinics in Tshwane District, Gauteng Province. Therefore, the theory that emerged will be specific to the context being studied. Further details on the limitations of this study were provided in Chapter 8.

1.20. ETHICAL CONSIDERATIONS

The researcher supported the implications of the Belmont Report and was committed to following the prescribed procedures to ensure that ethically sound research was conducted and that the rights of the participants throughout the process were protected (Polit & Beck 2008:170). The research was only conducted once the proposal had been approved by the Faculty of

Health Sciences' Research Ethics Committee of the University of Pretoria and the Tshwane University of Technology, permission to conduct the study had been obtained from the City of Tshwane, Department of Health, Student Health Services of the University of Pretoria and the Tshwane University of Technology, and informed consent had been granted by the participants. The cooperation of the managers of the selected PHC clinics was obtained before any data were collected. The following ethical principles were strictly adhered to.

1.20.1. RIGHT TO SELF-DETERMINATION, ANONIMITY, PRIVACY, CONFIDENTIALITY, FAIR TREATMENT; AND PROTECTION FROM DISCOMFORT

In this study, participants were provided with a detailed explanation of the purpose of the study in the form of written and verbal explanations. The participants were informed about their rights to decide to participate in the study, without any form of coercion and about their rights to withdraw from the study without fear of being discredited. Informed consent was obtained from the participants before they could partake in the study. The participants were guaranteed that all the information they provided would be treated with confidentiality. Pseudonyms were used during the interviews and transcription of data so that no information could be linked to a particular participant. To enhance privacy and dignity, the interviews took place at a private place chosen by the participants where they felt comfortable.

Audio-recordings were kept in locked cupboards, and the participants were informed about how the findings of the study would be disseminated. All participants were treated the same, irrespective of their background. No participant was given preference over the others. Participants were treated with respect, and the diversity of their contributions was acknowledged. The researcher acknowledged that the context of this study was sensitive due to the vulnerable nature of LGBTI participants, and the negative experiences that they endured due to discrimination. The researcher anticipated the possibility that the participants could be distressed during and/or after the interview.

Therefore, should the participants become distressed as a result of the interview, the researcher was prepared to contact the counsellor, Ms. Delta Tladi for debriefing so as to deal with any emotional crisis that might have arisen from the interview process. Nevertheless, in this study, none of the participants became obviously distressed during the course of the interviews. In addition, the researcher provided the participants with an information sheet (see Addendum H) indicating that they could contact the counsellor or their preferred counsellor should a need arise after the interview process.

1.21. DISSEMINATION OF RESULTS

The basic social processes that are involved in facilitating LGBTI youth-inclusive PHC will be shared with the Tshwane Department of Health and university-based PHC clinics. The researcher also plans to publish articles in nursing research journals and to present at nursing conferences. The thesis will be made available in the library of the Faculty of Health Sciences, University of Pretoria, as a reference for students, and hence become a resource for further research.

1.22. ORGANISATION OF THE CHAPTERS OF THE STUDY

This study is presented in eight chapters. This chapter provides an introduction and background context to the study and the significance of scientific investigation into the phenomenon. Chapter 2 presents preliminary and substantive review of literature focusing on sexuality, sexual orientation and health care needs of LGBTI youth including the interactions between LGBTI youth and nurses. Chapter 3 outlines the research methodology of the study which is constructivist grounded theory method making reference to the theoretical framework of symbolic interactionism which guided the study towards achieving its aim. The chapter also provide details into the philosophical assumptions underpinnings which shaped the study. Chapter 4 provides details on data analysis process which accounts for coding and theory construction and outlines how the four categories and sub-categories emerged. Chapter 5 presents the emergence and description of the core category in

relation to the four categories and related sub-categories that emerged through the data analysis processes as discussed in Chapter 4. Chapter 6 compares the core category to relevant literature, discussing how and where the findings fit or extend into those literature and theories. Chapter 7 outlines the details the process of theory synthesis, which informed the conceptual emergence of the substantive theory of facilitating LGBTI youth-inclusive PHC which is presented alongside the core category. Finally, Chapter 8 reviews how the key findings of the study contribute to the knowledge base of nursing and discusses its implications for practice, education; and future research.

1.23. CONCLUSION

This chapter provided the background to the study and an overview of how the study was conducted to eventually achieve the aim of the study which was to develop a substantive theory focused on facilitating LGBTI youth-inclusive PHC in Tshwane District of Gauteng Province in South Africa.

CHAPTER 2:

SUBSTANTIVE LITERATURE REVIEW

2.1. INTRODUCTION

This chapter provides a substantive review of literature by putting into perspective background to the study, and providing an overview of sexuality and sexual orientation, the health care needs and health care concerns of LGBTI population focusing mostly of the LGBTI youth. Furthermore, this chapter will explore the health care providers' attitudes towards LGBTI from the LGBTI patients' and the health care providers' perspectives. Strategies that have been developed to facilitate the care of LGBTI patients will also be explored.

2.2. SEXUALITY AND SEXUAL ORIENTATION

Youth is regarded as the years of self-discovery, a time when young people experience physical, emotional, cognitive and psychological changes (Saewyc 2011:258). At the same time, they start to explore and discover their sexuality, sexual identity and sexual orientation, identifying themselves as either heterosexual or homosexual (McCabe et al. 2011:142; Saewyc 2011:257-258). During the period of transition from adolescence to adulthood, young men and women who identify themselves as homosexual, experience challenges that are unique when compared to those of heterosexual persons. For example, most LGBTI youth experience health-compromising behaviours, poor psychosocial outcomes; and health inequalities, as compared to their heterosexual peers (Saewyc 2011:262).

Few studies have established that sexual orientation is multi-dimensional and complex and therefore cannot be characterised by simple dichotomies (Bauer & Jairam 2008:385-386; Yon-Leau & Muñoz-Laboy 2010:105-106; Saewyc 2011:257). Sexual orientation includes multidimensional constructs involving

three primary dimensions: sexual attraction, sexual behaviour, and sexual identity. The three primary dimensions are explained as follows:

a) sexual attraction is defined based on the sex of the individual(s) by whom one is sexually attracted to;
b) sexual behaviour as determined by the sex of the individual(s) with whom one chooses to have sexual contact; and
c) sexual identity as the self-identified label that an individual adopts to describe him or herself.

Therefore, when individuals categorise themselves on the basis of their own sexual attractions, desires and behaviours, they are in a way described as adopting a sexual orientation or identity (Igartua et al. 2009:603; SAHM 2013:507; Brewster & Tillman 2012:1168). Three sexual orientation identities are commonly recognised, namely: heterosexual (attraction to individuals of the opposite sex); homosexual (attraction to individuals of one's own sex); and bisexual (attraction to individuals of both sexes) (Higgins et al. 2011:15).

Researchers who are developing a body of literature on the health, health needs and health inequalities of LGBTI persons haven't reached consensus with regard to the definitions of the key terms used among this community (Dorsen 2014:6). The following descriptions are suggested:

- bisexual refers to a person who is sexually or romantically attracted to people of both sexes to a significant degree (IOM 2011:317).
- gay refers to a male person who is sexually and romantically attracted exclusively to another male (IOM 2011:317).
- homosexuality is an enduring pattern of emotional and/or sexual attractions primarily or exclusively to people of the same sex (IOM 2011:317).
- intersex refers to individuals who are born with ambiguous genital or reproductive anatomy and therefore cannot identify themselves as either men or women (Johnson et al. 2008:216).
- lesbian refers to a female person who is sexually attracted exclusively to other females (IOM 2011:317).

- transgender refers to people who have gender identities, expressions or behaviours that are not associated with their biological sex. Transgender people identify more with the opposite gender, i.e. women identify themselves as men and men identify themselves as women. They may be heterosexual, homosexual, bisexual or nonsexual (Johns et al. 2008:216).

Most researchers in sexuality use the umbrella term “LGBTI” to identify people with non-conforming sexual orientation and sexual identity. Researchers are of the opinion that the term is inclusive of the diversity among and within these groups, and that people with non-conforming sexual identity and sexual orientation experience similar dynamics and problems across (Eady et al. 2010:379). For example, most LGBTI people are victims of discrimination, homophobic attitudes and/or imprisonment (Thoreson & Cook 2011:5) and they experience significant health care inequalities as compared to their heterosexual counterparts (Pathela et al. 2006:422-424; Igartua et al. 2009:603; SAHM 2013:507; Saewyc 2011:257). Another frequently used term in the literature is “sexual minority”, which captures a diverse population of those who self-identify as lesbian, gay or bisexual, or whose sexual identity, behaviour, and attraction do not reflect a completely heterosexual orientation i.e., youth who have sexual identities or expressions that differ from societal norms (Berlan, Corliss, Field, Goodman & Austin 2010:366; Kann et al. 2011:2). The use of the term “sexual minority” in the literature may refer to people who self-identify as non-heterosexual, even if they had never had same-sex sexual experiences before (Nakamura, Semple, Strathdee & Patterson 2011:797; Berlan et al. 2010:366; Kann et al. 2011:2). Likewise, this term may be used to refer to people who have had same-sex sexual experiences, even if they do not self-identify as lesbian/gay or bisexual. However, the use of the term “sexual minority” when referring to the LGBTI population has been criticised for being too broad, and possibly leading to inaccurate generalisations about this diverse population (Kann et al. 2011:2, Allen 2013:2).

Most research has recognised that identity and behaviour often do not correlate (Bauer & Jairam 2008:383; Reback & Larkins 2010:769-772; Wells, McGee & Beautrai 2011:160-167; Yon-Leau & Muñoz-Laboy 2010:105). For example, the National Health and Nutritional (NHM) Survey 2001-2006 show that just over 7% of women reported to be involved in a same-sex sexual relationship, 50% reported a heterosexual identity, 32% identified as bisexual, and 18% identified as gay or lesbian (Xu, Maya & Markowitz 2010a:407). Using the same data, Xu, Sternberg and Markowitz (2010b:401-405) showed that about 5% of males reported a same-sex relationship, of which 40% identified as heterosexual, 22% identified as bisexual, and 38% identified as gay. Many LGB people do not prefer the use of the term homosexual to describe their sexual orientation, due to fear of discrimination, and most prefer to remain in the closet until into late adolescence and adulthood (Allen 2013:2).

Some researchers assert that the reasons why certain people self-identify as heterosexual whilst others self-identify as homosexual are unknown. Sexual orientation identity is complex because it is not fixed, and may change over time throughout an individual's lifespan (Igartua et al. 2009:60; McCabe et al. 2011:147148; Saewyc 2011:258; Brewster & Tillman 2012:1170; Mustanski, Van Wagenen, Birkett, Eyster & Corliss 2014:213). On the contrary, the IOM (2011:317) reported that literature reveals a few possible reasons why some people self-identify as heterosexuals and others as homosexuals, with the most overarching reason being the natural course of experimentation during young people's life as they assess and reassess their sexuality. Furthermore, "one of the major developmental tasks for lesbian and gay youth is the deconstruction of previously internalized [sic] heterosexual expectations and the construction of a new set of future expectations of the gay and lesbian life course" (Mustanski et al. 2014:213) which may involve a significant amount of experimentation. Another reason for the incongruence observed between the components of young people's sexual orientation suggested by researchers may be that sexual attraction naturally develops in early adolescence, while

sexual experience and sexual identity develop in early youth (Mustanski et al. 2014:213). At the same time, while the youth may be aware of same-sex attraction and self-identify as LGBTI, he or she may not be ready to engage in sexual behavior, or may not have found a partner with whom he or she wants to engage in sexual behaviour. Lastly, sociocultural norms and expectations have been found to play a significant role in young people's expression of sexual orientation, which may ultimately influence the youth's behaviours or self-identification (Igartua et al. 2009:607).

It is obvious from the literature that sexual attraction, sexual behaviour and sexual identity represent distinct dimensions of sexuality, particularly during youth years (Igartua et al. 2009:603; SAHM 2013:507). Therefore, it remains crucial to address each dimension of the youth's sexual orientation categorically in order to fully understand his or her experience and to address the range of possible health risks and inequalities (Igartua et al. 2009:603). Most researchers recommend that measures for sexual orientation ought to be developed and standardised (Saewyc 2011:257-258; Mustanski et al. 2014:243). However, authors like Moradi, Mohr, Worthington and Fassinger (2009:5) and Ridolfo, Miller and Maitland (2012: 113-124) are of the opinion that before appropriate sexual orientation measures may be developed, concise conceptual definitions of sexual orientation are needed. The lack of consensus with regard to the methods of defining and assessing sexual orientation and sexual minority status impedes the precise understanding of this population who experiences sexual orientation-related health inequalities (Pathela et al. 2006:422424; Saewyc 2011:257-258). Therefore, it remains uncertain whether the health and other social policies appropriately address the needs of sexual minority population to reduce such inequalities. In this study, the terms: lesbian and gay (LG), lesbian, gay and bisexual (LGB), lesbian, gay, bisexual and transgender (LGBT), lesbian, LGBTI, lesbian, gay, bisexual, transgender and queer (LGBTQ), homosexuals, nonconforming sexual orientation, non-heterosexual orientation and sexual minority will be used as cited by the authors in literature. However, LGBTI will be an acronym

used throughout the current study to refer to people with a non-conforming sexual orientation and sexual identity.

Most youth who may self-identify as gay or lesbian at earlier ages, prefer to remain in the closet (OUT Wellbeing 2016:1) well into adulthood (IOM 2011:138). As a result, they lack access to gay and lesbian peers and adult role models. They do not have accurate information about being gay or lesbian, which could help them to strengthen their self-esteem, dispel homo-negative stereotypes, and develop healthy gay or lesbian identities (IOM 2011:138). The study conducted by Mavhandu-Mudzusi and Sandy (2015:1054) aimed to explore religion-related stigma and discrimination experienced by LGBT students at a South African rural-based university, discovered that LGBT students conceal their homosexual orientation in order to cope with their stigma-related anxiety. Thus, they sometimes behave as heterosexuals. Similarly, some authors mention that homosexual people tend to conceal or suppress their sexual orientation in order to cope with their stigma-related anxiety, a strategy which Sedlovskaya, Purdie-Vaughns, Eibach, LaFrance, Romero-Canyas and Camp (2013:1) refer to as "divided self" when describing the concealment of part of one's identity. Most LGBTI youth conceal or suppress their sexual orientation as coping strategies by: 1) adopting "straight" behaviour; 2) trying to change sexual orientation through heterosexual dating or sexual activities (Mavhandu-Mudzusi & Sandy 2015:1054); and 3) rationalising same-sex attractions as only a phase (Saewyc 2011:261-264).

There is inadequate information and statistics about LGBTI health in sub-Saharan countries, since most countries do not acknowledge the existence of LGBTI populations (Ehlers, Zuyderduin & Oosthuizen 2001:849), and homosexuality has been regarded as a crime in about 38 African countries (Thoreson & Cook 2011:5). In the USA, almost 3.5% of the adult population identify as lesbian, gay, or bisexual, and almost 0.3% of adults are transgendered, which comprise of almost nine millions of Americans who self-

identify as LGBT (Gates 2011:1). South Africa is estimated to have 900 000 lesbian and gay people (Nell & Shapiro 2011:10) amongst a total population of 51,8 million in 2011 (Census 2011:14).

2.3. CLASSIFICATION AND DE-CLASSIFICATION OF HOMOSEXUALITY AS A MENTAL DISEASE

In 1952, non-conforming sexual orientation such as homosexuality was classified by the American Psychiatric Association (APA) in the DSM-I as a mental disorder, listed among the sociopathic personality disturbances (Tully 1995:1; Hinchcliff et al. 2005:346). This classification emanated from medicine and psychiatry tradition, which originated from the Christian religion (Bayer 1981:16-17; Taylor 2011:29). Homosexuality was initially regarded as immoral, and a sin (Bayer 1981:16-17), then transformed into crime (Taylor 2011:29; Thoreson & Cook 2011:5; Drescher 2015:568), then a mental disorder (Tully 1995:1; Drescher 2015:566); and eventually a lifestyle and a genetic disposition (Taylor 2011:29). During the 1970s, mental health practitioners used corrective therapies, which included group social demand treatments, heterosexual responsiveness instruction, aversion conditioning, social learning training, covert sensitisation, fantasy modifications, capacity for heterosexual intercourse, training for abstinence and celibacy, drug treatment, and fundamental spiritual treatments (Blackwell 2008:655). Some other therapies used to reverse the so-called “disorder” were coercive hormone replacements, electroconvulsive therapy, hypnosis, gender reassignment surgeries; and psychotherapies, which were later proven to be ineffective (Smith et al. 2004:429).

In 1973, homosexuality was declassified from the DSM II as a mental disorder by the APA after the majority of psychiatrists voted at a convention to remove it, due to the fact that homosexual people do not all manifest with signs and symptoms of psychopathology (Hooker 1957:18-21; Hinchcliff et al. 2005:346). APA later released a legal statement that rejected any form of discrimination on the basis of sexual orientation (Taylor 2011:29). It was later reclassified as

a sexual orientation disorder, because most psychiatrists were of the opinion that people with non-conforming sexual orientation such as homosexuals experienced internal conflict with their sexual orientation (Johnson et al. 2008:214).

Furthermore, in 1987, homosexuality was completely declassified from DSM IV as a disorder because:

a) not all homosexual people had signs and symptoms of mental disorder;
b) it was discovered that homosexual people require the same clinical care as their heterosexual counterparts; and
c) even if an individual did not have the desire to change from his/her homosexual orientation to being heterosexual, the distress and anxiety related to nonconforming sexual orientation couldn't be labelled as "ego-dystonic" sexual orientation (Cochran et al. 2014:675).

Over and above the other reasons why homosexuality was removed from the diagnostic manual were:

a) psychiatrists envisioning to eliminate the stigma attributed to homosexuality being a "pathology";
b) health care providers feared that continuing diagnosing homosexuality as a mental disorder would encourage the society's prejudice and advance homosexual people's social suffering;
c) health care providers could not provide evidence with regard to the psychodynamic and pathological causes of homosexuality; and
d) health care providers consequently wanted to develop guidelines of successfully treating the disease (Bayer 1981:14).

Nevertheless, homosexuality remained on the ICD list (the International Statistical Classification of Diseases and Related Health Problems (ICD).by WHO) until 1992. It was classified as "ego-dystonic sexual orientation", which the WHO defined as a condition whereby the person wishes that his sexual orientation and preferences were different, due to associated psychological and behavioural disorders (Cochran, Drescher, Kismödi et al. 2014:672-673).

The concept “ego-dystonic” homosexuality was integrated into mental disorders’ classifications as a part of the consensus-building process following the declassification of homosexuality as a mental disorder from the DSM IV. This meant that homosexuality could still provide the basis for a diagnosis as a mental disorder only if the individual had associated psychological and behavioural disorders. The classification was intended to clinically address the needs of those homosexual individuals who have the desire to develop heterosexual orientation, or to relieve the distress associated with the non-conforming sexual orientation. However, research revealed that their elevated distress was not linked to their inherent sexual orientation *per se,* but to their greater experiences of social rejection, discrimination, physical illness and/or poverty.

Though the ICD-10 does not clearly define what constitutes a psychosexual developmental disorder, sexual orientation is used as a central concept as categorised in the F66. However, the F66 category does not provide specific information about what is being treated, nor does it indicate how to treat the disorder, rather, it provides health care providers with an opportunity to apply an undefined mental disorder diagnosis to individuals’ homosexual orientation. The current F66 categories revised homosexuality as a sexual maturation disorder (F66.0), a concept that emerged from psychosexual development, which refers to the development of an individual’s sense of gender identity, sexual orientation and gender role behaviours. The core distinguished features of sexual maturation disorder are: 1) uncertainties about one’s gender identity or sexual orientation; and 2) experiencing distress about the uncertainty of the particular gender identity or sexual orientation (Cochran et al. 2014:672-673).

This kind of evolution in homosexuality highlights that perceptions about mental disorder can be rapidly evolving constructs that could change over time as the society eveolves (Igartua et al. 2009:60; McCabe et al. 2011:147-148; Brewster & Tillman 2012:1170; Mustanski et al. 2014:213). These changes emerged as a result of evolving human rights principles and the lack of

empirical evidence, supporting the classification of variations in sexual orientation expression as a mental disorder (Saewyc 2011:257-258).

2.4. THE HEALTH CARE NEEDS OF LGBTI PEOPLE

LGBTI youth share similar developmental issues (Hoffman et al. 2009: 222) and similar health care needs as any heterosexual youth (Johnson et al. 2008:214; Igartua et al. 2009:602). However, people who are identified as LGBTQ are prone to social exclusion and significant health inequalities (Rosenstreich, Comfort & Martin 2011:2; O'Byrne and Watts 2014:21; Rounds et al. 2013:99; Igartua et al. 2009:603; SAHM 2013:507; Saewyc 2011:256). For instance, LGBTI youth are subjected to a wide range of verbal, emotional and sexual abuse, discrimination and victimisation (Kipke et al. 2007:343; Kann et al. 2011:2; Everett 2013:230; Meyer 2016:82), homophobic attitudes and bullying (Brewster & Tillman 2012:1168; Kann et al. 2011:2; Saewyc 2011:265-266; Russell, Everett, Rosario & Birkett 2014:1113; Everett 2013:230), which significantly results in greater risk for negative physical and mental health outcomes than their heterosexual counterparts (Coker et al. 2010:463; Dilley, Simmons, Boysun, Pizacani & Stark 2010:462; Ochse 2011:3-4; Brewster & Tillman 2012:1168; Johns et al. 2013:85-86; Müller 2013:2; Newcomb, Birkett, Corliss & Mustanski et al. 2014:304; Mavhandu-Mudzusi & Sandy 2015:1053).

The health care needs of the LGBT population have also been inadequately reported within research specific to nursing (Marryfeather & Bruce 2014:115; Eliason, Dibble & Robertson 2011:1358). A review of the nursing literature published between 2005 and 2009 related to LGBT health within the ten top nursing journals, based on the five-year impact factor was conducted. The five-year impact factor refers to the average number of times the articles from a specific journal have been cited within the past five years. Key terms that were applicable to sexuality and gender were used for the CINAHL literature search and the number of hits that occurred within any field, within the title only, and within the abstract was identified (Eliason et al. 2010:209). The most common

hits within any field were: gay (2123), lesbian (1051), and bisexual (898). Hits for gay men in the title and within any field, were double the number of hits for lesbians. There were fewer hits for bisexuals and even less for transgender, as compared to gay men and lesbians. Out of almost 5,000 journal articles published between 2005 and 2009 within the top ten nursing journals, Eliason et al. (2010:209) identified eight articles (0.16%) that primarily focused on LGBT health issues. Of the eight identified articles: six were qualitative studies, six appeared in one specific journal (the Journal of Advanced Nursing), and none were from USA researchers. Furthermore, of the articles with a primary focus on LGBT issues, there were nineteen that were identified by conducting key word searches that mentioned, but did not focus, on LGBT issues (Eliason et al. 2010:209-214). Most articles demonstrated that LGBT literature exists; however, much of it is descriptive and little focused on developing health care providers to adequately provide care to the LGB population (Eliason et al. 2010:214).

Most literature reveal that LGBTI youth are prone to: alcohol and substance abuse (Ash & Mackereth 2010:5; Kann et al. 2011:2; McNair et al. 2011:40-41; Brewster & Tillman 2012:1168; Newcomb et al. 2014:304-305); obesity (Laska, VanKim, Erickson, Lust, Eisenberg, & Rosser 2014:623); smoking, depression, anxiety (Ash & Mackereth 2010:5), suicidal ideation (Haas, Eliason, Mays et al. 2011:10); certain cancers (Russell et al. 2014:1113); and STIs (Riskind et al. 2014:1959-1961, Everett 2013:223), including infection with the HIV (Hoffman et al. 2009:222; Müller 2013:2; Mavhandu-Mudzusi & Sandy 2015:1054), than their heterosexual counterparts. A large body of published empirical research emphasises that due to the stresses caused by stigma, discrimination and inequalities, LGB people are at an increased risk of psychological distress related to these experiences (Coker et al. 2010:463; Brewster & Tillman 2012:1168; Johns et al. 2013:85-86). This kind of psychological distress is often referred to by researchers as “minority stress”, a term used to describe the mental health effects of stigmatisation, discrimination, and harassment of minority groups such as the LGB population (Meyer 2016:81). The term is used

to create an understanding that isolation from social structures, norms and institutions can create psychological distress (Allen 2013:2). For example, transgendered men and women experience considerable discrimination and mistreatment in the health care system (Poteat et al. 2013:27), and consequently experience high rates of: depression (Meyer 2016:81); anxiety; substance abuse; and other mental health conditions (Marshal, Dermody, Shultz, Sucato, Stepp, Chung, Burton, Markovic & Hipwell 2013:276-277; Rosario, Corliss, Everett, Russell, Buchting & Birkett 2014:1113).

While not all LGB people experience increased risk of poor mental health as a result of minority stress, research has shown that some LGB people might experience anxiety and depression as a result of the psychological adjustment related to 'coming out' and acceptance of one's homosexual orientation (Allen 2013:4). Health care providers ought to discuss these experiences with LGB patients, including how that impacts on their mental health (Allen 2013:4). Health care providers ought to offer mental health screening for LGB patients and be able to identify mental health risk factors such as depression, anxiety, substance misuse, suicidal ideation and the lack of social support. Thus, health care providers ought to refer such patients to mental health services and/or other support services, such as counselling and psychotherapy, where necessary (Allen 2013:4). In SA, research pertaining to LGBTI health care needs and how these needs ought to be addressed by health care providers, as well as research on LGBTI's health, practices, and the theoretical concerns of health care providers, have been largely neglected (OUT LGBTI Wellbeing 2007:7).

A number of studies that have examined differential rates of smoking, alcohol and other drug use among adolescents by sexual orientation over the past decade found a higher prevalence of smoking, alcohol use, and other drug use, including injection drug use, among LGBQ youth as compared to their heterosexual peers (Coker et al. 2010:463-464; Brewster & Tillman 2011:1168; Marshal et al. 2013:273-277; Rosario et al. 2014:1113; Riskind et al.

2014:1961). The findings of a cross-sectional study conducted by Marshal et al. (2013:273-277), aimed at examining substance use and mental health inequalities among girls in the sexual minority revealed that compared with heterosexual girls, girls in the sexual minority reported significantly higher levels of negative mental health and substance use outcomes. The findings revealed that girls in the sexual minority were prone to risks of engaging in any form of alcohol use (OR = 2.71, $p < .001$) or binge drinking (OR = 2.96, $p < .001$) and they were over five times more likely to report any cigarette use (OR = 5.18, $p < .001$), marijuana use (OR = 3.61, $p < .001$) or any self-harm (OR = 6.87, $p < .001$) than heterosexual peers in the past year. Several longitudinal studies that focused on patterns of substance use over time of LGBTQ adolescents reported that adolescents in the sexual minority were more likely to begin drinking earlier than their heterosexual peers, and most sexual minority groups had engaged in higher levels of risky drinking (Coker et al. 2010:463464).

Most research on health inequalities has focused on concerns related to mental health, especially suicidal ideation and suicide attempts (Saewyc, Skay, Hynds, Pettingell, Bearinger, Resnick & Reis 2007:35-36; Coker et al 2010:464-465; Saewyc 2011:262). These studies have been conducted using diversity of sampling methods, measuring dimensions of sexual orientation in variety of regions and countries, and across time, within nearly all population-based studies. The findings of most studies have been remarkably consistent, revealing that a higher number of sexual minority youth present with emotional distress, depression, self-harm, suicidal ideation, and suicide attempts than their heterosexual peers (Saewyc et al. 2007:35-36; Coker et al. 2010:464-465; Saewyc 2011:262). A higher prevalence of suicidal ideation and attempts have been documented in population-based studies in countries such as Canada (Saewyc et al. 2007:30-32) and New Zealand (Fleming, Merry, Robinson, Denny & Watson, 2007:213–221).

The study of Goldberg, Habin & Campbell (2011:184) revealed that nurses stereotyped LGBTQ patients by reducing them to sexuality and sexual practices. In other words, LGBTQ were reduced to and equated with sex; either as being more sexualised than others, or as being more inappropriately sexual or having multiple sexual partners. This notion became evident in the 1980s, whereby the view of a “gay plague” emerged, an HIV and AIDS pandemic among gay men in the USA, which brought to the health care system’s attention some unique health care needs of the gay community. As a result, the HIV and AIDS pandemic among gay men in the USA served to promote prejudice and discrimination towards homosexual men (Douglas, Kalman & Kalman 1985:1309-1311; Durham & Lashley 2010:208-210; The Committee of Human Sexuality 2000:98-99; McCabe et al. 2011:142). In Canada, HIV affects men who have sex with other men more than it does heterosexual men, and accounted for the majority of the new HIV infections despite HIV being a preventable disease (Remis, Alary, Liu, Kaul & Palmer 2014:4; McCabe et al. 2014:142; Nakamura et al. 2011:797799). Similarly, according to Newman-Valentine and Duma (2014:3), SA has a higher prevalence rate of HIV, of approximately 17.4%, in comparison with international countries. This high prevalence of HIV amongst women may suggest an even higher infection rate amongst transsexual women because of their vulnerability. However, HIV prevention programmes that are available in SA target certain groups other than transsexual women. As a result, the lack of access to health and sexual education for this group, make them vulnerable to contracting HIV, as they believe that they are at a lower risk.

Several studies have explored risky sexual behaviours and sexual health behaviours among the LGBTI population (Rosario et al. 2014:1117-1118; Riskind et al. 2014:1961), such as: limited contraceptive usage; multiple sexual partners; survival sex; and a lower rates of condom use (Coker et al. 2010:465-466), which result in negative sexual health outcomes, including STIs and teen pregnancy among sexual minority youth in comparison with heterosexual teens (Coker et al. 2010:466; Kann et al. 2011:2; Saewyc 2011:263; Riskind et al.

2014:1957-1961; Mavhandu-Mudzusi & Sandy 2015:1054). LGBQ youth are more likely than heterosexual peers to have engaged in sexual intercourse before the age of thirteen, and are also more likely to report a higher number of lifetime or recent sexual partners (Coker et al. 2010:465). This prevalence in sexual risk behaviours indicates the inequalities in sexual health outcomes of LGBQ youth in comparison with their heterosexual counterparts. Thus they become prone to higher rates of self-reported STI history among sexually experienced LGBQ teens compared to heterosexual peers (Coker et al. 2010:466; Kann et al. 2011:2; Saewyc 2011:263; Riskind et al. 2014:1957-1961; Mavhandu-Mudzusi & Sandy 2015:1054).

Considering the fluidity of sexuality during youth, lesbians and bisexual youth are more prone to a higher rate of being pregnant when compared to heterosexual girls (Riskind et al. 2014:161; Mavhandu-Mudzusi & Sandy 2015:1054). Surveys throughout the USA in the past two decades have reported that LGBQ teens, both males and females have a two to ten times higher rate of pregnancy involvement than their heterosexual peers (Coker et al. 2010:465; Kann et al. 2011:2; Saewyc 2011:263; Riskind et al. 2014:1957-1961). However, despite these higher rates of teen pregnancy, there is lack of evidence with regard to teen parenting among LGBQ adolescents. In SA, many lesbians remain ‘in the closet’ due to the fear of becoming victims of discrimination and possible physical harm, including ‘corrective rape’ (Ochse 2011:3-4). Such form of sexual violence, driven by homophobia, places lesbians at higher risk of contracting HIV infection (Müller 2013:2).

In the 1980s, a body of literature was developed regarding possible increased risk of breast cancer among lesbian women, which continued to be an active area of interest in the study of lesbian women (Meads & Moore 2013:2-3). Bjorkman and Malterud (2009:239) emphasise that lesbians might suffer from health problems to a greater extent than heterosexuals or the general female population as a result of marginalisation. Lesbian women are less likely to access regular pap smear tests and mammograms; and are more prone to

alcohol, tobacco and substances abuse, thus more likely to develop breast cancer (Bjorkman & Malterud 2009:239).

2.5. EXPERIENCE OF DISCRIMINATION

LGBTI youth are subjected to homophobic attitudes, which include domestic and community violence, bullying and victimisation. The extent of violence against homosexual people has been reported as malicious and often involves a high degree of inhumaneness (Berlan et al. 2010:2-3; Kann et al. 2011:2; Saewyc 2011:264; Russell et al. 2014:1113). Despite SA being estimated to have 900 000 lesbian and gay people (Nell & Shapiro 2011:10), there is still limited evidence as to the prevalence of LGBTI discrimination and hate crimes, which can inform services, interventions and advocacy to address the concerns of LGBTI people (OUT Wellbeing 2016:1). The last study to measure the level of empowerment amongst LGBTI people was conducted only in the North West Province of SA in 2010 (OUT Wellbeing 2016:1). In 2015, OUT Wellbeing conducted an online survey to determine the prevalence of discrimination among LGBTI people in SA and to understand their experiences when using public services. A total of 2 130 people participated in that study, with 63% of them being between the ages of 16 and 29. More than half of the sample comprised gay men, a third lesbians, 1% bisexuals, and 18,3% transgender. Over half of the respondents, i.e. 55% reported that they preferred to remain in the closet due to fear of experiencing discrimination should they decide to disclose their sexual orientation. About 56% of the respondents indicated that they were victimised at schools due to their homosexual orientation, with verbal insults being the most common form of discrimination, and the second common form being actual physical or sexual abuse (OUT Wellbeing 2016:6). The findings of the mentioned study yielded similar results to those studies on LGBTIs' experience of discrimination in SA conducted by Ochse (2011:3-4); Akhan & Barlas (2013:435); Müller (2013:2); Mavhandu-Mudzusi and Sandy (2015:1049) and Hayman, Wilkes, Halcomb and Jackson (2013:121). However, contrary to the findings of these studies which demonstrated that most LGBTI people experience negative attitudes

when they access health care services, the study of OUT Wellbeing (2016:8) revealed that only 10% of the respondents reported being discriminated against in the health care sector.

2.5.1. DISCRIMINATION IN THE HEALTH CARE SERVICES

Access to health care is defined as the ability of an individual to identify their health needs and to seek health care services relevant for their health needs (Levesque, Harris & Russell 2013:1). In most countries, access to health care is a fundamental human right of all citizens irrespective of their race, class, religion, gender or sexual orientation. In SA, discrimination on the basis of sexual orientation has been outlawed by the SA Bill of Rights. Section 27(1) (a) of the Constitution (Act 108 of 1996) was instituted in order to eliminate health inequalities and improve access to and utilisation of health care services (Graves 2009:46). Furthermore, SA promotes the rights to health care of the youth including LGBTI youth through the development of the Adolescent and Youth Health Policy (2012) and National Implementation Guidelines for Adolescents and Youth Friendly Health Services (2012-2016) guided by the National Youth Policy (2009-2014). These guidelines are aimed at preventing and responding to health problems of the youth including among others the LGBTI youth as a vulnerable group, and to addressing the barriers that prevent them from accessing health care services (OUT LGBT Wellbeing 2007:2; Human Rights Watch 2017:546).

In most countries, PHC is regarded as the first entry point into the health care system and is geared towards health promotion, disease prevention, early diagnosis and treatment of diseases and referral to secondary and tertiary health care (Fairman, Rowe, Hassmiller, & Shalala 2011:193; Dookie & Singh 2012:2). The scarcity of primary care physicians and the health care reform has resulted in an increased demand for PHC services to rely on nurse practitioners to man the services. In most countries, 70-80% of nurse practitioners man the PHC services at a lower cost and without compromising on the quality of care (Naylor & Kurtzman 2010:893; Fairman et al. 2011:193).

In the USA, more than 16 million people receive PHC provided by nurse practitioners, who fulfill roles related to primary care, prevention, and care coordination, with continued health care reform in large and small private and public practices (Fairman et al. 2011:193; Naylor & Kurtzman 2010:893-894). Studies have shown that primary care services provided by nurse practitioners are as safe and effective as those services rendered by physicians, and that in most cases, nurse practitioners provided longer consultations and more information to clients than physicians do (Fairman et al. 2011:193; Naylor & Kurtzman 2010:893-894). With this increased presence of nurse practitioners within PHC, it is anticipated that nurse practitioners will provide care to a more diverse client population, including those from the LGBTI community. Maza and Krehely (2010:2) assert that in the USA, LGBTI youth consult PHC first when they need health care; the same applies to most countries including SA. It is obvious that nurse practitioners, who work in PHC, must be adequately trained in order to deliver culturally competent care to this population (Lim, Brown & Jones 2013:198).

Many countries, such as Europe and the USA, have developed policies that promote human rights and equitable health care services, and have clearly made an appeal to implement all possible mechanisms of eliminating all forms of discrimination and prejudice (Ash & Mackereth 2010:5-6; Meyer 2016:82). As awareness of the needs of sexual minority youth increases, numerous organisations have also developed policy statements that eliminate violations of human rights (ARC International 2014:2). Numerous organisations have also developed professional guidelines to guide health care providers to ask relevant questions when taking a sexual history during young people's visits to health care facilities (American Academy of Pediatrics (AAP) 2013:200; National Association of Pediatric Nurse Practitioners (NAPNP) 2011:9A10A). In the USA, Healthy People (2020:np) have acknowledged the sexual minority population as a vulnerable and underserved population, and has therefore included the health, safety, and well-being of LGBTQ individuals among its goals. Both the Society for Adolescent Health and Medicine and the American

Academy of Pediatrics have published guidelines aimed at providing specialised and comprehensive care to meet the unique health needs of LGBTQ youth. These guidelines highlight that medical care provided to the LGBTI youth should be “comprehensive, confidential, and developmentally appropriate” and be provided in a teen-friendly and welcoming environment (Reitman et al. 2013:506-510). In SA, there is still a lack of recognition of sexual minority groups in the health care system, which might result in an increase in the morbidity and mortality rates of this population, which is contradictory with the aims and objectives of the SA health legislation (Newman-Valentine & Duma 2014:3).

Despite many countries having developed and implemented policies and guidelines that outlaw discrimination on the basis of sexual orientation, in many African countries, homosexuality is still regarded as a crime, and an expression of homosexual orientation increases LGBTI people’s vulnerability to being victims of discrimination or imprisonment (Thoreson & Cook 2011:5). A study of gay men in Malawi, Namibia, and Botswana in 2011, found that 18,5% gay men were afraid to visit health care services and 5,1% were denied access to health care (Thoreson & Cook 2011:5). Most research on LGBTI people and their health care experiences to date suggests that they experience challenges when accessing health care services (Rispel et al. 2011:47; O’Byrne & Watts 2012:21; Hayman et al. 2013:121; Banwari, Mistry, Soni, Parikh & Gandhi 2015:95) as a result of some individual and structural barriers (Buchmueller & Carpenter 2010:489; Rosenstreich et al. 2011:2; Hayman et al. 2013:121; Cele et al. 2015:4). LGBTI patients experience stigmatisation and discrimination when accessing health care services (Hayman et al. 2013:121; Rounds et al. 2013:99; Cele et al. 2015:4); as a result, they become vulnerable to health risks (Buchmueller & Carpenter 2010:491; Saewyc 2011:257; Müller 2013:2); and experience significant health care inequalities as compared to their heterosexual counterparts (Müller 2013:2; Kennedy, Baral, Fielding-Miller, Adams, Dludlu, Sithole et al. 2013:3; Rosenstreich et al. 2011:2). For example, there is a lack of targeted health promotion information for LGBTI people

(Lambrese & Hunt 2013:225; NewmanValentine & Duma 2014:3) and a lack of preventative health care services (Dilley et al. 2010:463). LGBTI people are vulnerable to the effects of stigma and discrimination and insensitivity to their health concerns by health care providers (Hoffman et al. 2009:227; Tjepkema 2008:57; Hayman et al. 2013:120; Rounds et al. 2013:99), therefore have unique health needs that might not be addressed by existing health care services (Tjepkema 2008:57; Maza & Krehely 2010:2; Rispel et al. 2011:47; Rounds et al. 2013:99).

There has been limited research on issues related to the delivery of PHC to LGBTQ youth (Levine 2013:e297-e313; Coulter, Kenst & Bowen 2014:e105-e112). According to Snyder, Burack and Petrova (2016:445), in order to address the complex challenges related to providing health care to the LGBTQ community, it is important to assess their perspectives with regard to the ways in which health care might best meet their needs. Snyder et al. (2016:443) conducted a study aimed at determining whether PHC services are perceived as adequately addressing the needs of LGBTQ youth, to assess gaps in the services; and to identify areas for improvement in the delivery of PHC using a mixed methods study. The findings of the qualitative and quantitative data show that the majority of sexual minority participants experienced poor patient-provider communication and disrespect, and lack of discussions about sexual health, including sexual orientation, sexual behaviour, and STI during clinical visits. The participants raised concerns about physicians not respecting confidentiality, and the inappropriate comments made by some physicians' about their sexual orientation or gender identity. The majority of the participants welcomed the organisation of special clinics for LGBTQ youth and expressed a willingness to use them for their PHC needs. However, the discussion in the focus groups revealed ambivalent attitudes with regard to having special clinics for LGBTQ youth: 1) some participants perceived the risk for isolation from other adolescents if they have special clinics; 2) some raised concerns about being "labelled" for attending such clinics; and 3) some expressed their doubts regarding the physicians preparedness to care for

LGBTQ youth. The study also found that only a few LGBTQ youth initiated discussions of their sexual orientation with their physicians, possibly because of the perceived fear of breach of confidentiality by the health care providers. Therefore, the study demonstrated the need for better interaction between LGBTQ youth and their primary care physicians, including discussing sexual orientation in a sensitive and respectful manner, and providing education and guidance about a variety of medical and psychosocial concerns unique to this population (Snyder et al. 2016:443-445).

A few studies revealed contrary findings to most studies by revealing that not all LGBTQ youth experience poor health outcomes and health inequalities (Saewyc 2011:266; Meyer 2016:82; Macapagal, Bhatia & Greene 2016:439). The findings of a study conducted by Macapagal et al. (2016:439) revealed that 84% of the participants were never denied access to health care services, and 88.3% denied postponing or not seeking health care, due to discrimination based on their non-conforming sexual orientation and sexual identity. Likewise, many countries have witnessed an improvement in the wellbeing of LGBT people (Savin-Williams 2005:17-18; SAHM 2013:506; Meyer 2016:82), mostly due to the fact that there has been an improvement in the attitudes towards LGBT people in some countries (Savin-Williams 2005:17-18; Meyer 2016:82). Researchers assert that the same protective factors applicable to heterosexual youth such as: supportive and nurturing family relationships; supportive friends (SAHM 2013:506); caring adults such as teachers and coaches; and connectedness to school and religiosity, have also helped in promoting healthy developmental outcomes among LGBTQ youth (Savin-Williams 2005:17-18; Meyer 2016:82). However, Savin-Williams (2005:17-18) is of the opinion that the negative effects that sexual minority people experience are the residues of the past generations, who were infiltrated by cultural and religious stigma and prejudice. Savin-Williams (2005:18) however points to LGBTQ youth who are experiencing an era of social inclusiveness and non-discrimination as “New Gay Teenager”, which makes the past experiences of stigma and discrimination less relevant.

Other protective factors identified by researchers are anti-homophobia policies and training for staff in schools and the involvement of LGBTQ youth in LGB support groups or gay-straight alliance clubs, which have resulted in lower rates of harassment and suicide attempts among LGBTQ youth (Saewyc 2011:267). Likewise, Meyer (2016:82) and SAHM (2013:506) suggest that eliminating or reducing the stigma and prejudice towards LGBT people would significantly reduce the excess stress to which they are exposed. As a result, LGBT will not experience negative health outcomes caused by minority stress, thus reducing the health inequalities that exist between them and heterosexual people. Saewyc (2011:267) suggests that more studies that focus on LGBTQ people who are living healthily despite experiencing stigma and discrimination should be conducted in order to identify factors that assist them to thrive. Such findings call for more investigations into what is known about the minority stress and social inclusion and its impact on health outcomes.

2.5.2. DISCRIMINATION FROM THE HEALTH CARE PROVIDERS

The International Council of Nurses (ICN) Code of Ethics (2012:1) is clear in its mandate that nurses should respect human rights and not discriminate against any patient. The ICN Code of Ethics (2012:1) further states that “inherent in nursing, is respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect”. Furthermore, the ICN Code of Ethics (2012:1) and the Code of Ethics for Registered Nurses (CNA, 2008:1) states that “nursing care is respectful of and unrestricted by considerations of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status”. Similarly, the nurses’ pledge of service and the Code of Ethics for Nursing Practitioners in SA mandate the nurses to respect human rights without consideration of age, colour, race, creed, disability, illness, nationality, gender, sexual orientation or social standing. Nevertheless, some nurses may experience an internal struggle between their personal attitudes and beliefs and their professional responsibilities with regards to providing care to LGB patients. As a result,

LGBTI patients still experience many covert and overt forms of stigma and discrimination, which includes verbal and emotional abuse, and are sometimes denied health care by health care providers (Rounds et al. 2013:99).

Stigma is defined as “the inferior status, negative regard; and relative powerlessness that society collectively assigns to individuals and groups that are associated with various conditions, statuses and attributes” (IOM 2011:61). Both covert and overt forms of stigma have been suggested to result in negative health outcomes on LGBTI patients (Igartua et al. 2009:602; Ochse 2011:4; McCabe et al. 2011:142; Hyman et al. 2013:121; Rounds et al. 2013:99). Among other barriers that prevent LGBTI people from accessing health care services, is a fear of discrimination or perceived and actual homophobic attitude by health care providers (Müller 2013:2; Rispel et al. 2011:47; Cele et al. 2015:5). Health care providers contribute to the violation of the health and human rights of LGBTI youth by being prejudiced, hostile and discriminating against them (Rispel et al. 2011:47; Adams et al. 2013:6; Mavhandu-Mudzusi & Sandy 2015:1052; Cele et al. 2015:4). Thus, LGBTI youth are discouraged from disclosing their sexual orientation, often resulting in inadequate treatment and unmet health care needs (Rispel 2011:138; Cele et al. 2015:5). As a result, some LGBTI people prefer to consult private health care sector as they perceive it to be more understanding than the public health sector (Rispel 2011:138).

Similarly, Rounds et al. (2013:99) found that LGBTI patients experience verbal abuse as well as many other forms of discrimination, and a general lack of satisfactory care, including health care professionals refusing to provide them with treatment. In the study of Eliason, Dibble and Robertson (2011:1366-1367), 65% of the participants have witnessed discriminatory remarks being made by their colleagues to sexual minority patients, where 34% had witnessed discriminatory actions towards those in the sexual minority. In the same manner, LGBTI people have a perception that health care providers treat them differently from the general population (Ash & Mackereth 2010:5; Cele et

al. 2015:5) and that they do not understand their health needs (Coker et al. 2009:213; Hayman et al. 2013:120). For example, some research reveals that health care providers refuse to provide health care services to those in the sexual minority, and some health care providers are uncomfortable to discuss sexual identity or relationships with LGBTI patients (Bjorkman & Malterud, 2009:239).

In the literature, the term heterosexism, heteronormativity and homophobia are used either interchangeably or synonymously as referring to holding a belief and attitude that homosexuality is irrational and unnatural (IOM 2011:137; Morrison & Dinkel 2012:124). Heterosexism is a form of discrimination where people hold the belief that everyone is, or should be heterosexual and that any alternative sexual orientations are unnatural and/or abnormal (IOM 2011:137; Morrison & Dinkel 2012:124). Most literature reports that the homophobic attitude of health care providers appears to originate from heteronormativity and normative assumptions about gender (Akhan & Barlas 2013:435). According to Morrison (2011:2573), homophobia refers to fear, negative affect, cognition, and behaviours directed toward individuals perceived, whether correctly or incorrectly, to be gay or lesbian. Akhan and Barlas (2013:435) describe homophobia as a form of judgement or negative attitude and unfair treatment of homosexual patients in the health care sector. Akhan and Barlas (2013:435) assert that health care providers' homophobic attitudes are influenced by the social and patriarchal structures of society, which preserve heteronormative beliefs and attitudes. Thus, legal and social structures are designed to accommodate heterosexuality, denying the rights and status of different sexualities (Newman-Valentine & Duma 2014:2; Dysart-Gale 2010:24; Morrison & Dinkel 2012:124). For example, Dysart-Gale (2010:24) asserts that within the clinics, heterosexuality among health care providers seemed to be the norm, and is therefore expected. As a result, the general assumption of heterosexuality renders people with non-conforming sexual orientations invisible or inferior in the health care settings, which affects the care for LGBTQ patients negatively (McDonald 2009:264; Hudak 2015:73).

Most LGBTI people reported that health care providers display heterosexist attitudes towards them, by asking questions or making treatment decisions that simply presume heterosexuality (Röndahl, Bruhner & Lindhe 2009:2340-2343; Hayman et al. 2013:121; Mavhandu-Mudzusi & Sandy 2015:1059; Cele 2015:6; Hudak 2015:73). Most LGBTI people describe that they find the experience of the health care providers to be stressful, uncomfortable, or discriminating (Rispel et al. 2011:47; Hayman et al. 2013:121; Mavhandu-Mudzusi & Sandy 2015:1059; Cele 2015:6; Hudak 2015:73). As a result, they find visits to the health care facilities anxiety-provoking, and therefore often postpone to seek for health care and/or choose not to disclose their sexual identity to health care providers (Rounds et al. 2013:99; Hudak 2015:85; Mavhandu-Mudzusi & Sandy 2015:1059). For example, Bjorkman and Malterud (2009:239) found that lesbians would tend not to attend screening programmes for females, such as pap smears and mammograms, due to the fact that health care providers express it to be unnecessary for them to undergo such screening.

The assumption of heteronormativity by health care providers became apparent in two studies of lesbian prenatal and birthing experiences, where lesbians were of the opinion that health care providers assume all females to be heterosexuals (Röndahl, Bruhner & Lindhe 2009:2340-2343; Hayman et al. 2013:121). In these studies, it was reported that the clinical forms had questions related to heterosexual persons; and the midwives continued to make reference to the male partner as the father of the baby (Röndahl et al. 2009:2340-2343; Hayman et al 2013:121). Likewise, in the study conducted by Röndahl et al. (2009:2239-2240), almost all participants reported that nursing staff routinely displayed heteronormativity through written, verbal and nonverbal communications. Pamphlets and other information in waiting rooms, intake forms and documentation, routine questions about family relationships; and insistence on doing pregnancy tests on lesbian women conveyed heterosexist messages. Similarly, the study by Hudak (2015:75) reveals that

patients' intake forms and health questionnaires are required to be more inclusive for homosexual people, however, those health care providers who receive and process the information, react in a manner reflecting that they still hold negative attitudes towards LGBTI people.

In contrast, there are some studies that showed positive attitudes by health care providers towards the sexual minority (Dinkel et al. 2007:12; Röndahl 2009:148; Goldberg et al. 2011:10; Glessener, Vanden Langeber; Mc Carthy & LeRoy 2012:326). The study of Dinkel et al. (2007:12) found little evidence of stigma and discrimination against gay people by 188 registered nurses enrolled in graduate nursing, and 15 teaching in an undergraduate nursing school, respectively. It became uncertain as to whether the results of these studies could be attributed to a more tolerant atmosphere of academia, or to increased socially desirable response of participants when participating in a research project at their own school or place of employment. Similarly, the findings of the studies of Savin-Williams (2005:17-1) and Meyer (2016:82) revealed that LGBTQ youth currently experience a new era of social inclusiveness, with less stigma and discrimination.

Some studies have demonstrated that nurses have generally been perceived as having positive or neutral attitudes toward LGB patients (Röndahl 2009:148; Goldberg et al. 2011:10). For instance, in a study conducted by Röndahl et al. (2009:2340) concerning perinatal care for lesbian mothers, it was discovered that most of the lesbian mothers experienced positive attitude from the nursing staff. Similarly, in a study by Röndahl (2009:150) in Sweden, it was again revealed that most participants had experienced nurses to be caring and friendly. Equally, the study of genetic counsellors' knowledge and attitudes toward LGB patients revealed that 86% of nurse participants were "comfortable" working with LGB patients (Glessener et al. 2012:326). Dorsen (2014:16) asserts that the differences in the findings regarding health care providers' attitudes towards the sexual minority could be a result of numerous factors, such as varying samples of professionals, demographics and/or

geographic location, diversity of data collection instruments, and inconsistent definitions or methodologies. However, most studies that reveal that health care providers display positive attitudes towards LGBTI patients are obsolete, being more than ten years old. Recent studies still reveal that health care providers show negative attitudes towards LGBTI patients (Dorsen 2014:13).

LGBTI youth have experienced intolerance of their non-conforming sexual orientation by families and individuals who have some religious associations, who convey homophobic religious messages and behaviours. As a result, they experience psychological distress, shame, guilt and internalised homo-negativity (Page, Lindahl & Malik 2013:2). Many attempts have been made by the society to transform homosexual people into heterosexuals, a term referred to by Mavhandu-Mudzusi and Sandy (2015:1052) as 'heterosexualisation'. For instance, LGBT participants in the study of Mavhandu-Mudzusi and Sandy (2015:1052) reported that they were offered exorcism in the form of prayers and were sprinkled with potions and solutions by students and academic staff who were spiritual believers. This was done to cast out the perceived evil spirits that caused them to have non-conforming sexual orientation.

The results of the studies that examined the relationship between religiosity and attitudes of health care providers towards sexual minorities (Yen, Pan, Hou, Liu, Wu, Yang & Yang 2007:77-78; Dorsen 2014:64; Mavhandu-Mudzisi & Sandy 2015:1059) reveal an increase in negative attitudes towards LGB people by health care providers who self-identified as very religious. Similarly, within the nursing context, nurse practitioners who are religious were seen to be problematic, especially when caring for LGBTI patients (Röndahl 2009:149; Cele et al. 2015:5). In most cases, health care providers gave priority to influencing LGBTI patients to change into heterosexual orientation, neglecting to treat them holistically. Equally, this negative attitude was sometimes displayed by married health care providers, who associate homosexuality as being against 'what God had created families for', viz. procreation, and

therefore were of the opinion that homosexual people needed to be converted to a heterosexual orientation (Akhan & Barlas 2013:435).

Most studies demonstrate that the lack of basic knowledge on LGBTI health care contributes to the health care providers portraying negative attitudes towards LGBTI population (Kitts 2010:737-738; Eliason et al. 2010:213-214; Dorsen 2014:96; Hudak 2015:90-91). Most studies emphasised that most health care providers are incompetent regarding LGBTI health and health care issues, as a result of the lack of formal educational programmes that focus on LGBTI people and their health care needs (Kitts 2010:737-738; Dorsen 2014:96; Hudak 2015:90-91). For example, Eliason et al. (2011:1357) found that the majority of nurse participants lacked basic knowledge of LGBTI health issues and almost 50% held negative attitudes towards LGBT people, especially towards transgender clients. Similarly, the study of Kitts (2010:737-738) on physicians' knowledge and attitudes in the context of the increased risk of depression and suicide among LGBTI adolescents established that the majority of the participants lacked the skills necessary to address the issues of sexual orientation and/or gender identity with their patients.

Equally, research revealed that those health care providers with increased levels of education correlated with increased positive attitude toward sexual minorities (Yen et al. 2007:77). Literature revealed also that there is often a limited amount of information or education within health care training curricula that addresses LGBTI concepts, experiences; and the needs related to health and illness (Röndahl 2009:2341; Eliason et al. 2011:1358; Brennan et al. 2012:96; Knight et al. 2014:665). Most studies in LGBTI health care reveal that nursing students' attitudes toward LGBTI individuals support the need for LGBTI content to be included in the nursing curricula for both undergraduate and postgraduate programmes (Carabez, Peelegrini, Mankovitz, Eliason; Ciano & Scott 2015:323). The findings of Hudak (2015:77) reveal that if health care providers are not aware of the sexual activities that non-heterosexual people engage in, they may lack the necessary knowledge to understand and

make treatment decisions about the types of STDs that patients might be at risk for, and/or what it means to be sexually healthy.

Müller (2015:4) suggests that there is a need to teach health care providers about sexual orientation and gender identity, and to provide them with the necessary knowledge about LGBTI patients in order to improve their attitudes and behaviours. Müller (2015:4) further asserts that various opportunities for teaching about sexual orientation and gender identity in health professions' curricula are available. For instance, patient-provider interaction training, rights-based teaching frameworks, clinical subjects, and health professionals in the field are available who can model appropriate care and interest in LGBTI patients, mentor LGBTI students; and conduct research on LGBTI health-related issues. Equally, Lim et al. (2013:201) and SAHM (2013:506) suggest health care providers' curriculum needs to be revised to address the gaps in LGBT-related topics. Educational strategies regarding LGBT health could readily be integrated into the curriculum in order to increase the knowledge and skills related to LGBTI content (Eliason et al. 2011:1356-1358; Müller 2015:4).

Researchers provide supporting evidence with regard to the information regarding LGBTI health care that should be included in the curricula in order to improve the ability of health care providers to provide culturally competent care to LGBT clients. For instance, aspects of sexual orientation and gender identity ought to be included in health care providers' curriculum with an emphasis on the ethical didactic content, using conferences, journal clubs, and workshops (American Academy of Family Physicians (AAFP) 2016:1), case studies, LGBT panels, group discussions, simulation experiences, key informant interviews, and standardised patients' simulation (Eliason et al. 2011:1367). Furthermore, some authors suggest that the training of health care providers ought to include, among other things, nursing care plans, course development, independent study, elective courses, clinical affiliations and assignments (Lim et al. 2013:201). In addition Brennan et al. (2012:102-103) suggest panel discussions that create sensitivity and empathy; group projects, reflective

activities where students write both positive and negative associations with various terms; and literature, film and music that evoke discussion. Röndahl's (2011:346) descriptive study aimed at evaluating students' perceptions of their education with regard to sexual orientation conducted by using semi-structured group interviews with nursing and medical students in Sweden, found that the theme of heteronormativity was consistent throughout all of the interviews. The study also found that there was a lack of specific teachings about LGBT people and that homosexuality was mentioned only when it was connected with STI. The participants were of the opinion that the content regarding LGBT individuals could be integrated into the curriculum in various methods (Röndahl 2011:346). Therefore, integrating various teaching-learning strategies such as an online cultural self-assessment, case scenarios, and cultural assessment of clinical agencies, could be significant in developing culturally competent practitioners (Cross, Brennan, Cotter & Watts 2008:151-153).

Another barrier that has been identified in nursing education is the unpreparedness of the nurse educators in teaching LGBT health content, due to lack of knowledge and skills in the area (Sirota 2013:219, Röndahl 2011:348; Fish & Evans 2016:160). A descriptive study conducted by Sirota (2013:227) to explore the attitudes of 1,282 nurse educators toward homosexuality revealed that 78.6% felt that teaching nursing students about homosexuality was important to extremely important. However, 71.9% of the participants indicated that they were 'not at all prepared' (56.6%) to 'somewhat prepared' (15.3%) to teach the content. Nevertheless, the findings of the study concluded that nurse educators had a favourable attitude toward homosexuality. Sirota (2013:225) recommended that nurse educators need to gain confidence, cultural competence, and strong knowledge and skills base to proficiently teach content about sexual minorities and to work with LGB patients and students. Likewise, the American Association of Colleges of Nursing (AACN 2008:30) also realised the significance of including cultural competency in nursing education as a means to educate future nurses in providing patient-centred care, along with the importance of addressing and

eliminating inequalities faced by diverse and vulnerable populations (AACN 2008:30; Brennan et al. 2012:96).

2.6. DEVELOPMENT OF POLICIES AND STRATEGIES TO PREVENT DISCRIMINATION IN HEALTH CARE SERVICES

As literature creates awareness about the health care needs and inequalities of sexual minorities, many professional organisations have made recommendations to promote provider-patient communication about sexual orientation as part of providing quality health care to these patients. The AAFP (2016:2-3) acknowledges the significance of health care providers having knowledge of their patients' sexual orientation in order to provide optimal screening and appropriate patient education (AAFP 2016:2-3). However, they neither provide guidelines with regard to the health care providers' responsibilities in initiating the communication, nor the content and structure of the discussion, which still leaves a gap in provider-patient communication.

Likewise, the National Association of Pediatric Nurse Practitioners (NAPNAP) emphasises that in order to fully address the needs of the youth, health care providers ought to explore each young person's perception of his or her gender and sexual orientation by using LGBTQ-inclusive questions and gender-neutral language, and should promote a supportive, LGBTQ-safe health care environment (NAPNAP 2011:9A-10A). Furthermore, NAPNAP (2011:9A-10A) recommends that the health care providers ought to address various dimensions of sexual orientation with LGBTQ patients in a respectful, non-judgmental health care environment, in order to have detailed information about the LGBTQ adolescent's health care needs. For example, health care providers ought to be able to ask about the patient's sexual development, self-perception and sexual partners in order to assess the health and sexual risks related to STIs, unintended pregnancy, potential sexual violence (Pathela & Schillinger 2010:879; Riskind et al. 2014:1959; Carabez et al. 2015:232) and mental health risks such as depression, anxiety, self-harm and suicide (Kitts 2010:736; FredriksenGoldsen, Kim, Barkan, Muraco & Hoy-Ellis 2013:1806-

1807). Having knowledge about multiple dimensions of sexual orientation better equips the health care provider to initiate appropriate health screening, interventions and education so as to minimise risks and to enable LGBTI patients to achieve optimal health outcomes. However, Eliason et al. (2010:208) assert that nursing scholarship and the nursing profession have mostly been silent regarding LGBTQ health and their health care concerns. Some authors have therefore made an appeal for emancipatory efforts in nursing education, research and professional advocacy, so as to provide culturally competent care that would address the needs of the LGBTQ population (Eliason et al. 2010:207208; Dysart-Gale 2010:24; Shatell & Chinn 2014:77).

2.7. PROVISION OF CULTURALLY COMPETENT CARE BY HEALTH CARE PROVIDERS

Traditionally, the concept of "culture" has been used mainly to refer "to integrated patterns of human behaviour that include the language, thoughts, communications, actions, customs, beliefs, values; and institutions of racial, ethnic, religious, or social groups" (Anderson, Scrimshaw, Fullilove, Fielding, Normand & the Task Force on Community Preventive Services 2003:68). As a result, reference to "cultural competence" is mainly focused on traditionally and linguistically appropriate care, including the use of interpreters; and health care inequalities related to socioeconomic and ethnic differences (Anderson et al. 2003:68). There are different definitions of cultural competence by different authors, which proves that there is still significant controversy regarding the conceptualisation of the term "cultural competence" (Kumagai & Lipson 2009:782). Culturally competent care as defined by De Chesnay and Anderson (2008:25) and refers to client care that is sensitive to diversity in the clients' population. Likewise, Brusin (2012:130) defines cultural competence as the ability to provide care to diverse clients that satisfies their linguistic, social, and cultural needs. On the other hand, Campinha-Bacote (1999:203) defines cultural competence as "the process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural

context of a client (individual, family or community)". Some authors view cultural competence as care that includes fundamental change in the individual's thinking, understanding, and interacting with the world around them (Krajic, Strassmayr, Karl-Tummer, Noval-Zezula & Pelikan 2005:279; Dunn 2002:107). However, there is still a dearth of research that examines the effect of "culturally competent" care on LGB health care utilisation or outcomes (Dorsen 2014:117).

From a constructivist viewpoint, the first approach to culture pertains to the fact that most clients who receive care, irrespective of their sexual orientation, may experience a sense of vulnerability and uncertainty when interacting with the health care providers. This may be due to the need to discuss intimate parts and sensitive aspects of their lives with others (Flemmer, Dekker & Doutrich 2014:545). Thus, it is necessary for nurse practitioners to take steps to ensure that the clinical environment is safe; to allay LGBT clients' anxiety; to foster provider-client trust; and to facilitate collaboration toward mutual goals (Flemmer et al. 2014:546). Nurse practitioners must provide culturally competent care by tailoring interventions and strategies that addresses the health inequalities and the health care needs of LGBT clients (Brennan et al. 2012:96; Eliason et al. 2010:208). Nevertheless, literature still reveals that LGBT people are not receiving culturally competent care, and as a result, they still continue to experience inequalities in the health care system (Eliason et al. 2010:206; Brennan et al. 2012:96).

The participants in a Canadian study of lesbian birthing experiences conducted by Goldberg et al. (2011:184) viewed health care providers to be LGBTQ friendly when they felt grateful about being treated well, receiving quality care, and when their female partners were being acknowledged as partners. Likewise, some studies demonstrated that participants were grateful when they were being treated like other patients (Sinding, Barnoff & Grassau 2004:182). The findings of the study of Goldberg et al. (2011:184) concluded that, for the nurses, acknowledging diversity of LGBTQ patients included viewing all

patients as individuals and thus perhaps avoiding stereotyping LGBTQ patients. In that study, it became evident that nursing staff perceived LGBQ patients as more than their ethnicity, or sexual orientation, or gender identity, and avoided doing harm to any patient by either stereotyping, making assumptions, or discriminating against them (Goldberg et al. 2011:184-185). At the same time, some nurse participants emphasised the importance of knowing patients' sexual orientation or gender identity in order to avoid offending them verbally. In the same way, in a grounded theory study by Johnson and Nemeth (2014:635-637) wherein nine women self-identifying as lesbians or bisexuals were interviewed, revealed the significance of disclosure of sexual orientation to health care providers. The results of the study revealed that for the participants, disclosure of sexual orientation to the health care provider was a critical point when the provider's response to this disclosure indicated the provider's ability to provide high quality, culturally competent care as perceived by the participant. The study found that lesbian women wanted their health care providers to have knowledge about same-sex relationships, sexuality, sexual health, and other topics specific to lesbian and bisexual women (Johnson & Nemeth 2014:637).

2.8. LITERATURE LIMITATIONS

There are several potential limitations to this literature review. Most published literature related to LGBTI populations and their health care needs have significant methodological, conceptual and theoretical limitations (Saewyc 2011:257). Therefore, interpreting, operationalising and generalising of the results should be left to the discretion of those health care providers who have interest in the topic. In most quantitative studies, having a representative sample is an essential prerequisite, as it enables researchers to draw conclusions on the generalisability of findings of the study (LoBiondo-Wood & Haber 1998:263-264). Most qualitative studies used convenience samples of varying sizes, since it is more convenient and inexpensive to access. This type of sampling is a limitation that ought to be taken into account, since researchers use their discretion to select the participants (Parahoo 1997:223),

which increases the risk of bias by the researcher, as it does not allow for control of sampling error (LoBiondo-Wood & Haber 1998:249; Burns & Grove 2001:804).

Some studies reveal a correlation between health care providers' attitudes and LGBTI patients' health care outcomes. In most studies, educational achievement emerged as one of the variables most closely linked to positive attitudes toward LGB patients (Dorsen 2014:117). However, not all of the studies explored the correlation between the levels of education and nurses' attitudes. There has also been a lack of consistency among instruments used to explore attitudes toward LGB patients. For example, the existing studies on nurse attitudes toward LGB patients used different instruments to measure attitudes and beliefs, which resulted in difficulties in cross study comparisons, interpreting and generalising across studies. Thus, complete reliability and validity of information is missing from the majority of existing studies (Polit & Beck 2010:1451-1458).

Research on the frequency with which health care providers discuss the distinct dimensions of sexual orientation with LGBTQ adolescents is limited (Igartua et al. 2009:603; Coker et al. 2010:458; SAHM 2013:507; Riskind et al. 2014:1958). As such, there is a significant need to conduct studies on topics related to dimensions of sexual orientation and how that impacts on LGBTQ adolescents, and to evaluate the quality of care provided to LGBTQ adolescents. Coker et al. (2010:470) is also of the opinion that there is a need to determine whether discussing different dimensions of sexual orientation with LGBTQ youth has a positive or negative effect on their health outcomes. Equally, it is important to assess whether the health inequality gap between LGBTQ youth versus heterosexual youth is narrowing as a result of more frequent and higher quality health care provider-patient discussion about sexual orientation (Coker et al. 2010:469; Hudak 2015:5).

Much of the existing literature has been developed through studies on health care experiences of LGBTI populations. However, it is essential to recognise that the LGB population actually consists of distinct populations with their own health needs, health care needs, and differing levels of stigma (Tjepkema 2008:57; Maza & Krehely 2010:2; Rispel et al. 2011:47; Rounds et al. 2013:99). Therefore, more research is needed on the health care experiences of sub-populations of sexual and gender minorities. More quantitative research using broader samples of health care providers, focusing on examining the relationships between attitudes towards LGB patients, nursing care and patient outcomes should be conducted (Levesque 2013:98-99).

2.9. CONCLUSION

Most of the literature suggests that LGBTI people experience some covert and overt forms of stigma and discrimination when accessing health care, with health care providers' attitudes contributing significantly to the health inequalities among LGBTI populations. However, it is not only the actual negative attitudes of health care providers towards LGBTI people that contribute to the health disparities among LGBTI persons, but also the fear of anticipated or perceived homophobia. This kind of fears contributes to LGBTI people delaying or avoiding to access to health care. It is therefore important to take into consideration the experiences of patients with regard to the nursing care they receive and the role that perceived homophobia play in their experiences. Considering the fluidity of sexuality and sexual orientation during the youth, researchers who are developing a body of literature on health, health needs, and health inequalities of LGBTI persons have not reached consensus with regard to the definitions of the key terms used among this population. As a result, health inequalities amongst this population are still not addressed. Health care professional organisations recommend that research ought to be done on multiple dimensions of sexual orientation such as sexual attraction, sexual behaviour, and sexual identity, which are significant aspects of adolescent health care. This is recommended as a result of the enormous

inequalities in the health outcomes observed between LGBTI youths and heterosexual youth.

CHAPTER 3:

RESEARCH METHODOLOGY

3.1. INTRODUCTION

This chapter intends to unpack the paradigm and the philosophical perspectives. It also outlines the research methodology used, justifying how it has guided data collection, analysis, and eventually the development of theory.

3.2. RESEARCH PARADIGM

In this section, the research paradigm applicable to the study will be discussed.

3.2.1. PARADIGMATIC ASSUMPTIONS

Paradigms play a fundamental role in research. In understanding the term paradigm and the role that it plays in the research process, the researcher attempted to explore its meaning. The concept of 'paradigm' originated from the book of Thomas Kuhn called: **The structure of scientific revolutions** first published in 1962 (as cited in Mouton 1996:203). Subsequent to Kuhn's intervention, the term paradigm drew attention to the role of paradigms in the history of social and natural sciences. Different researchers and authors assigned different meaning to it as this discourse proliferated, as illustrated in Table 2.

Grix (2004:64) argues that researchers use specific paradigms, which essentially have differing paradigmatic assumptions of reality and knowledge, and which underpin their particular research approach, as reflected in their methodology. Before the researcher can choose the appropriate paradigm and methodology to guide the course of study, the following questions should be asked:

a) What is the nature of reality of the phenomena being investigated?
b) Is the social phenomenon objective in nature or is it created by the human mind?

c) What are the bases of knowledge corresponding to the social reality, and how can knowledge be acquired and disseminated?
d) What is the relationship of an individual with his/her environment? (Grix 2004:64).

Table 2: Meanings of the term paradigm

Definition of paradigm	Authors
"…a framework of basic assumptions with which perceptions are evaluated and relationships are delineated and applied to a discipline or profession"	Grover and Glazier (1986:234)
Established research traditions in a particular discipline	Mouton (1996:203)
A basic set of beliefs that guide action	Creswell (2009:6)
Model or framework for observation and understanding	Creswell (2007:19); Babbie (2010:33); Rubin & Babbie, (2010:15); Babbie (2011:32)
Philosophical framework	Collis and Hussey (2009:55)
A worldview	Creswell (2009:6); Denzin and Lincoln (2005:3)
A way of acquiring knowledge in order to make sense, and is influenced by thoughts and perceptions	Creswell (2009:6); Denzin and Lincoln (2005:3)
Whole system	Neuman (2011:94)

Therefore, to clarify the structure of inquiry, the researcher started by providing an explanation of the assumptions of the paradigm adopted followed by a discussion of the specific methodology used in this study. Creswell (2007:15-16) identified paradigmatic assumptions that lead to the researcher's choice of qualitative research namely: ontology, epistemology, theoretical perspective, and methodology, which are illustrated in Figure 1 and discussed as follows:

3.2.1.1. ONTOLOGICAL ASSUMPTIONS

Ontology refers to the nature of social reality, the study of being, i.e. how humans view the world (Crotty 1998:10). Ontological assumptions are concerned with what constitutes reality. This study assumed a relativist ontological position in researching and understanding reality (Mills et al.

2006:2). Relativism assumes that realities are subjective and are mediated by our senses (Guba & Lincoln 1994:110) since the world does not exist independently of our knowledge of it (Grix 2004:83). Constructivism holds that the way people understand their lived experiences is a reflection of how they construct their social reality (Charmaz 2000a:499). This study emphasizes understanding of human experiences and the generation of a substantive theory. Therefore, the social reality that this study explored was that of the interaction between LGBTI youth and nurses working in the PHC clinics. The researcher attempted to explore the experiences of LGBTI youth and nurses as they interact with each other during clinical interaction in the PHC setting and the meaning that participants attach to the interaction.

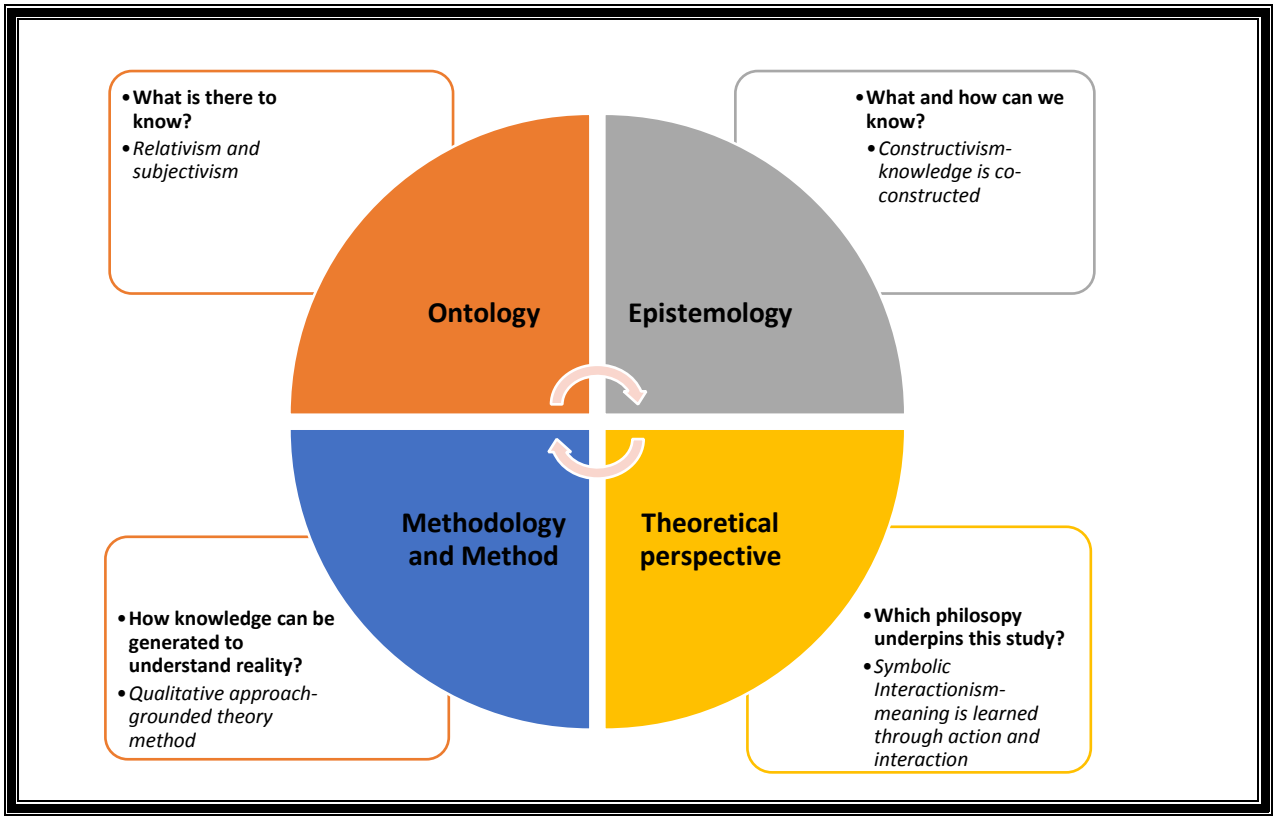

Figure 1: Paradigmatic Assumptions

3.2.1.2. EPISTEMOLOGICAL ASSUMPTIONS

Epistemology is concerned with how knowledge is generated, acquired and communicated, in other words, “what it means to know” (Holloway & Wheeler 2010:21). Epistemologically, this study assumed that a subjective relationship between the researcher and the participants contributes to a comprehensive understanding of the phenomenon being studied (Mills et al. 2006:2). This study was based on the epistemological perspective of constructivism, which denotes that reality is constructed when LGBTI youth and nurses interacted with the PHC setting. Charmaz (2014:13-14) declares that as an epistemological stance, constructivism studies reality and is constructed by individuals as they give meaning to their world. Therefore, constructivist grounded theory actively repositions the researcher as the author of a reconstruction of experience and meaning (Mills et al. 2006:26). This implies that, participants interpret reality and attach meaning to it as they experience it during clinical interaction in a PHC setting whilst the researcher interprets how the participants interpret reality. Reality should be depicted in an interpretive way, since the participants and the researcher are involved in the process of constructing it (Charmaz 2014:3, Mills et al. 2006:26).

This study is concerned with understanding and discovering the basic social processes involved in facilitating LGBTI youth-inclusive PHC by seeking answers to questions such as 'what is going on here?' from LGBTI and nurse participants’ perspective. The researcher chose a method which is flexible and allows for exploration of new areas of knowledge and to acquire in-depth meaning of the phenomenon being investigated leading to theory development. In this study, the researcher interpreted data obtained from researcher-participant interaction and analysed it in order to co-create and co-construct the theory (Watling & Lingard 2012:852) thereby answering the research questions: “How do nurses and LGBTI youth experience their interaction in PHC in Tshwane District, Gauteng Province, South Africa?” and “What are the basic social processes involved in facilitating LGBTI youth-inclusive PHC in Tshwane District, Gauteng Province, South Africa?” The knowledge gained

from this study should assist nurses in understanding and applying the basic social processes involved in facilitating LGBTI youth-inclusive PHC. Table 3 depicts the characteristics of constructivist epistemology and related methodology applicable to this study. Further details of constructivist grounded theory that this study is assuming will be discussed later in this Chapter under the heading Research Methodology.

Table 3: Characteristics of constructivist epistemology and methodology

Epistemology	Methodology	Methods
Approach • Qualitative approach • Descriptive and exploratory • Naturalist Inquiry • Subjectivism • Multiple realities	• Grounded theory ***Sampling*** • Human participants • Purposive sampling • Initial sampling • Theoretical sampling	• Interviews • Field notes ***Data analysis*** • Inductive data analysis • Sensitizing concepts • Theory generation • Theoretical generalization

3.2.1.3. METHODOLOGICAL ASSUMPTIONS

Methodology relates to a plan of action, which guides the selection and application of particular methods (Crotty 1998:3). According to Guba and Lincoln (1994:108), methodology attempts to unfold a process of how the researcher can attempt to find facts about whatever they believe can be known. Methodology is a plan of actions which links philosophy to the suitable research methods and connects philosophical ideas to applicable research strategies. This study used constructivist grounded theory methodology to discover the nature of reality. Constructivist grounded theory signifies that even though reality exists, and can be discovered through inquiry, it is never perfectly apprehensible (Hallberg 2006:146). Constructivist grounded theory is interpretivist in nature, meaning that the notion of a shared reality is interpreted or discovered by the researcher and that "…reality arises from the interactive process and its temporal, cultural, and structural contexts" (Charmaz 2000a:523).

In this study, the researcher started by collecting data to discover how participants constructed their worlds as they described the events, thoughts and actions, as they were experienced (Charmaz 1990:1162). By asking how, why and under which conditions an existing sociological concept works in this specific field, existing concepts were used as sensitising concepts, as Blumer motivates for (Charmaz 1990:1166). Sensitising concepts suggested a point of departure, a way of seeing and organising experiences and provided "starting points for building analysis to produce a grounded theory" (Charmaz in Bowen 2006:14-20). Sensitising concepts were used to lay the foundation for the analysis of research data, examining substantive codes, with a view to developing thematic categories from the data (Charmaz in Bowen 2006:14). In this study, sensitising concepts were PHC and LGBTI youth-inclusive PHC. PHC refers to the first entry point into the health system, and is geared towards health promotion, disease prevention, early diagnosis and treatment of diseases, and referral to secondary and tertiary health care (Dookie & Singh 2012:2). LGBTI youth-inclusive PHC refers to the health care that is sensitive to the health care needs of LGBTI youth (National Implementation Guidelines for Adolescents and Youth Friendly Heath Services 2012-2016). Further details of constructivist grounded theory that this study is assuming will be discussed later in this Chapter under the heading 'Research Methodology'.

3.2.1.4. THEORETICAL ASSUMPTIONS

Theoretical assumptions are a means of understanding the world and making sense of it (Crotty 1998:50) and provide a context through which to view the chosen research methodology (Crotty 1998:3). Traditionally, constructivist grounded theory research is ontologically informed by the interpretivist philosophy, and is based on the theoretical perspectives of symbolic interactionism. The foundation of symbolic interactionism theory is "meanings" and the source of data is "human interaction" (Blumer 1969:2; Bryant & Charmaz 2007b:21; Aksan, Kisac, Aydin & Demirbuken 2009:902; Plummer & Young 2010:310). Symbolic interactionism has been described as "the study of

how the self and the social environment mutually define and shape each other through symbolic communication" (Clamp & Gough 1999:136; Klunklin & Greenwood 2006:34). Symbolic interactionism is a sociological theory, which is based on the following three guiding principles:

a) humans act towards things on the basis of the meaning they attach to them;
b) the meaning of things is derived from the social interaction with others; and
c) the meanings are modified through an interpretive process (Blumer 1969:2; Plummer & Young 2010:310).

Thus, symbolic interaction examines the meanings evolving from the mutual interaction between individuals in social environments, and focuses on answering the question "which symbols and meanings emerge from the interaction between people?" (Aksan et al. 2009:902).

Blumer (1969:51) asserts that humans formulate "meaning" in two ways:

a) meaning is something attributed to objects, events, phenomenon; and
b) meaning is a "physical attachment" imposed on events and objects by humans.

These facts are related to how people form meaning and the fact that meaning is based on personal perceptions, as well as changes in time, and is formed differently for anyone (Glaser 2005:np). The main aim of the study was to gain insight into participants' perspectives on their experiences, actions, interactions and meanings on how they handled their situation during patient-nurse interaction in the PHC setting. Discovering more about the concerns of LGBTI youth when accessing PHC and how the nurses could assist them in accessing LGBTI youth-inclusive health care services was critical to this study. Symbolic interactionism holds that social life consists of interactions, actions, and processes (Charmaz 1990:38). Interaction within the 'self' and with others allows people to understand a situation and make a choice by deciding whether to change, adapt or maintain their course of actions (Klunklin & Greenwood 2006:34; Crooks 2001:15).

Given the background of symbolic interactionism, the researcher believed that it is through dialogue and interaction, that human beings become aware of their and others' thoughts, feelings and attitudes. In this study, important contextual features were: LGBTI youth, nurses and LGBTI youth-inclusive PHC services. Thus, through actions and interaction with LGBTI youth and nurse participants, the researcher constructed meaning by interpreting the dialogue they shared with each other, as illustrated in Figure 2.

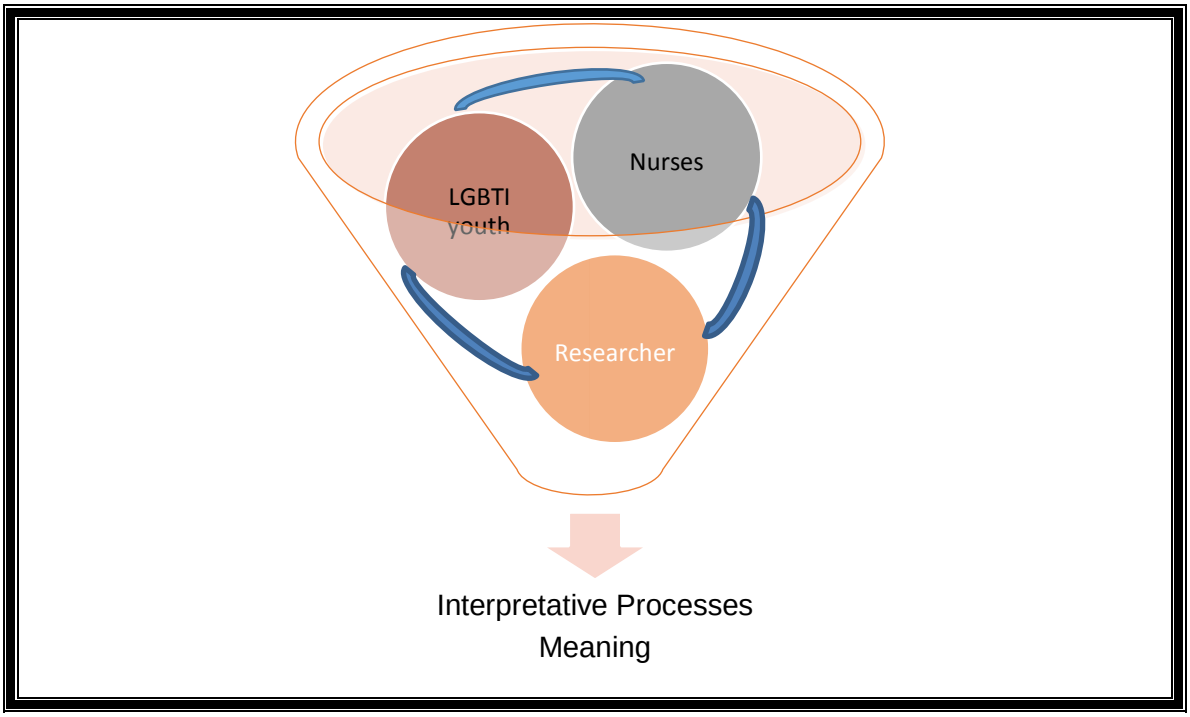

Figure 2: Interaction between nurses, LGBTI youth and nurses

The researcher sought to uncover the meaning of how participants interpreted LGBTI youth-inclusive PHC and health care needs, by exploring and describing how nurses and LGBTI youth experience their interaction in PHC in Tshwane District. The basic social process involved in the facilitation of LGBTI youth-inclusive PHC in the District emerged from the findings. The researcher explored and described how nurses and LGBTI youth experience their interaction in PHC by asking questions about past and present experiences, opinions and problem solving strategies as outlined in the interview guide in Addendum A. The main focus was being on presenting the process through

which those views were developed. Hence, Charmaz (2005:510) asserts that our theoretical analyses are interpretive images of reality, and not the objective reporting of it (Charmaz 2005:510).

In addition, an explanation of the basic elements of the paradigm adopted in this study included the following paradigmatic assumptions:

3.2.1.5. AXIOLOGICAL ASSUMPTIONS

Axiological assumptions inquire about the way in which the values of the researcher can influence what is to be studied. It is based on a branch of philosophy dealing with values, and those of ethics, aesthetics, or religion. Axiological assumptions hold that the findings of qualitative research are influenced in one way or the other by the researcher's values; where the researcher becomes immersed in what is being studied. It is therefore vital that researchers of qualitative research reveal their values with regard to the studied phenomenon and how they may affect or influence the research (Hall & Callery 2001:257). The researcher should also describe measures that will be employed to reduce the effect of influence. In this study, the researcher held the belief that people are in interaction with themselves and with others and that influence how they think and behave during interaction with others. The researcher also believed that all patients including vulnerable groups such as LGBTI patients should be treated equally and in a humane and respectful manner despite their circumstances. The researcher kept a reflective personal journal and memos that assisted in identifying and mitigating the effects of own values and beliefs on the research process.

3.2.1.6. RHETORICAL ASSUMPTIONS

Rhetorical assumptions examine the language and the writing approach of the researcher. Rhetorical assumptions use metaphors, personal and literal language based on definitions that evolve during a study rather than being defined by the researcher (Creswell 2007:16-19). In this study, the researcher seek to understand how the participants understood their world, and shared

their interpretations and meaning thereof. However, the researcher acknowledged that the words of everyday language are rich in multiple meanings, which are influenced by the context under which they are interpreted. Interviews were transcribed verbatim and during data analysis, where the researcher referred to the concepts as defined by participants. Available literature was not considered until the theory began to emerge to ensure that the concepts that emerged were original and grounded in the data.

3.3. RESEARCH FOCUS

The intention of the study was to find new ways of contributing to existing knowledge about LGBTI youth-inclusive PHC. Therefore, this study was undertaken to develop substantive theory focused on the basic social processes involved in facilitating LGBTI youth-inclusive PHC in Tshwane District of Gauteng Province in South Africa. Substantive theory refers to an emergent theory developed inductively from interpreting the data generated within the context of the phenomena that the theory represents (Bryant & Charmaz 2007b:610). Substantive theory in this study refers to the concepts and statements that emerged from the findings of the study and focused on the basic processes involved in facilitating LGBTI youth-inclusive PHC.

The study is significant, as it seeks to bring new insights into theory and practice that will facilitate LGBTI youth-inclusive PHC. Specifically, the objectives of the study were to:

- explore and describe the experiences of LGBTI youth regarding health care they received in PHC clinics;
- explore and describe the experiences of nurses regarding caring for LGBTI youth in PHC clinics; and
- explore and describe the basic social processes involved in facilitating LGBTI youth-inclusive PHC.

Grounded theory method, a qualitative approach that remains rare within studies related to LGBTI health care in SA was used to achieve the objectives of the study. Grounded theory research is an exploratory method that seeks to

understand the basic social processes underlying phenomena of interest. Thus, grounded theory was suitable for this research, as it is a method used specifically to explore and describe the basic social processes involved within human interactions, which in this study implied the LGBTI youth and nurses interaction within the PHC system.

3.4. RESEARCH QUESTIONS

To achieve the aim and objectives of this study, a qualitative study was undertaken, using a constructivist grounded theory approach. The study was guided by the following two main research questions:

- how do nurses and LGBTI youth experience their interaction in PHC in the Tshwane District of Gauteng Province in South Africa?; and
- what are the basic social processes involved in facilitating LGBTI youth-inclusive PHC in the Tshwane District, Gauteng Province, South Africa?

Such a broad focus research questions are consistent with a qualitative design as it places the researcher in a position that is open to the discovery of issues and concepts which are embedded in the phenomenon under study. The research questions of this study required a research method concerned with understanding of human social interaction. Thus, constructivist grounded theory approach had the potential to provide insight into a complex human social interaction (Glaser & Strauss 1998:115).

In this study, the initial research questions defined the scope of the study and guided how data should be collected, while allowing flexibility for the researcher to follow on the unexpected turns that might arise as data was being analysed (Watling & Lingard 2012:852). However, the researcher still maintained consistency and continuity between the research questions, aims and data collection methods (McCann & Clark 2003c:38).

3.5. RESEARCH METHODOLOGY

Burns and Grove (2001:223) define research methodology as the total strategy, from the identification of the problem, to the final plans of data collection and analysis. According to Charmaz (2006:150), when choosing a methodology, several factors have to be considered. The method should enable the researcher to capture the participants' lived experiences and should be able to interpret and co-construct the data captured. According to Stern (2007:114), a true grounded theory must always be generated from the data, should make sense, and the reader should immediately be able to recognise that the theory is about people and objects to which they can relate. Theorising is an interpretive process that involves constructing an explanatory scheme from the data that systematically integrates various concepts through statements of relationships (Strauss & Corbin 1998:25; Goulding 2002:44). Therefore, the substantive theory of this study provided a theoretical analysis of how meanings, actions and social structures are constructed (Charmaz 2006:151). This study examined a method that complimented the ontological, epistemological and theoretical assumptions proposed in this study, by capturing the experiences of both LGBTI and nurse participants.

This study attempted to answer the research questions by making use of constructivist grounded theory research methodology. Therefore, this study used constructivist grounded theory because the method enabled the researcher to develop a theory relating to the substantive area being studied (Turner 1981:225). Glaser defines grounded theory as "…a general methodology of analysis linked with data collection that uses a systematically applied set of methods to generate an inductive theory about a substantive area" (Glaser 1992:16). Thus, the goal of grounded theory research is to develop a theory (Glaser 1992:16; Bowen 2006:13, Atkinson, Coffey & Delamont 2003:150) through an interactive process of integrative analysis and comparison of data (Charmaz 2005:510; Coyne & Cowley 2006:508; Moghaddam 2006:53). The method must attempt to answer the conceptual question, "what is the basic social process that underlies the phenomenon of

interest?" (Glaser 1978:96; Reed & Runquist 2007:119). Therefore, the basic social processes in this study referred to facilitation of LGBTI youth-inclusive PHC, and were the core category upon which the grounded theory developed. The use of constructivist grounded theory approach in this study enabled the development of a theory relating to the substantive area being studied (Turner 1981:225).

3.5.1. RESEARCH DESIGN

This section provides an overview of the research design adopted in this study, which is grounded theory. The origins and the philosophical underpinning of grounded theory will be discussed. This section also set out the rationale for adopting grounded theory within the context of a historical overview. Subsequently, the researcher accounts for the decision made to adopt constructivist grounded theory by discussing the key debates about different approaches to grounded theory considering which approach is most relevant to the current study. Firstly, the researcher defines grounded theory as an inductive qualitative method, explaining the distinctive features that qualify the method as a qualitative method. Secondly, the researcher provides consideration of Glaser and Strauss's objectivist grounded theory within the context of this study, setting out why the researcher has opted not to adopt this approach. Thirdly, Strauss and Corbin's version of grounded theory with reference to the current study will be discussed. Finally the version of Charmaz's constructivist grounded theory, setting out the rationale for adopting the method in this study will be discussed.

Burns and Grove (2001:223) define research design as the clearly defined structures within which the study is implemented. This study used a qualitative approach, using a constructivist grounded theory design. A qualitative approach is an in-depth inquiry that attempts to understand the "what" and "why" of human behaviour. Grounded theory focuses on everyday life experiences; values, participants' perspectives; is an interactive process

between researcher and participants; it is descriptive, and relies on people's words (Charmaz 2014:3).

According to Cole (2006:26), qualitative researchers are "more concerned about uncovering knowledge about how people feel and think in the circumstances in which they find themselves, than making judgments about whether those thoughts and feelings are valid". This implies that qualitative researchers are concerned in the means of explaining how people make sense of their experiences and worldviews. In an attempt to answer the research question, an inductive method of data collection was adopted, which enabled the researcher to progress simultaneously between data collection and analysis, a process referred to as constant comparative data analysis, thus generating new concepts to inform the next stage of data collection (Glaser 2001:146). The researcher attempted to seek individual participant's account on how a particular phenomenon unfolded. Therefore, in this study, the researcher started by collecting data from the LGBTI and nurse participants to discover their experiences, and how they construct their own worlds (Charmaz 2014:3; Strauss & Corbin 1998:15). The researcher explored how, why and under which conditions an existing sociological concept works in order to construct a theory that described the basic social processes involved in facilitating LGBTI youth-inclusive PHC in Tshwane District.

3.5.1.1. GROUNDED THEORY METHODOLOGY

Grounded theory methodology is aimed at developing the core category of the theory, which explains, describes or predicts the basic social process involved in the phenomenon being studied. The core category can be any kind of theoretical code: a process, a condition, two dimensions, or a consequence (Glaser 2005:np). Basic social process is fundamental and patterned process in the organisation of social behaviours which occur over time and continue regardless of the conditional variation of place (Schreiber 2001:57). The universality of such core processes gives rise to the word "basic" in basic social process (Glaser & Strauss 1967:70; Glaser 2005:np). Basic social

process attempts to problematic nature of patterns of behaviour (Glaser 2005:np; Cutcliffe 2005:425).

Glaser and Holton (2004:np) assert that when the researcher chooses a core category, she/he must first look at variables that are related. They advise researchers to work on one category at a time and in cases where more than one category emerged, the researcher must first work on the one that has more relevance to the phenomenon being investigated and then filter the others into the theory as a relevant "near core", but not core category. In this way the researcher will ensure that the other core categories are not abandoned since they can still take a central focus in another writing. Glaser and Holton (2004:np) describe criteria by which a researcher can make a decision about determining the core category as follows. It must:

a) be *central*; that is, related to as many other categories and their properties as possible. This criterion of centrality indicates that the core category accounts for a large portion of the deviation in a pattern of behaviour;
b) *recur frequently* in the data, and be a stable pattern that becomes increasingly related to other variables;
c) take more *time to saturate* the core category than other categories; and
d) connect meaningfully and effortlessly with other categories without being forced.

These criteria assisted the researcher to get through the data analyses processes of this study and to eventually develop the core category that informed the substantive theory of the study.

This study began by exploring the experiences of LGBTI youth and nurses working in PHC services in Tshwane District as they interact with each other in the PHC context. The researcher became interested in understanding their actions, interaction and the meaning that they attached as they interacted with each other. This was done to develop a theory that describes the basic social processes involved in human interaction, which in this study implies the facilitation of LGBTI youth-inclusive PHC. Through memo writing, the LGBTI

data has helped in the development of codes and subsequently probing questions that were used during theoretical sampling (Bryant & Charmaz 2007:245-264; Charmaz 2006:72-95). Data analysis revealed the interplay between what nurses and LGBTI participants revealed as the main concern of facilitating LGBTI youth-inclusive PHC, which manifested in value-laden tension and conflict that they have experienced. This study makes a theoretical contribution by providing a description of basic social processes involved in facilitating LGBTI youth-inclusive PHC that can be operationalised, and tested in future research. The theory could also assist in improving health care and health seeking behaviour among LGBTI youth. In this study, the researcher analysed and interpreted data obtained from researcher-participant interaction in order to co-create and co-construct the theory (Watling & Lingard 2012:852). This was done to answer the research questions: How do nurses and LGBTI youth experience their interaction in PHC in the Tshwane District, Gauteng Province, South Africa? What are the basic social processes involved in facilitating LGBTI youth-inclusive PHC in Tshwane District, Gauteng Province, South Africa? The study of these social processes is expected to answer questions:

a) what are the core concepts of the process?
b) what are the relationships between these concepts? and
c) what are the factors that influence the process?

Consequently, a substantive theory focused on the basic social processes involved in facilitating LGBTI youth-inclusive PHC in Tshwane District, Gauteng Province, South Africa was developed. By asking how, why, as well as under which conditions an existing sociological concept works in this specific field, the researcher used existing concepts as sensitising concepts (Charmaz 1990:1166).

Table 4: Definition of grounded theory methodology

DEFINITION OF GROUNDED THEORY METHODOLOGY	AUTHORS
Grounded theory is an inductive method whereby the researcher is guided by the data and its codes and categories as the theory emerge.	Bowen (2006:13); Charmaz (2014:4)
"The discovery of theory from data systematically obtained from social research."	Glaser and Strauss (1967:2)
"Grounded theory is a highly systematic research approach for the collection and analysis of qualitative data for the purpose of generating explanatory theory that furthers the understanding of social and psychological phenomena." "The objective of grounded theory is the development of theory that explains basic patterns common in social life."	Chenitz and Swanson (1986:3)
"The grounded theory approach is a qualitative research method that uses a systematic set of procedures to develop an inductively derived grounded theory about a phenomenon."	Strauss and Corbin (1990:24)
"Grounded theory is a qualitative research approach used to explore the social processes that present within human interactions."	Streubert and Carpenter (1999:99)
"The objective of grounded theory is the development of theory that explains qualitative research method that uses a systematic set of procedures to develop an inductively derived grounded theory about a phenomenon."	Strauss and Corbin (1990:24)
"Grounded theory methods consist of systematic inductive guidelines for collecting and analyzing data to build middle range theoretical frameworks that explain the collected data."	Charmaz (2000a:509)
"Grounded theory methodology is a specific, highly developed, rigorous set of procedures for producing formal, substantive theory of social phenomena."	Schwandt (2001:110)

Grounded theory is a qualitative approach, which enables the development of a theory generated directly from data collected during research (Chenitz & Swanson 1986:3; Strauss & Corbin 1990:24) to help understand complex social processes (Glaser 1978:96). Grounded theory has several distinguishing practical features, as compared to other qualitative approaches. It is defined by many authors in different ways as outlined in Table 4, with the common themes being inductive qualitative method, and development of theory from data. It is

considered to be a rigorous methodology, since it outlines a sequence to be followed when collecting and analysing data (Glaser & Strauss 1967:102-109).

Table 5: Comparison between objectivist and constructivist grounded theory (Adapted and expanded from Charmaz (2007)

OBJECTIVIST GROUNDED THEORY	CONSTRUCTIVIST GROUNDED THEORY
Fundamental Assumptions • Adopts an external reality • Adopts discovery of data • Assumes that conceptualisations emerge from data analysis • Understands data as unproblematic	**Fundamental Assumptions** • Adopts multiple realities • Adopts mutual construction of data construction between the researcher and participants • Adopts that the researcher construct categories
• Adopts the neutrality, passivity and power of the researcher	• Assumes representation of data as problematic, relativistic, situational and partial • Adopts that the researchers knowledge, values, positions and actions affect perception
Objectives • Aims to achieve context-free generalisation • Aims for abstract conceptualisations that transcend historical and situational locations • Aims to create a theory that fits, works, has relevance and is modifiable	**Objectives** • Views generalisation as contextual and conditional, situated in space, time, positions, actions and contextual • Aims for interpretive understanding of historically situated data • Aims to create a theory that has credibility, originality, resonance and usefulness
Implication for Data Analysis • Perceives data analysis as an objective process • Perceives emergent categories as part of data analysis process • Views reflexivity as a possible source of data • Provide priority to researcher's analytic categories and voice	**Implication for Data Analysis** • Acknowledges subjectivity throughout data analysis • Perceives co-construction of data as providing analytic direction • Engages in reflexivity throughout the research process • Views participants' views and voices as the key to data analysis

A distinctive feature of grounded theory is the constant comparative analysis of data. During data analysis, data obtained from participants are coded, then compared and contrasted throughout the data collection and analyses phase of the study (Bowen 2006:13; Schurink 2004d:2). Key issues raised by the participants are followed up through theoretical sampling and subsequent

interviews (Glaser & Strauss 1967:4). Unstructured, open interviews and observational field notes are used to gather the data, to ensure that the participants' subjective views are permitted to emerge. Therefore, the theory that develops is believed to be grounded in the data, discovered, and not preconceived by the researcher perceptions (Glaser & Strauss 1967:254; Glaser 1978:37-41, 93). The theory must be developed prior to conducting an in-depth literature review (Glaser & Strauss 1967). Table 5 depicts the comparison between objectivist and constructivist grounded theory.

3.5.1.2. EVOLUTION OF GROUNDED THGEORY METHOD

Grounded theory was founded by Barney Glaser and Anselm Strauss in the 1960s in the US who studied patients dying in hospitals in the field of health (Glaser 1967, 1978; Strauss & Corbin 1990, 1998; Charmaz 2006) and illuminated in a book titled *The Discovery of Grounded Theory* (Glaser and Strauss 1967). Grounded theory involves more than one version of how researchers can implement procedures whilst maintaining standards of rigour consistent with qualitative research (Glaser & Strauss 1967:1). Hence, it is expected that different researchers will focus on different aspects of collected data, which is influenced by their background, beliefs and values.

Glaser and Strauss (1967:1) assumed an objectivist or positivist paradigm, which states that the researcher is a passive participant in the research process and they referred to the method as classical grounded theory. Glaser and Strauss (1967:1) assert that within the objectivist paradigm, the researcher ought to inductively develop a theory that is grounded in the data. The objectivist paradigm seeks to represent the participants' view truthfully and accurately. Thus, the researcher ought to begin by collecting data without any preconceived ideas, without reviewing the existing literature, and without referring to any existing theories (Glaser 1978:25). This does not necessarily imply that objectivist grounded theory is less concerned with the researcher's perspectives. It implies that the aim of objectivist grounded theory is to explore participants' perspectives not only from a descriptive or interpretive approach,

but to raise these perspectives to a conceptual level (Glaser 1978:84). Therefore, objectivist grounded theory aims to identify a pattern of behaviour that emerge from empirical data in order to provide a theoretical, rather than descriptive or interpretive, rendering of participants' behaviour (Glaser 1978:58).

Glaser and Strauss, the pioneers of grounded theory method, separated from each other in the 1980s, due to their contrasting points of view (Glaser 1992:6; Goulding 2002:3). Strauss then partnered with Corbin and developed a different perspective on grounded theory methodology illuminating in their book *"Basics of Qualitative Research; techniques and procedures for developing grounded theory"* (Corbin & Strauss 1990; Strauss & Corbin 1998). The authors believe that the theory that develops as part of a given study should be based on observation and the understanding that the theory is already contained in the data and awaiting to be discovered.

Strauss and Corbin (1990:90,123) highlight the important features of grounded theory as follows:

a) Conducting research in a natural setting of participants who experienced the phenomenon being investigated.
b) The importance of developing a theory, based on real life experiences, and the ability of the method to improve an area of academic thought.
c) The opinion that the acquisition of knowledge is a process that is subject to constant change.
d) That people are engaged in and can influence "the world" around them.
e) The focus is on the dynamic and progressive nature of the social world.
f) The focus is on the relationship between meaning and action.

Strauss and Corbin's version also outlines a sequence of additional practical steps and techniques, which are anticipated to improve "theoretical sensitivity." Strauss and Corbin (1990:1976) assert that "we need theoretical sensitivity; the ability to "see" with analytic depth what is there". Corbin and Strauss

(1990:419-422) furthermore identify eleven basic processes to be followed in the development of grounded theory method as follows:

a) data collection and analysis are interrelated processes;
b) concepts are the basic units of analysis;
c) categories must be developed and related;
d) sampling in grounded theory proceeds on theoretical grounds;
e) analysis makes use of constant comparisons;
f) patterns and variations must be accounted for;
g) process must be built into theory;
h) writing theoretical memos is an integral part of doing grounded theory;
i) hypotheses about relationships among categories are developed and verified as much as possible during the research process;
j) a grounded theorist need not work alone; and
k) broader structural conditions must be brought into the analysis, however microscopic in focus is the research.

Strauss and Corbin (1998:127-128) introduced three levels of coding namely: open coding, axial coding, and selective coding. Open coding identifies concepts, their properties and dimensions from data. Axial coding examines the relationship between categories of the phenomenon in the data according to: “who, when, where, why, how, and with what consequences?” Selective coding identifies the core category which is “the central phenomenon around which all other categories are integrated” (Strauss & Corbin 1990:116). Strauss and Corbin (1990:145), unlike Glaser and Strauss, allows the use of literature to inform the research process and improve theoretical sensitivity.

On the other hand, constructivist or interpretivist paradigm believes that the researcher is an active participant in the research process, who has prior knowledge of the phenomenon being investigated. Constructivist researchers acknowledge the participants’ experiences with regard to the phenomenon being studied and how they construct their view of reality (Charmaz 1995c:50). A constructivist paradigm seeks to generate data that communicates an

insightful, valid and useful message to the readers (McCann & Clark 2003:24). The aim of grounded theory is not to narrate participants' stories, but rather to identify and explain theoretically an on-going behaviour, which seeks to address an important area of concern. Simply put, the **'**findings' of a grounded theory study are not about people, but are about the patterns of behaviour in which people engage (Glaser 2002:10). Thus, the unit of analysis is not the person *per se*, but incidents contained in the data (Breckenridge 2012:np).

Constructivist grounded theorists do not assume that the researchers enter the research scene without an interpretive frame of reference. Rather, they believe that what researchers see and hear depends upon their prior experiences, interpretive frames, biographies, and interests as well as the research context, their relationships with research participants, and methods of generating and recording empirical data (Mills et al. 2006a:8). Constructivists study how and why participants create realities, thus inform the process, methods and way of thinking in research (Mills et al. 2006a:8). Thus, the research participants share in constructing what they define as data. In constructivist grounded theory, conceptual categories arise through the interpretations of data rather than emanating from them (Charmaz 2005:510). Thus, knowledge and theory is constructed and co-constructed by both the researcher and participants by giving meaning to the empirical evidence within the research context (Charmaz 2005:510). However, constructivist grounded theorists need to think about how to keep originality and consistency when developing a conceptual analysis of participants' stories whilst at the same time still creating a sense of their presence in the final text (Mills et al. 2006:32). Objectivist researchers are criticised by Charmaz (2006:132) for maintaining a 'distant' relationship with participants, by assuming the role of authoritative experts, who bring an objective view to the research.

The methodology of grounded theory aims to create new theory based on interrelated concepts rather than testing existing theories (Glaser 2001:13). The theory generated from grounded theory design aims to explain and/or

predict phenomena, based on empirical data. Constructivist grounded theory method in this study made use of four different phases in developing concepts and theoretical frameworks:

a) creating and refining the research and data collection questions;
b) raising terms of concepts;
c) asking more conceptual questions on a generic level; and
d) making further discoveries and clarifying concepts through writing and rewriting (Charmaz 1990:1162; Glaser 2001:13).

The result of constructivist grounded theory methods must be a theory of abstracted ideas about a social process (Reed & Runquist 2007:120).

Charmaz, who has extensive experience in the application of grounded theory, developed a "new version" of grounded theory, which she named constructivist grounded theory. She believed that the "new version" was setting out a new approach for the future of grounded theory by saying "…we look back into the history of grounded theory in the twentieth century and look forward into its yet unrealized [sic] potential for the twenty-first century" (Charmaz 2006:1). The constructivist approach to grounded theory of which Charmaz is a proponent was adopted and adapted from the version of Strauss and Corbin, which is based in the interpretative tradition of grounded theory. Charmaz (2006:9) claims that she has realigned the emphasis of grounded theory by reverting to the philosophical roots of pragmatism by "examining processes, making the study of action central and creating abstract interpretive understandings of the data". Charmaz (2006:178) asserts that constructivist grounded theory is a fluid and interactive process in which the researcher plays a significant part in shaping both the process and outcome of the study. Charmaz (2003:250) advocates a constructivist paradigm that "assumes the relativism of multiple social realities, recognizes [sic] the mutual creation of knowledge by the viewer and viewed, and aims toward an interpretive understanding of subjects' meanings". Therefore, Charmaz (2006:104) believes that theories are co-constructed and not discovered. According to Charmaz (2008:402), the core principle of constructivist grounded theory is to give participants a voice in

rendering their views and visions with regard to their lived experiences. Charmaz (2008:398-401) asserts that Glaser and Strauss's approaches to grounded theory methodology holds a contrary view to her approach, as they assume an objective reality and adopt a positivist and objectivist paradigm. Constructivism thus opposes the notion that there is an objective truth that can be measured or captured through research (Crotty 1998:42).

Glaser (1992:6) later criticised Strauss and Corbin's perspective of constructivist grounded theory based on the following reasons:

a) the analysed data does not reflect the participants' voice as the process requires that the researcher interrogates the data that departs from the central problem of the people in the substantive area; and
b) furthermore the method questions what accounts for the variation in processing the problem.

The use of the researcher's preconceived ideas for asking questions of the data and the fact that subsequent analysis of data forced data into the framework rather than allowing the categories to be discovered from the data itself.

This study followed the constructivist grounded theory method, as adapted and adopted by Charmaz, and to a lesser extend the method as adapted and adopted by Strauss and Corbin, since it was the researcher's intention to understand the social constructions that form participants' realities, and the effect that these realities have on their behaviours (Milliken & Schreiber 2001:181). For the researcher, Charmaz's approach offered a version of grounded theory that is relevant and applicable to qualitative inquiry and has been significant in the development of ideas and way of thinking around the philosophical and epistemological underpinnings of grounded theory as a research process. The researcher discarded Glaser's perception that reality is objective and neutral, and that the researcher is a passive participant in the research process, because she asserts that the researcher and the participants construct their view of reality based on their experience,

background, beliefs and values with regard to the phenomenon being studied (Charmaz 1995c:55; Cutcliffe 2000:1480). Hence, the theory developed in this study is constructed by both the researcher and participants by giving meaning to the empirical data within the research context (Plummer & Young 2010:313).

This study began with the broad purpose of examining a particular area of interest, with specific focus on research questions, emerging and refined as data analysis proceeds. By starting with collecting data from the lived experience of the research participants, the researcher could from the beginning, attend to how the participants constructed their worlds (Charmaz 2006:10). Therefore, those lived experiences as narrated by participants, guided the way in which data collection and analysis should be approached (Charmaz 1990:1162). In this study, intensive interviews were used as a means of sourcing empirical data using the interview guide, followed by probing questions, writing of field notes and memos. During the interview, the researcher commenced by exploring participants' experiences regarding the phenomenon being studied, which is the interaction between nurses and LGBTI youth in PHC in Tshwane District of Gauteng Province in SA, and the basic social process involved in facilitating LGBTI inclusive PHC. Simultaneously, conceptual labels were assigned and labelled as codes as data was being analysed. Codes were then grouped into abstract categories from which the theory emerged. The complex data collection and analysing process is illustrated in Figure 3. The figure illustrates the circular process with its data sources and many different kinds of coding, comparing and memoing of each interview.

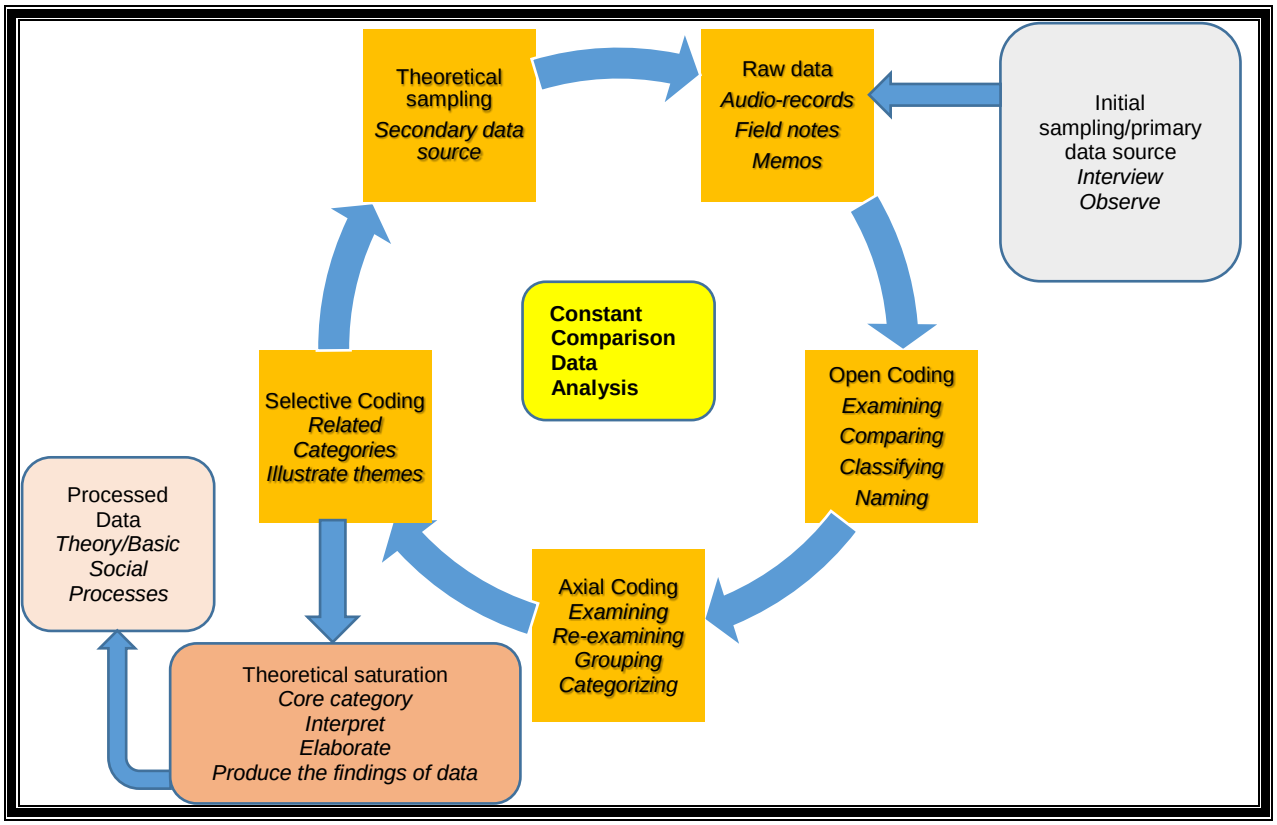

Figure 3: Data collection and analyses process

The analysing process was an ongoing process where codes, categories, memos and interviews were revisited many times throughout the whole process of analysis to form the core category and eventually the substantive theory.

3.5.2. THEORY DEVELOPMENT

Theory concerns carefully developed concepts that are put together by mutually related statements forming an integrated conceptual framework that explains or predicts a phenomenon or an event, thereby providing guidance to actions (Glaser & Strauss 1967:70; Walker & Avant 1995:25; Glaser 2005:np; Hallberg 2006:142). According to Chenitz and Swanson (1986:3), the objective of generating a theory is to further our understanding of "basic human patterns common in social life". This objective of theory generation implies a focus not just on description rather on analysis and conceptualisation. Therefore, there are implications for the way in which the researcher analyses data and

conceptualises the theory. As such, the interpretation of the data is an iterative process linked to the researcher's own worldviews. However, in acknowledging the intimate relationship between the researcher and the analysis of the data, the principle is to let the theory emerge from the data as part of the research process, rather than being preconceived or forced onto the data.

Glaser and Strauss (1967:3) suggested that the role of theory is:

a) to enable explanation and to some degree prediction of behaviour;
a) to help both researchers and participants to understand and have some control over as many situations as possible;
b) to provide a perspective of behavior; and
c) to guide research.

Glaser reflects that theory is a process that is still developing and therefore can only be presented as a momentary product. The form in which the theory is presented does not necessarily make it a theory; rather the fact that it explains or predicts something makes it a theory (Glaser 2005:np). Strauss argues that an empirically grounded theory is both generated and verified in the data. It is important that the theory is grounded in the data and not predetermined by any theoretical perspective (McCann & Clark, 2003a:8). However, in this study, the theoretical perspective of symbolic interactionism and sensitising concepts were used to provide guidance in asking relevant questions and analysing the data (Watling & Lingard 2012:855)**.** This implies that the developed theory can be applied and used in practice without further testing (Hallberg 2006:143).

Both Glaser and Strauss differentiate between substantive and formal theory. Formal theory concerns a more general process or phenomena with a broader application area and can be generalised; most grounded theorists address specific substantive areas (Hallberg 2006:143). Substantive theory is applicable to a delimited and specific context and therefore cannot be generalised but transferred to situation with similar characteristics (Glaser & Strauss 1967:32-35; Glaser 1998:115). Substantive theory concerns an emergent theory that is developed inductively from interpreting the data generated within the context of the phenomena that the theory represents and

is applicable to, a delimited and specific area. The purpose of substantive theory is to predict, explain, and interpret phenomena and to enhance understanding and inform action (Glaser & Strauss 1967:32-35). Substantive theory in the context of this study relates to the concepts and statements that emerged from the findings of the study and focused on the basic social processes involved in facilitating LGBTI youth-inclusive PHC.

3.5.3. RATIONALE FOR GROUNDED THEORY

The purpose of grounded theory design is to identify the basic social process for which people must account, explain, predict or adapt in the social phenomenon being investigated and to advance the development of a substantive theory with respect to that social process (Glaser 2005:np; Baker, Norton, Young & Ward 1998:548). The choice of grounded theory approach for this study was based on the following considerations:

a) the need to develop of understanding the interaction of LGBTI youth and nurses working in PHC clinics of Tshwane District using an exploratory methodology;
b) grounded theory is an inductive qualitative methodology which allows data to emerge from the participants rather than testing a hypothesis; and
c) grounded theory is a method which openly sets out the researcher's philosophical stance, acknowledging the researcher's role in the analysis and thus the construction of the theory which emerges (Charmaz 2008:403).

Hence, constructivist grounded theory has been selected for this study as the approach fits all these criteria (Charmaz 2008:403). Grounded theory was best-suited design for this study, as it aimed to explore and develop an explanation of basic social processes involved in human interaction which in this study involves LGBTI youth and nurses interaction in PHC. Again, grounded theory approach was appropriate for this study as little theoretical or factual knowledge on LGBTI-youth inclusive PHC in SA is available.

3.5.4. STUDY POPULATION AND SAMPLE

According to Burns and Grove (2005:40), population refers to “all the elements (individuals, objects or substances) that meet certain criteria for inclusion in a given universe”. This study comprises two accessible target populations i.e., self-identified LGBTI youth, and nurses in public sector and university-based PHC clinics in the Tshwane District. Burns and Grove (2005:40) define a sample as a subset of a target population, which contains all the characteristics of the target population. In constructivist grounded theory, two sampling methods are applicable, namely initial sampling and theoretical sampling (Charmaz 2006:96-100; Coyne & Coyle 2006:507), which were discussed in detail in Chapter 1 (refer to 1.13.3).

Tshwane has a total population of 3 152 162 (City of Tshwane 2016/21 IDP 2016:30), of which 35% comprises of youth between the age of 15 and 24 years, who form the majority of the population (City of Tshwane 2016/21 IDP:40). Information regarding the LGBTI people is difficult to obtain since in most African countries LGBTI do not disclose their sexual orientation (Thoreson & Cook 2011:5; Mabvurira et al. 2012:218-223; Mavhandu-Mudzusi 2014:710). SA is estimated to have 900 000 lesbian and gay people (Nell & Shapiro 2011:10) amongst a total population of 51,8 million in 2011 (Census 2011:14). However, there is limited data on the total population of LGBTI youth in the Tshwane District, Gauteng Province, SA. In this study, the sample constituted of self-identified LGBTI youth residing in Tshwane during the time of study and has experience of using public and/or university-based PHC services in the District and nurses working in the public sector and university-based PHC clinics in Tshwane District. The Gauteng province has a total number of 75 104 nurses (registered and enrolled) as of end of 2016 (www.sanc.co.za/stats.htm). However, information regarding the total number of nurses working at public and university-based PHC is not readily available.

3.5.4.1. SAMPLING METHOD

The sampling method in grounded theory research is purposive and guided by theoretical considerations (Goulding 2002:66). When adopting grounded theory, data collection and analysis of data occur simultaneously, starting with initial sampling that seeks to maximise variations in experiences and descriptions by using participants from different backgrounds. The researcher purposefully selects sources of data that are considered likely to provide rich information relevant to the research questions (Watling & Lingard 2012:856). In this study, participants were selected based on the information that they share that could contribute to the understanding of the phenomenon being studied, the development and the refinement of emerging categories and eventually the formulation of the theory. Initial sampling was guided by the research questions (Charmaz 2006:96-100) and the sensitising concepts of the study (Watling & Lingard 2012:856) as discussed in Chapter 1. Theoretical sampling implies that the researcher sourced further data until when codes were saturated, elaborated upon, and fully integrated into the emerging theory (Boychuk-Duchscher & Morgan 2004:610). The two types of sampling were discussed in Chapter 1 (refer to 1.13.3) and will be discussed briefly in this Chapter.

3.5.4.1.1. INITIAL SAMPLING

In this study, during initial sampling, the primary sources of data that were likely to provide rich information relevant to the research questions were purposefully selected (Watling & Lingard 2012:856). The clinics that were selected were public sector PHC clinics in Mamelodi and Central Pretoria, and the university-based PHC clinics of the Tshwane University of Technology and the University of Pretoria.

To ensure that participants met the criteria, participants were asked questions related to pre-set criteria (refer Chapter 1 under 1.15.1.1). Initial sampling of participants was conducted to begin the process of data collection and analysis as guided by the participants' inclusion criteria. As concepts began to emerge

from the data, and later as categories emerged, the initial sampling was followed by theoretical sampling.

Table 6: LGBTI participant's demographics

Pseudonyms	Age	Gender	Sexual orientation	Sampling method
P2	22 years	Male	Gay	Initial sampling
P1	23 years	Male	Gay	Initial sampling
P3	23 years	Male	Bisexual	Initial sampling
P4	21 years	Male	Gay	Initial sampling
P5	22 years	Male	Gay	Initial sampling
P6	22 years	Female	Lesbian	Initial sampling
P7	21 years	Female	Lesbian	Initial sampling
P8	20 years	Female	Lesbian	Theoretical sampling
P9	19 years	Female	Lesbian	Theoretical sampling
P10	22 years	Female	Lesbian	Theoretical sampling

To guide the research, the initial sample comprised of seven LGBTI youth and five nurses. Informed consent was obtained from both LGBTI and nurse participants. Table 6 and Table 7 provide the demographic information of both LGBTI and nurse participants respectively, who were included in the study. Intensive face-to-face interviews were conducted with each participants using probing questions, where this process provided a reasonable insight and considerable amount of data from which relevant concepts for theoretical sampling emerged (Charmaz 2006:97).

Table 7: Nurse Participant's demographics

Pseudonyms	Age	Gender	Nursing Rank	Years of experience in PHC	Sampling method
NP 2	47 years	Female	Registered Nurse	21 years	Initial sampling
NP 1	54 years	Female	Registered Nurse	12 years	Initial sampling/Theoretical sampling
NP 5	41 years	Female	Registered Nurse	13 years	Initial sampling
NP 4	45 years	Female	Registered Nurse	3 years	Initial sampling
NP 3	50 years	Female	Registered Nurse	11 years	Initial sampling
NP 6	49 years	Female	Registered Nurse	10 years	Theoretical sampling
NP 7	54 years	Female	Registered Nurse	24 years	Theoretical sampling

A database comprising of participants' names and contact numbers was kept electronically to help in keeping track of participants for possible theoretical sampling, and was only accessible to the researcher. On completion of each interview session, each participant was informed of the possibility of having another interview following data analysis process. Established on the basis of the emerging concepts and categories, the researcher progressed from initial sampling to theoretical sampling to identify and include further participants to allow for the construction of the substantive theory (Charmaz 2006:100).

3.5.4.1.2. THEORETICAL SAMPLING

Theoretical sampling is the process of data collection for developing a theory whereby the researcher concurrently collects and analyses the data and decides what data to collect next and where to find them, in order to develop the theory as it emerges (Glaser & Strauss 1967:45; Glaser 1998:43; Charmaz 2006:102). The aim of theoretical sampling is to allow for and enhance concepts and categories emerging from the data; and to ensure that the grounded theory is complete (Charmaz 2014:193; Urquhart 2013:134,186). Thus, theoretical sampling is an integral part of the data collection and analysis process in grounded theory studies (Glaser 1998:43; Coyne & Cowley 2006:507). During theoretical sampling, the sample is selected based on the developing categories in the emerging theory, rather than on variables such as age, class or characteristics of the sample. As the researcher discovers codes and saturates them by theoretical sampling in comparison groups, successive criteria for further data collection emerge: 1) what categories and their properties to be sampled; and 2) where to collect the data (Glaser & Holton 2004:np). Through theoretical sampling, the researcher is able to develop an explanation of concepts in the theory through conceptualisation, a process which allows the researcher to keep track of the emerging storyline behind the theory as it emerges from the data (Urquhart 2013:18,184). Theoretical sampling directs the researcher on the subsequent in-depth data to source in order to develop the analytically directed emerging concepts and categories (Urquhart 2013:194; Charmaz 2006:100; Birks & Mills, 2011:10-11). In this

study, during theoretical sampling, three self-identified LGBTI youth and three nurse participants were interviewed (of which two were also interviewed during initial sampling) following constant comparative data analysis process, and as informed by emerging theory and the participants' main inclusion criteria until theoretical saturation was achieved (Hallberg 2006:144). Saturation implies that the categories and the relationships between the categories that were formed from the concepts of the theory have been finalised (Watling & Lingard 2012:856). Theoretical saturation implies that: 1) no new data with regard to a category emerge; 2) the category is intense enough to cover variations and process; and 3) relationships between categories are defined adequately (Moghaddam 2006:57). Hence, the collection of further data ceased when no new data concerning a category emerged, individual codes were saturated, elaborated upon, and fully integrated into the emerging theory (Boychuk-Duchscher & Morgan 2004:610).

Data from the initial sample of LGBTI and nurse participants were used initial phases of the coding process. However, only data obtained from the nurse participants through theoretical sampling was used to produce the core category and to explain the processes of facilitating LGBTI youth-inclusive care as the nurses are regarded as the gatekeepers and implementers of LGBTI youth-inclusive PHC. The data from the LGBTI participants was mostly used to explore and describe their experiences with regard to the health care they received in PHC clinics, a process which aided in the emergence of the categories and sub-categories and facilitated theoretical sampling (Glaser 1978:36).

3.5.5. DATA COLLECTION

Though grounded theory is a qualitative design, it is not similar to other qualitative methods in sense that it is a flexible method, with no fixed steps; hence, it allows data collection and data analysis to occur concurrently (Watling & Lingard 2012:852). For the purpose of this study, data was obtained through the interviews using main and probing questions in Addendum A and

field notes that were written during and immediately after the interviews (refer to Addendum N). As the study progressed, the probing questions became more focused and concentrated on gathering more information regarding the emerging categories (Coyne & Cowley 2006:508).

3.5.5.1. THE INTERVIEW PROCESS

In order to facilitate the process of data collection, the researcher had to first realise the importance of developing an understanding of the interview process as a method of data collection. In order to enhance understanding of the interview process, the researcher studies the literature and attended a workshop related to the method. Kvale (1996:2) refers to interview as “inter viewing” i.e., exchanging views between people who are having a conversation on a particular phenomenon. In this study, the interview was conducted with LGBTI youth and nurses working in public sector and university-based PHC clinics in Tshwane, because they have the knowledge and experience of the phenomenon being studied. The way the interview was conducted was determined specifically by the philosophical perspective underpinning the research paradigm.

An understanding of the phenomenon being studied is dependent upon a dynamic human interaction between the participants and the researcher. The researcher met with individual participants at the time and setting selected by them. Two meetings were set with each participant. During the initial meeting, the researcher began by establishing rapport with individual participants to reduce the effect of alienation, power and authority (Charmaz 1995c:58) and to brief the participants about the study and their rights as participants. This was done to allow participants time to decide to participate in the study. Once the participants were ready to participate, they called the researcher and met *visà-vis* to set up date and time for the next meeting, where the actual interview was conducted. Before the interview could commence, the researcher requested participants to sign two copies of the consent form, one copy remained with the participants and the other copy was filed. During the interview, the researcher

presented the questions in such a way that they promoted interactive discussions. The researcher approached the participants with empathetic understanding and encouraged them to participate actively (Hallberg 2006:146) so that the human relationship takes priority over the data collection (Charmaz 1995c:59).

As an icebreaker, the researcher introduced herself to the participants and requested the participants to do the same. The interview was conducted and guided by probing questions (McCann & Clark 2003b:21). The interview questions were framed and ordered as follows: 1) short face-sheet; 2) informational; 3) reflective; 4) feeling; and 5) ending were extracted from the probing questions in Addendum A. The short face-sheet questions were intended to be factual, limited to necessary information and to set the tone and mode for the interview. The informational questions were developed to ask participants about their experiences, for example to bring into perspective of types of events, to establish their chronology and to establish the participants' degrees of awareness about those events.

Once the participants answered one or two questions, the probing questions became more focused and new questions related to the developing categories emerged (Coyne & Cowley 2006:508). Probing questions were refined by bringing in reflective, feeling, probing and ending questions to address direct issues (Charmaz 1990:1167) as reflected in Table 1 and as guided by emerging theoretical ideas, which were based on the researcher's interpretation and insight of the participants' response. As data was collected, field notes were noted and reviewed. Field notes were used to help uncover the meaning of non-verbal cues and also to guide a series of subsequent questions about the phenomenon being investigated. As the interviews progressed, it became apparent that participants were voicing their experiences during their interaction in the PHC context. The interview sessions ranged from between 45 minutes and 60 minutes, with the average time being 50 minutes. Theoretical sampling then followed, based on what was emerging

in the data. Some participants were interviewed more than once, in order to find out more about particular categories that had emerged during analysis. A total of seventeen participants comprising of ten self-identified LGBTI youth and seven nurses participated in the study. All self-identified LGBTI youth participants were between the age of 18 and 24, from different ethnic groups and backgrounds. All nurses had more than two years' experience in PHC and have engaged with LGBTI youth before. All discussions were audio-recorded with the permission of the participants and transcribed verbatim. At the end of the interview sessions, most participants expressed their appreciation of participating in the study.

Concurrently, constant comparative data analysis was conducted to conceptualise the data; to validate the conceptualised data against the original and new data with the aim of developing codes, categories and eventually the theory (Klunklin & Greenwood 2006:35; Charmaz 2005:508). The process of on-going data collection and comparison with codes and categories was the key process to describe the basic social processes that facilitate LGBTI youth-inclusive PHC. The process of data collection was terminated once theoretical saturation had occurred. Memos were also kept throughout to keep track of the data analysis process and to provide material for the theory construction. A list of questions were constructed from the analysis of memos and as codes and categories emerge (refer to Addendum O), and were subsequently used to sensitise particular aspects that required attention in the next interview.

3.6. CONTEXT OF THE STUDY

This study was conducted at three public sector PHC clinics and two university-based PHC clinics in Tshwane District. Details of the context of the study were provided in Chapter 1 (1.13.2).

3.7. DATA ANALYSIS

The constructivist paradigm views knowledge as actively constructed and co-constructed as the product of human interactions and relationships. The

research process involves active engagement, where the researcher brings his or her own background and assumptions to the analytic process (Watling & Lingard 2012:852). Grounded theory entails understandings of the participants' actions and meanings, offering of abstract interpretations of empirical relationships, and creating statements about the implications of their analyses (Charmaz 2005:508). Thus, researchers can emphasise analysis of the relationships between human agency and social structure that pose theoretical and practical concerns in social studies. Grounded theory seeks to derive conceptual understanding of a process by carefully examining the elements and categories related to that process emerging from the data collected (Watling & Lingard 2012:855).

The goal of data analysis in grounded theory is to discover dominant social processes and not to describe phenomena. Glaser (1992:31) asserts that researchers using grounded theory method should refrain from making reference to other theories in their study. He asserts that the theory ought to develop systematically as the researcher progresses through the stages of data analysis namely:

a) codes (examining, comparing and identifying key elements in the data);
b) concepts (collection of codes allowing for grouping of data);
c) categories (groups of similar concepts allowing theory generation); and
d) theories (collection of categories that explain the phenomenon being studied).

Once data has been generated, constant comparative analysis was conducted by employing three types of coding, namely: open coding, axial coding, and selective coding (Hallberg 2006:143).

3.7.1. OPEN CODING

Strauss and Corbin (1990:61) define 'open coding' as "the process of breaking down, examining, comparing, conceptualizing and categorizing data" [sic]. Initial or open coding begins by examining each interview transcript and field note text

line-by-line or set of lines in an effort to recognise key words or phrases which connect the participant's description to the phenomenon being studied (Strauss & Corbin 1998:65-68; Moghaddam 2006:56).

The aim of line-by-line coding is to build analysis from data. This analysis process is provisional and tentative, rendering a multitude of codes that will later be collapsed, reorganised and reordered into a more representative whole (Boychuk-Duchscher & Morgan 2004:608). Boychuk-Duchscher and Morgan (2004:608) assert that during the initial coding, the following set of questions should be asked:

a) what is the data a study of?
b) what category does this line or incident indicates?; and
c) what is actually happening in the data?

In this study, the coding process was done manually in the beginning of data analysis, followed by the use of ATLAS.ti *7* Software Programme after the researcher has received training on how to use the programme. The use of the ATLAS.ti 7 Software Programme in this study has significantly facilitated the process of organising, rearranging, and managing the considerable amount of data.

The coding process began by making:

a) Comparison within a single interview

   At the beginning of data analysis process, data within one interview were compared to each other. Every line of the interview transcript and field notes were studied to determine what exactly has been said and to find words and phrases with similar meaning in order to produce initial codes (Poteat et al. 2013:25). At the same time, different parts of the interview were compared and examined to maintain the consistency of the interview as a whole. Raw data was conceptualised with the aim of organising and developing codes, categories and concepts and eventually theories.

b) Comparison between interviews

> Once more than one interview has been conducted, the interview transcripts and field notes were compared. The selection of participants became informed by theoretical ideas and hypotheses, which emerged and needed to be verified in other cases.

The data was reviewed many times, looking and re-looking for emerging codes (Moghaddam 2006:55). Once a lead was discovered through developing a code in one interview, then, parts from different parts of the interviews were compared with those that the researcher has interpreted as yielding the same meaning and having been assigned the same code (Boeije 2002:397). The researcher reverted back to earlier interviews and re-examined whether these codes made sense on earlier data. The researcher used *in vivo* coding because it focused the analysis of what participants said in their own words about issues of importance to them, thereby ensuring that concepts were developed from codes drawn directly from the data (Elliot & Jordan 2010:32*). In vivo* code implies that the researcher uses the actual language of the participant as a code name (Harry, Sturges & Klingner 2005:5).

After coding the interviews, searches for specific text strings were conducted across all interviews and relevant paragraphs containing the search string were compared on screen or printed. Code names were assigned to each discrete data piece, which was a sentence, a paragraph, or even a page. As analysis progressed, it became apparent that during the process of coding, one text yielded more than one code. As codes recur, the indicators were compared for similarities and differences. Eventually, codes were examined and re-examined for overlap, and then collapsed into categories (Wuest, Merritt-Gray, Berman & Ford-Gilboe 2010:798).

3.7.2. AXIAL CODING

While open coding divides the data into categories, axial coding organises related categories, and put them back together by making connections between a category and its sub-categories (Moghaddam 2006:58). Strauss

and Corbin (1998:124) refer to the process as “reassembling data”. During axial coding, using theoretical sampling, the researcher further sought new participants to collect data as categories emerged from earlier stages of data analysis. Through constant comparative data analysis method, the “core category” of this grounded theory study emerged, and included parts of the data, i.e. emerging codes, categories, properties and dimensions as well as different parts of the data, which were constantly compared with all other parts of the data to explore variations, similarities and differences in data (Hallberg 2006:143). During axial coding, it became clear that certain data relates in terms of particular features, certain categories were absorbed by others, whilst other categories were divided, as distinct sub-categories emerged during the process of data examination (Watling & Lingard 2012:853). Where and when necessary, individual participants were re-interviewed to clarify, elaborate and verify information of the initial interviews in order to develop, expand or challenge the emerging theory.

3.7.3. SELECTIVE CODING

The final stage of data analysis is selective coding. Selective coding can be described as the process by means of which categories are related to the core category, ultimately becoming the basis for the grounded theory. In selective coding, the researcher identifies a “storyline” and writes a story that integrates the categories (Creswell 1998:57). Glaser and Strauss (1967:114) refer to this inductive process, as one where the analyst is: “…forced to bring out underlying uniformities and diversities and to use more abstract concepts to account for differences in the data”. The analysis must be elevated from the categorical to conceptual level in order to generate theory. Analysis at the conceptual level requires asking questions of the data: what is happening here? What is this incident an example of? (Watling & Lingard 2012:853). The codes and categories that developed during selective coding were further explored by reviewing the coded statements (Mehmetoglu & Altinay 2006:12-33), giving attention to understanding the inter-relationships. Memos to assist in the process of creating order and making sense of the data were also used.

3.7.4. TRANSITION FROM EMERGING TO EMERGED THEORY

Once the theory has emerged from the data, the researcher considered how existing theories might relate or differ from the emergent theory (Watling & Lingard 2012:855; McGhee et al. 2007:341). Thus, reading and integrating the literature later in the research process was a strategy that prompted the exploration of various ways of analysing the data. Again, postponing the literature review decreased the probability that the researcher already had preconceived conceptual ideas upon entering the field, and in interpreting the data. Charmaz (1990:1163) asserts that once the researcher has developed a new set of categories, he or she will be able to compare them with concepts that are in the literature, and thus begin to position his or her study within its appropriate perspectives (Charmaz 1990:1163). In this study, a comprehensive integration of literature was conducted to refine the theory as detailed in Chapter Six. This process assisted the researcher to link the study with the existing body of knowledge in the subject area. The theory that developed was critiqued to substantiate the claims that the emerging theory made (Charmaz 2006:168) towards the facilitation of a LGBTI youth-inclusive PHC.

3.8. MEMO WRITING

Memo writing is a process that involves a useful and systematic approach to handling and analysing data, which, if applied creatively, may lead to innovative perspectives (Fendt & Sachs 2008:448). Memos are a record of notes of thoughts and ideas that enable the researcher to reflect on the interview and data analysis process (Coyne & Cowley 2006:512). Memo writing escalates as coding saturates, and ends when the final draft is complete (Coyne & Cowley 2006:512; Charmaz 1990:1169). A memo can be a sentence, a paragraph, or a few pages that achieve one or more of the following intents: 1) exhausts the researcher's ideation; 2) keeps track of the analysis process by documenting what the data is revealing about different codes and categories; 3) captures the relationships between categories (Glaser 1978 in Boychuk-Duchscher & Morgan 2004:610); 4) captures the

theoretical ordering of the categories (Coyne & Cowley 2006:508; Watling & Lingard 2012:854); 5) presents hypotheses about connections between categories (Glaser & Holton 2004:np); and 6) explores methodological issues and begins to discover the emerging theory (Eaves 2001:659).

Throughout this study, the researcher kept track of the research process by writing her own ideas, assumed associations, and theoretical reflections related to each of the emerging categories in a research journal (Hallberg 2006:144). Memos were written regularly (refer to Addendum K) as data was collected and analysed, and as codes and categories emerged. Memos contained the impression and reaction about the participants' experiences. The researcher's theoretical background and perspectives were used to deepen the analytic understanding of the emerging theory (Charmaz 1990:1169). Memos were written to explore the researcher's own perceptions, experiences and existing knowledge, which were then constantly compared with other data. The process has helped the researcher to reflect on the 'self' and to separate the 'self' from the participants, thereby reducing the possibility of immersing in the setting or data and assuming the stance of the researcher. Eventually, the finished memos were used to rethink, revise, toss out, organise and present data in various ways. At the later stages in the research process, memos were revisited and used to refine the research question, to attach meanings to the participants' statements and to compare concepts identified in interview transcripts to each other and to existing literature.

3.9. USE OF LITERATURE

Coyne and Cowley (2006:514) and Glaser and Holton (2004:np) assert literature to be another source of data that ought to be integrated into the constant comparative analysis process once the core category, its properties and related categories have emerged. However, Backman and Kyngäs (1999:148) caution researchers as to the danger of becoming absorbed in existing frameworks, which seem to offer a quick solution and end up trying to force the data to fit. There is also the risk of a biased interpretation of the data,

if the researcher is too saturated with concepts from the literature. However, the detachment from the literature maybe difficult for a novice researcher, because reading the literature usually helps to focus one's thoughts and to narrow down the topic of the research.

Constructivists' researchers argue that first allowing the grounded theory to emerge, free of existing theoretical constraints, only later integrating relevant existing theories to enrich it, seems to be simulated and unrealistic. The statement is confirmed by Watling and Lingard (2012:855), who argue that for the constructivist researcher, the researcher's background and theoretical perspective on the phenomenon being studied may provide vital sensitising concepts that will guide them in asking relevant questions. On the other hand, objectivists researcher emphasises seeing the data on its own, as a window of an objective world that should not be biased by the researcher's views or extant theory (Furniss, Blandford & Curzon 2011:121). The defining feature is that the grounded theory must arise inductively. Thus, the researcher acknowledges that she had some prior knowledge of the relevant literature and a developing theoretical sensitivity (McGhee et al. 2007:341). Therefore the researcher recognised, the need to stay open-minded, being faithful to constant comparison method and that the staging of the literature is just a means to an end, and not an end in itself, thereby eliminating any form of bias that might arises from pre-knowledge (McGhee et al. 2007:341).

3.10. RIGOUR

Grounded theory focuses on determining the main concern of the participants rather than assuming that you know what their concern is (Crooks 2001:22). The integrity of the data analysis process is achieved when the researcher works back and forth between the data and the new codes, by ensuring that the analysis moves from narrative description to generate theoretical concepts (Elliot & Jordan 2010:33). In this study, the risk of biased interpretation, which results when the researcher becomes too involved in the process (Backman & Kyngäs 1999:148), will be counteracted through reflexivity.

Reflexivity and relationality provide criteria for rigour that make it clear how data are created within grounded theory studies (Hall & Callery 2001:257). Reflexivity addresses the influence of researcher-participant interactions on the research process, relationality, addresses power and trust relationships between participants and researcher and have the potential to increase the validity of the findings in grounded theory studies (Hall & Callery 2001:258). Reflexivity can be an important tool for researchers to be able to identify the effect of 'self' in these relationships. The reflection on the 'self' should commence from the time of recruiting participants into a project, and continue until when the eventual grounded theory.

To ensure reflexivity, the researcher kept a research journal (see Addendum L) during the process of data collection and data analysis. The research journal is an important tool for reflection on the research process as it includes the reciprocal influence of the researcher on the participants (Bringer et al. 2006:247). Information on the research process, verbal and non-verbal information gathered during the interview were recorded, the researcher's role during the interview process was made explicit. This assisted the researcher to reflect on the power relationship between herself and the participants, and how the relationship affected the research process and outcomes. Charmaz (2006:182-183) suggests four key criteria for evaluating grounded theory studies: credibility, originality, resonance, and usefulness.

3.10.1. CREDIBILITY

Credibility implies that the complexity and range of data collections is adequate enough to support the analytic claims made. Credibility also depends on the systematic process of constant comparative analysis that ensures that the argument that emerges is logical and linked clearly to the data. The depth and range of data collection should be sufficient to support the argument that the theory that emerges is logical and linked clearly to the data. For this study, data was collected until theoretical saturation was

reached. Audio-recorded interviews were transcribed verbatim so that the product of analysis can be compared with the primary data. In vivo codes were initially used to link the theory to the data. The interview guide was adapted, for the verification of the concepts, categories and emerging theory. The constant comparison of data and categories provided a further data source for analysis and justification of the emergent theory (Charmaz 2006:182). Since, it was the aim of this study to make unique and specific contributions to the existing body of knowledge, available literature was not considered until the theory begun to emerge (Charmaz 2006:182).

The methods for enhancing credibility in grounded theory methodology involved:

a) letting participants guide the inquiry process (preliminary codes reflect the language used by the participants so that the product of analysis remains close to the primary data);
b) checking the generated theoretical construction against participants' meanings of the phenomenon (as theory is constructed codes are checked and verified for their relevance to participants' meanings); and
c) articulating the researcher's personal views and insights regarding the phenomenon explored.

3.10.2. ORIGINALITY

Originality implies that the research offers new insights, fresh conceptual understandings, and that the analysis is theoretically or socially significant (Watling & Lingard 2012:855). The researcher acknowledges that the findings of the research is not always the definitive truth, but is influenced by the researcher's interpretations and understandings. However, the researcher still ought to demonstrate that the findings of the research are 'constructed truths' and that they are firmly grounded in the data. Therefore, the concepts developed in this study are original and grounded in the data, and will offer new insights into the basic social processes involved in facilitating LGBTI youth-inclusive PHC.

3.10.3. RESONANCE

Resonance implies that the grounded theory makes sense to the participants and captures the essence and fullness of their experiences (Watling & Lingard 2012:855). The researcher collected data and continued with the constant comparison process to ensure that the categories were saturated. The theory that developed will provide the nurses with a deeper insight into the processes involved in facilitating LGBTI youth-inclusive PHC.

3.10.4. USEFULNESS

Usefulness implies interpretation that can be used in day-to-day situations by individuals who have interest in the phenomenon under study (Watling & Lingard 2012:855). Detailed information about the sample and setting characteristics of the study was provided so that people who want to adopt and use the basic social processes that emerged from the study can decide whether it may be applicable to their context. The usefulness of a theory depends on the reader's ability to interpret its applicability in similar settings i.e., LGBTI youth health.

3.11. PRESENTATION OF FINDINGS

Grounded theory ought to focus on meaning, action, and process in the studied social context. The result of a constructivist grounded theory study should be presented by the researcher as a theory, including categories, with a focus on understanding of social processes. Thus, the researcher's analysis tells a story about people, social processes, and situations (Hallberg 2006:146).

3.12. LIMITATIONS OF THE GROUNDED THEORY METHODOLOGY

Grounded theory methodology, like any other research methodology, also has limitations. Grounded theory methodology is complex, time-consuming, and tedious research process that "happens sequentially, subsequently, simultaneously, serendipitously and [as] scheduled" (Glaser 1998:1). This

study has dealt with the lengthy process of constant comparison analysis using software and manual organisation and analysis of data. Grounded theory is also a subjective process, which relies on the researcher's abilities to explain, predict a phenomenon, or to build a theory. Further details on the limitation of the grounded theory methodology are provided in Chapter 8.

3.13. CONCLUSION

This chapter outlined the paradigmatic assumptions and methodological considerations of this study which is constructivist grounded theory. The process of data collection and data analysis was analysed. Interviews were conducted with participants, who had varied experiences with regard to the phenomenon being investigated. Data analysis involved constant comparison, whereby the codes were compared and assembled together to form categories and further data were sourced as categories emerged. Categories were compared together so that they eventually form the core category. By having the core category, the research focused on the basic social process that was present as a substantive theory of the study. The process of data analysis involved keeping track of memos detailing what led to new ideas and connections.

CHAPTER 4:

DESCRIPTION OF THE FINDINGS

4.1. INTRODUCTION

In this chapter, the empirical findings that relate to input from the LGBTI and nurse participants are described in an integrated manner. However, the description of the emerging theory predominantly focused on nurse participants' data rather than those of the LGBTI participants as the nurses in the context of this study are the key drivers of process of facilitating LGBTI youth-inclusive PHC. Data from LGBTI participants were used during constant comparative data analysis and memo writing and therefore facilitated the emergence of categories and sub-categories, new questions that informed subsequent interviews and to guide participants to be interviewed during theoretical sampling. In grounded theory, research findings are "presented in isolation of both extant theory and contemporary literature and then discussed in relation to each other" (Birks & Mills 2015:130). In the next chapters, the findings as it is reflected in the categories will be discussed in relation to extant theory and contemporary literature. The constant comparison process that was previously used to identify categories and sub-categories will be used to debate the contribution that this theory will be making (Furniss et al. 2011:121) to the knowledge base of LBTI youth-inclusive PHC. The aim of grounded theory research is to tell a story about people, social processes, and situations. The researcher composes the story that reflects the views of the researcher and the participants (Charmaz 2000:522).

Four categories and related sub-categories emerged during data analysis: 1) recognizing personal subjectivity; 2) tackling and overcoming personal subjectivity; 3) seeking understanding about LGBTI people; and 4) maintaining professional objectivity. Gerunds that are easily understood contributed to the use of the theory (Charmaz 2014:288). The four main categories that explain actions, interactions, and conditions that comprised the theory were

interrelated and connected through sequential and causal statements of relationship.

Table 8: Summary of the categories with their concept groups and descriptions

Category	Codes	Description	Symbolic Interactionism	Quotation
Recognising personal subjectivity	Perceiving homosexuality as "a taboo object", "unreal", "immoral", "exhibition of anti-Christian behaviour" and as an "uncomfortable subject to discuss"	Identifying and reflecting on their own values, beliefs and attitudes and how they influence thoughts and decisions during interaction.	A person can interact and act with himself, have perceptions about himself and communicate with himself thereby forming and guiding his conduct (Blumer 1969:62).	*I as a professional (nurse) I said but do you--do you -- feel satisfied—about -- being gays, because -- according to the bible -- God said a man is going to marry -- a woman and then not a man marry a man…*
Tackling and overcoming personal subjectivity	Setting aside their personal values, beliefs and attitudes.	Reflecting further on personal and professional values, beliefs and attitudes as a way of pursuing personal and professional transformation.	People form meaning about objects, thus, are open-minded to change the meaning and perceptions about the object when they are presented with new facts and evidence (Blumer 1969:11-12).	*… we as nurses, we must have a very good attitude, we must have a very good attitude according -- so that when they see us, they must never be afraid, they must feel that they are welcome in the clinic.*
Seeking understanding of LGBTI people and their health care needs	Lacking adequate knowledge and skills in treating and caring for LGBTI patients.	Recognising the need to learn about LGBTI people.	Human being recognizes himself and perceives himself as a student and acts accordingly by learning new facts and information (Blumer 1969:13).	*… there's a gap, to be honest, -- it's something that we were taught, it's something that you learnt -- the skill, -- if the skill is there, you find it -- by interaction thing and I -- still think today it's not really addressed -- in that sense, I don't know if there are places that addressing it directly -- I think -- there's room for improvement and there's room to sharpen the skill that is that.*

Category	Codes	Description	Symbolic Interactionism	Quotation
Maintaining professional objectivity	Recognising responsibilities towards caring patients in a humane manner.	Acknowledging professional and moral obligations which are guided by core values of nursing.	Through interaction with others, people begin to develop an identity about who they are, as well as empathy for others (Blumer 1969:11-12).	*I looked back into the pledge of service. Why did I choose to become a nurse, to help people, in accordingly, in appropriate to what are the symptoms, not to be judgmental, because -- you need -- to put up your listening skill -- upfront, and then you give the patient [time] to ventilate, the main reason, sometimes you see for -- you reach out to the patient who's there for a certain main reason.*

Sub-categories that emerged from the nurse participants, LGBTI patients, and contextual aspects were linked through patterns of conditions and intervening relational statements. Together, the categories mentioned refer to the acknowledgment and management of obstacles that can hinder the rendering of LGBTI primary health care services and factors that can facilitate that process. Table 8 provides a summary of the categories with their concept groups and their descriptions. Categories should not be perceived as separate concepts, but ought to be related and interdependent (McCann & Clark 2003a:14). This chapter demonstrates the interrelationship and interdependence between categories. The categories and relationships between the categories together with integration with extant theory and contemporary literature will form the theory (Birks & Mills 2015:115) for LGBTI youth-inclusive primary health care, which is presented in the later in this study.

In this chapter, the properties of the categories are described as they surfaced during memo-writing. The researcher wrote memos as proof of the integration of the processes of collecting data, coding of data and its conceptual analysis (Glaser & Holton 2004:np) in order to conceptualise the theory (McCann & Clark, 2003a:16) for LGBTI youth-inclusive primary health care. Memos form the basis for the storyline presentation of the emerging theory (Charmaz 2014:285). In this chapter, the findings are described in a storyline format. According to Birks and Mills (2015:114), the storyline in grounded theory research has a dual function. It assists in the production of a theory, and is also a means to convey the theory to the reader. The researcher opted to describe the emerging theory (the findings) in a storyline format. A storyline should be "digestive for the reader and reflective of analysis" as it is an "abstraction of what has been constructed through careful and grounded analysis" (Birks, Mills, Francis & Chapman 2009:409). The categories and relationships between the categories form the constructs of the emerging theory that will become the theory once the discussion of the emerging theory with literature has been completed (Birks et al. 2009:410). The constructs are validated through grounding in the data by means of the use of quotations. In the quotations, each LGBTI participant were referred to as P, followed by a number for example P1, P2 etc. and nurse participants were referred to as NP followed by a number, for NP1, NP2 etc. As the storyline is an abstraction, a limited number of quotations were used. Too many quotations force the presentation of the constructs into a description of the phenomenon and the emerging theory takes second place (Birks et al. 2009:411).

4.2. CATEGORIES AND SUB-CATEGORIES

In this section, the discussion of the research findings, the researcher's perspective on the process and the variables of data collection, their implications for the data collection and analysis, and ultimately the development of the core category will be provided. The discussion will commence with the description of each category followed by emerging sub-

categories that informed the core category. Relevant quotes from participants will be presented to expand the categories.

The four categories reflect the participants' (LGBTI youth and nurse participants) internal conflict when they experienced that their values and beliefs were incongruent, how it influenced their interaction, their mechanism for dealing and overcoming the conflict to ultimately achieve therapeutic nurse-patient relationships. LGBTI participants experienced prejudice and discrimination when they disclosed their sexual orientation to the nurses as a result of the nurses holding different values and beliefs to their own. Nurse participants, on the other hand, were able to identify and reflect on their own values, beliefs and attitudes, how that influenced their interaction with LGBTI patients, and ultimately develop their mechanism of dealing and overcoming the conflict that prevailed. In this study, the terms values, beliefs and attitudes will be used indiscriminately and/or interchangeably. Values are defined as what is considered right or good by individuals or the group. Liaschenko (1999:36) describes values as having both cognitive and affective aspects that can help to build a moral expression by which people can evaluate themselves and others as either right or wrong.

The findings of the data revealed that the internal conflict that arose in clinical practice was multifactorial. While nurse participants are subject to the profound inspiration of professional values and ethics on the development of a moral and professional identity, they are at the same time influenced by their own socially acquired values and beliefs. Therefore, conflict within and between personal and professional values became a possible source of stigma and discriminatory behaviour towards LGBTI patients by nurses. Values and beliefs that were acquired through personal traits, socialisation, culture, life experiences and professional values, became contributory factors in how nurses behaved, and what motivated their responses and perceptions about situations during their interaction with LGBTI patients.

Under each category, a number of sub-categories are outlined, each sub-category providing more details and meaning to the category being discussed. Collectively, categories provide an account of the basic social processes involved in facilitating LGBTI youth-inclusive primary health care service. A detailed description of each category and its dimensions follow. The categories are presented in a storyline format with references to symbolic interactionism. The sub-categories are substantiated with quotations from the interviews with the participants. In this chapter, the categories will be indicated in bold and the sub-categories in italics.

4.2.1. CATEGORY 1: RECOGNISING PERSONAL SUBJECTIVITY

Category 1, 'recognising personal subjectivity' will be discussed in relation to its and its properties.

The nurse participants in this study demonstrated a variety of ways of thinking about, understanding, and interacting with LGBTI patients. The findings of data analysis interestingly demonstrated that nurse participants held multiple approaches and contradictory understandings of LGBTI patients and their health care needs. The findings also revealed how their understanding of non-conforming sexual orientation influenced the way they perceived and interacted with LGBTI patients. There are two key points in the category of 'recognising personal subjectivity' and they tend to happen simultaneously as the nurse participants cognitively reason through the concerns related to having their personal values and beliefs challenged. In interaction with LGBTI patients, the nurse participants became aware of their own beliefs, values and attitudes (sub-category 1). They also developed perceptions about the LGBTI patients (sub-category 2). Recognising personal subjectivity became a process whereby nurse participants seem to be identifying and reflecting on their own values, beliefs, and attitudes. Their values, beliefs and attitudes influenced how they thought, felt, and acted in the clinical practice. Through the process of identifying and reflecting on their values, beliefs and attitudes, nurse participants better understood the factors that contributed to the conflict that

they had experienced when they recognised that their values and beliefs were incongruent with those of the patients. The nurse participants were influenced by multiple values in their functioning. In this study, it became vital for nurse participants to identity their own values and beliefs and how they influence how they care for their patients. For one to be able to identify one's own values, beliefs and attitudes, one needs to be knowledgeable the values and beliefs that they hold in order to determine which ones are being affected during their interaction with the people around them.

Mead (1967:135-138) asserts that people interact with themselves and become aware of their beliefs, values and attitudes. They become objects to themselves. Their ability to interact with themselves is attributed to the development of the 'self', which develops over time in social interaction with others. The 'self' is an object to the person the same way as other people are objects to that person. That is to say, the person views him or herself in such cases as other people would have viewed him. The object that he or she becomes to his or herself represent not only how others (the society) react towards him, but also to how he as a member of society contributed to society's views. The person as a member of society shapes the views of society and when society interacts with him or her, they in fact to some degree interact with themselves. When they interact with themselves and judge their own values and beliefs it is in fact society who interacts with them. In interaction with members of the society, values and beliefs are shaped, and when nurse participants become aware of their own values and beliefs, this happens through interaction with themselves, and thus, with society more broadly.

For the nurse participants, personal subjectivity was influenced by intrinsic factors that originated from interactions within the 'self', others and the environment. Intrinsic factors such as beliefs, values and attitudes contributed to the nurse participants' understanding of their own personal identity, impacted on the way they made decisions, and how they reacted in a particular

situation. These cognitive and affective processes provided nurse participants with the capacity to understand how their beliefs, values and attitudes impacted on their function, gaining insight into their own biases and perceptions about others and limiting their competencies in caring for LGBTI patients. Being aware of their own values, beliefs and attitudes provided the nurse participants with the moral judgement of counteracting any prejudice and intolerance that they might have towards LGBTI patients. The researcher suggests that this category is relative to the proposition made by Blumer (1969:2), where he asserts that people act towards things on the basis of the meaning they attach to objects, people or the world.

A person can interact and act with himself, have perceptions about himself and communicate with himself, thereby forming and guiding his conduct. Self-interaction enables the person to evaluate himself and his actions (Blumer 1969:62). Thus, in this study, for nurse participants, developing awareness of one's own beliefs, values and attitudes became a process that involved self-interaction, self-reflection and self-critique. Consequently, nurse participants were able to recognise and acknowledge the way in which their values and beliefs influenced their thoughts and perceptions about oneself, others, and the environment, how they differ from those of others, and how they influenced interaction with others.

4.2.1.1. *SUB-CATEGORY 1.1: DEVELOPING AWARENESS OF OWN VALUES, BELIEF AND ATTITUDES*

By integrating focused codes into higher level concepts, the process of *developing awareness of own values, beliefs and attitudes* emerged as a feature that most nurse participants discussed. In this study, there was some commonality in the process of *developing awareness of own values, beliefs and attitudes* amongst the nurse participants. The process involved being self-aware and understanding of what has influenced the development of one's personal values and beliefs as well as how and why they may be adapted over time. Consequently, *developing awareness of own values, beliefs and attitudes*

by the nurse participants has enhanced understanding of the 'self', others and the environment. In this study, nurse participants found themselves in circumstances that directly or indirectly challenged their values and belief systems. For the nurse participants, the most crucial step when responding to encounters where they believed that their personal values and belief systems were challenged was through a reasoned way of *developing awareness of own values, beliefs and attitudes*, appreciating factors that resulted in the conflict. In this study, a variety of strategies were used by nurse participants to develop self-awareness. These included strategies such as identifying and reflecting on their own values, beliefs and attitudes.

The process of *developing awareness of own values, beliefs and attitudes* began when some nurse participants were able to identify their values, beliefs and attitudes in order to obtain a better understanding of themselves and how they perceive LGBTI people. For some nurse participants, by identifying their own values, beliefs and attitudes, they formed frames of reference that informed how they felt, thought and behaved during their interaction with LGBTI youth. It became apparent that based on their values, beliefs and attitudes, some nurse participants described being LGBTI as "a taboo object", "unreal", "immoral", "exhibition of anti-Christian behaviour" and as an "uncomfortable subject to discuss". Most nurse participants felt uncomfortable when they were providing care to LGBTI patients as they believed that their own values and beliefs were incompatible with the culture of LGBTI people. Being socialised in a hetero-normative society for one nurse participant, non-conforming sexuality was a taboo object during her childhood. She only realised that not all people were heterosexual when she met a LGBTI patient for the first time in clinical practice. Therefore, this perception was identified as emanating from her social background and life experiences.

> *I'm from the rural area where … lesbians, gays … I can't say a 'no go' area or not, no let me put it that way … not existing so … that's why I was shocked; okay they actually do exist* (NP5).

In the same way as Nurse Participant 5, Nurse Participant 1's values emanated from her social background and life experiences from which she was socialised about heterosexuality. As a result, she believed that being LGBTI was not right and was an act of insanity.

> *… a girl, you are not supposed to stay with a girl and if you're a boy you are not supposed to be staying with a boy; but the way it is, I, before I, I said these people are mad, you know, this is not right…* (NP1).

In an attempt to understand how beliefs, values and attitudes are identified and reflected during the interaction with LGBTI patients, some nurse participants were able to indicate the source of their core beliefs and values. The main source of their beliefs and values emanated from their socialisation, personal opinion, culture, and religion, which in this study, were found to be incongruent with those of LGBTI patients. However, religious beliefs and values seemed to be the factor most predominant in influencing the nurse participants' interaction and response towards LGBTI patients. The extent of the nurse participants' spirituality and how they considered what is wrong or right could have been the root cause of their overt or subtle, intentional and unintentional forms of personal bias, preconceptions, and negative attitudes towards LGBTI patients. Most nurse participants in this study upheld Christian hetero-normative values, which they considered to be 'right'. As a result of their spiritual beliefs, they defined non-conforming sexuality as 'wrong' and being against the bible. For instance, Nurse Participant 1 wanted to understand how content her patient was about being gay. The question was posed to obtain a better understanding of herself, her patient and how she perceived LGBTI people. She consequently imposed her religious values on the patient by raising a concern that the bible prescribed heterosexual relationship and not homosexuality.

> *… I, as a professional* (nurse) *I said but do you … do you … feel satisfied … about … being gays, because … according to the bible … God said a man is going to marry … a woman and then not a man marry a man …* (NP1)

For Nurse Participant 1, according to her religion, which emerged as the major source of her values and beliefs, non-conforming sexual orientation was viewed as immoral and an act of insanity. Furthermore, she likened being in a same sex relationship to an act of Satanism. She believed that satanic possession has taken its toll in the communities; hence, she reasoned that people were starting to adopt LGBTI lifestyle. According to her, being LGBTI did not conform to the prescripts of the bible.

Again, some nurse participants indicated the source of their core values and beliefs as constituting their socialisation and personal value system, which were found to be incongruent with those of LGBTI patients. Their personal value system became a moral framework of how they thought, felt and acted in particular situations. Their personal value system became a fundamental source of maintaining a sense of integrity, because it enabled them to act on their own principles and in ways that were personally meaningful to them.

In this study, when nurse participants realised that their personal values were incongruent to those of LGBTI patients, they created opportunities for self-reflection and refinement of their personal value system. Consequently, they implemented counterproductive coping strategies to deal with the threats to their values which ranged from being subjective, ignorant to rationalisation for one's behaviour. On that note, data revealed that for Nurse Participant 3, over and above her religious values, her personal values made her vulnerable to engaging in an open communication about sexuality with LGBTI patient. Her subjectivity became evident when she mentioned that from her personal point of view, she still hasn't bridged the gap of asking her patient about their sexual preferences or sexuality yet. Consequently, she did not even feel comfortable to talk about the patient's sexual orientation.

> *Well, I believe God created Adam and Eve and … that's how it should be and … I think … coming from that … I'm not … comfortable talking about sex but asking a person straight out … "What is … what do you*

> *prefer, men or women?" I … haven't breached that yet…* (NP3)

According to Nurse Participant 3, she assumed that a man ought to be in a relationship with a woman, and not the other way around. However, reflecting on personal values, beliefs and attitudes provided Nurse Participant 3 with the moral judgement of counteracting any prejudice and intolerance that she might have had towards her LGBTI patients. She was able to set aside her own feelings by letting her patient know that she did not uphold issues related to non-conforming sexuality. At the same time, she refrained from being judgmental, by perceiving having non-conforming sexuality as inherent, and not a choice. She believed that people wouldn't choose to become a member of LGBTI whilst being aware that it is culturally unacceptable.

> *… I really don't know … is it really something that … they're going through, is it something they were really born with, because then it … contradicts my … belief again. So … I … don't have an opinion about that because I don't just wanna condemn and say "Yah, it's your choice, the choice you made you decided to be like that" because I also don't think somebody will -- decide to be like that if it goes against … what is expected of us ...(NP3).*

In the case of Nurse Participant 3, though she was shocked when the patient revealed his sexual orientation to her, she stated that she had never been insensitive to LGBTI patients. She mentioned that lately, she will no longer react with shock when she encounters LGBTI patients because being LGBTI has become more profound than before as a lot of LGBTI are comfortable to disclose their sexual orientation. Nurse participant 3 admitted:

> *I don't think I was ever insensitive to them but nowadays I think … t's more pronounced, more on the forefront, more often I think the children are maybe coming out more and I think this … has just made me more aware of it, so … it's not really that much of a shock or it won't be that much of a shock, if … it should happen again …* (NP3).

The way the nurse participants reflected on their personal values was consistent with the feelings shared by LGBTI participants that emerged during the interview with LGBTI participants. LGBTI participants had experienced nurses imposing their own values and beliefs on them during their interaction in clinical practice. They were experiencing discriminatory reaction from the nurses through subtle and overt ways of judgement. LGBTI Participant 4 voiced being judged subsequent to deciding to disclose his sexual orientation to the nurse. He became intimidated when he noticed disapproving facial expression from the nurse, and that's when he realised that the nurse had a problem with him being gay. He mentioned that the nurse responded with an angry face when he told him that his boyfriend did not live with him. Further to his interaction with the nurse, he began noticing the nurse probing him with questions about his relationship, to an extent where he even imposed his values and beliefs upon him. The nurse asked if he knew that it was against the bible when a man is having a relationship with another man. He responded that he was a churchgoer and he knew what the bible said, but that being gay was not his choice but something inherent and that's how he identified the "self". He was puzzled by the nurse's reaction, because he had assumed that health care providers would be professional, and not judge people based on their inner being.

> *… he asked if I had a partner, actually he thought I have a female partner and I said to him, my boyfriend doesn't live with me, he lives distantly with me and … his face changed, that's where I started to see that he has a problem actually and then, I was quite for a bit and then he asked again … he started to ask me things about my relationship with … where it even led to a Christian way, where he even asked if I knew that it against the bible, it is said that it is a sin when a man is in love with another man and my answer was, I know … I go to church, I do fellowship too; and then because it is within me it's not what is outside that's why I … be myself* (P4).

When LGBTI Participant 4 was questioned about what the experience with the nurse meant to him, he responded that he just told himself that it was fine, since the nurse gave him the medical attention that he needed, despite doing so begrudgingly. He articulated that it came as a surprise for him because he did not expect such reaction from nurses. Rather, he expected the nurse to be friendly to him.

Reflecting on own beliefs, values and attitudes was another process that was revealed subsequent to nurse participants identifying their own beliefs, values and attitudes. For the nurse participants, reflecting on his own beliefs, values and attitudes became a process that involved the self and self-interaction and was triggered by questioning own beliefs, values, attitudes and actions. The process emerged as a result of nurse participants being asked about how their personal beliefs, values and attitudes influenced the way they interacted with LGBTI patients in clinical practice. In their response, nurse participants expressed experiencing cultural shock when they noticed that their values were incongruent with those of LGBTI patients. As part of cultural effects, gender socialisation played a vital role in determining the nurse participants' behaviour towards LGBTI patients. The majority of nurse participants asserted that they were socialised in a hetero-normative society. Therefore, hetero-normativity may have led to stereotypical gender-related behaviours that they displayed towards LGBTI patients. This study revealed how nurse participants, when they became aware of the difference that existed between their cultures and those of LGBTI patients, experienced cultural shock. Some nurse participants perceived the culture of LGBTI patients as strange and unacceptable to them, a perception which was brought about by the experiences of what they perceived as normal, i.e. being heterosexual. One nurse participant uttered:

> *I thought now this guy is lying … maybe I was a little bit shocked … but … I can't recall any negative things … that didn't know that this is something I can't deal with* (NP3).

For most nurse participants, as they reflected on their core values and beliefs which they had acquired through socialisation, experiences, culture, religion and their profession, they noted how this influenced the way they interacted with and perceived LGBTI patients. It was interesting to note that Nurse Participant 3 became shocked when the patient disclosed his sexual orientation to her, because she couldn't detect any visible features from the patient that would have suggested that the patient was gay. According to her personal experience, she expected gay people to have feminine looks, which it was not the case with the LGBTI patient:

> *… I can't recall the gestures but they … are a little more [e]feminite at times but that … was lacking and it was the same as if it was a big joke … and I think that was rather a shock to me, because I didn't see him … as a person with different sexual orientation …* (NP3).

Similarly, Nurse Participant 5 reacted with shock when the patient disclosed to her that she was a lesbian woman. Her reflexive response emanated from the fact that it was her first encounter with a patient who disclosed her sexual orientation to her, because according to her culture, non-conforming sexuality was almost non-existent, and talking about it was a taboo. Nurse Participant 5 was questioned about why she reacted in shock when the patient disclosed her sexual orientation to her. She responded that she had never seen LGBTI people in real life situations before, but only heard of them on television and then suddenly realised that she was interacting with a lesbian woman in real life.

> *… you know it was a shock to me because I'm from the rural area where … lesbians, gays … are still … I can't say a 'no go' area or not, no let me put it that way … not existing so … that's why I was shocked, okay they actually do exist … because it's something that you hear about from the … TV … then it was something then now it's like the person is sitting next to you … okay it does exist …* (NP5).

LGBTI participants in this study shared the same sentiment as those of Nurse Participant 5 when they reflected that nurses reacted with shock when they revealed their sexual orientation to them. When questioned about the nurse's reaction following his disclosure, LGBTI participant 1 noted that, when he disclosed his sexual orientation to the nurse, he realised that the nurse was shocked. He could detect the gesture of disapproval from the nurse's facial expression. He said that the nurse was surprised because he did not have external features that could suggest that he was gay, since he looked "straight", meaning, like a heterosexual man. Furthermore, the nurse questioned why a handsome man like him could be doing "stuff" like that, referring to him as being a gay man. Thereafter, she realised that the nurse became uncomfortable about having to interact with a gay man and that affected their communication, which ceased as a result of his disclosure of his sexual orientation to her.

> *… do you know how you get infected and that's it and then you go to the testing, however … the facial expression, that tell a lot at the end of the day… and whatever questions that when I ask about … about sex … they already shut down … so, so there was like nothing else to talk about after that …* (P1)

On the same note, when LGBTI Participant 6 was asked about the nurse's reaction when he disclosed his sexual orientation to him, he also reported that the nurse responded with shock, as firstly, she was not expecting him to disclose his sexual orientation to her and secondly, the nurse was shocked that a Tsonga (*a native South African tribe*) man like him could be gay.

> *… it's always a shock for most of the people, and she didn't expect it because … she asked what (name) … what does it mean, then I told her, it was like … it's really rare to find Tsonga people being gay and what not, so she was a bit shocked, but in the South Africa that we live in, we have to be accepted as it is…* (P6).

4.2.1.2. *SUB-CATEGORY 1.2: DEVELOPING PERCEPTIONS ABOUT OTHERS*

Developing perceptions about others was another sub-category that emerged during data analysis. As data analysis advanced, it became obvious that as nurse participants developed awareness of their own values, beliefs and attitudes, they in a subjective way developed frames of reference that impacted on their perceptions towards LGBTI patients. Those frames of reference formed a baseline for nurse participants of how they orientated themselves with regards to what being LGBTI meant. Consequently, nurse participants developed perceptions about LGBTI patients that influenced how they behaved and interacted with LGBTI patients during clinical practice. *Developing perceptions about others* seemed to provide a definition of what non-conforming sexual orientation is, and how LGBTI people made sense of their own being. Nurse participants developed perceptions about LGBTI patients, which became a lens through which they viewed others and their world. Interesting information emerged from determining properties and dimensions of where, when and how the nurse participants developed perceptions about their non-conforming sexual orientation (LGBTI) patients. As data analysis progressed, it revealed that *developing perception about others* involved a cognitive and an affective process that required a thoughtful reflection of the self in the context of providing nursing care to LGBTI patients. Data reflected on how powerful personal factors such as experience, beliefs and values influenced the way in which the nurse participants perceived the self and others, as well as their decision-making and problem-solving capacity. At the same time, it was interesting to note how the majority of nurse participants in this study attempted to justify how they perceived the nature of being LGBTI. As nurse participants identified and reflected on the self, they were consequently able to understand how their experiences, values and beliefs affected their perception about others within the context of interacting with the LGBTI patients in clinical practice.

Data revealed that, for nurse participants, *developing perceptions about others* became a process that was formed through reasoning by nurse participants, as they attempted to explain or rationalise LGBTI behaviour, consequently developing attitudes and stereotypes about LGBTI people. During comparative data analysis, “developing perception about LGBTI people” became explicit when nurse participants acknowledged how their personal values, beliefs and attitudes made them develop different perceptions about LGBTI patients. First, some believed that being LGBTI was inherent, perceiving it as the “inner self” which people have no control over. Second, some were of the opinion that being LGBTI was genetically inherited from their forefathers. They believed it to have been a condition that manifested during the early childhood development. Third, some believed that being LGBTI was influenced by extrinsic factors and therefore became a lifestyle choice made under duress. Fourth, some perceived being LGBTI as a manifestation of actions and behaviour of insanity or Satanism. Fifth, some perceived being LGBTI based on the external traits and gestures that they have observed on the patients, and last, some related nonconforming sexual orientation to the clinical findings that the patients presented within clinical practice.

Most nurse participants in this study related that, as a PHC nurses, they came across many LGBTI youth, and they had observed how they behaved and conducted themselves. Thus, based on their observation, they could classify them as LGBTI. This perception emanated from the fact that in some cases, when LGBTI youth presented themselves at the clinics, they related to nurses the reasons that brought about’ their non-conforming sexuality. This caused them to believe that having a non-conforming sexual orientation was a condition that was brought about by certain personal and social circumstances, which is eventually exhibited in the person’s behaviour or actions. Most nurse participants developed social perceptions based on their personal experiences as to how LGBTI people ought to look and behave. According to Nurse Participant 1, she perceived non-conforming sexual orientation as hereditary,

and she described it as an attribute that is manifested in the early childhood development when a boy child starts to behave like girl and vice versa.

> *… it's hereditary, so that is why I say no, man these children they don't do, they don't just do it on themselves, you know they, they, this thing it come from somewhere the child start developing thing and then starts to behave like a boy, and do you know funny things, it's like the boys communicate with boys, start to … click with boys and he start to change, if he is a girl, he start wearing … boys clothes, you know doesn't, it it's a girl, she doesn't look like a girl, she starts behave like boys and then to play, in fact you will see it from childhood, you'll … know this child but from childhood this one … this girl was not playing with … dollies …* (NP1)*.*

Nurse Participant 1 believed that parents neglect to notice the signs of non-conforming sexuality from early childhood. Neglecting to notice the signs of non-conforming sexuality has created problems for children when they grow up, because as an adolescent, they would like to be identified as heterosexual people and be involved in a heterosexual relationship. Similarly, Nurse Participant 1 is of the opinion that being LGBTI was caused by intrinsic factors over which there is no control.

> *… but because this thing is in them there's nothing that they can do, they have to behave like that, so if it's like that as human being …* (NP1).

Data revealed that some nurse participants regarded non-conforming sexual orientation as a lifestyle choice, rather than an expression of an inner sense of being. In the case of Nurse Participant 1, her gay patient informed him that he became a homosexual in order to receive financial assistance from his male partner, because male partners are more financially resourceful than females. The patient asserted that a male partner would provide for him financially since he comes from a poor family, and would understand him better, since they are of the same sex. This caused Nurse Participant 1 to believe that having a non-conforming sexual orientation was a conscious choice that people made in

order to escape from or cope with unpleasant life experiences or social problems. On the same note, Nurse Participant 1 questioned why the patient chose to be gay, since she perceived being gay as a choice, rather than an aspect of the inner being. Similarly, Nurse Participant 2 revealed that she wanted to find out from the patient what made him to choose to be bisexual and what feelings he had for him to conclude that he was bisexual. The patient responded that he was not sure if being bisexual was as a result of him being molested by his uncle when he was still young, since he enjoyed being intimate with men than with women. Therefore, Nurse Participant 2 developed a perception that being LGBTI was a choice made by the patient as a mechanism of coping with unpleasant childhood experiences.

> *… I said for curiosity, I want to know, what made, what feelings is he, is he having to make sure that he is bisexual … are the feelings authentic or not … then he said … he was … molested when he was 9 years old by … his uncle, so then he is not sure whether … the thing of being sleeping with men is it because of that because he said he had a girlfriend but he's more, he's having a girlfriend but he enjoys sex more with men …* (NP2).

In cases of Nurse Participant 1 and 2, based on their perceptions about LGBTI people, it could be concluded that they were trying to seek deeper understanding of nonconforming sexual orientation by rationalising what being LGBTI meant to them. Nurse Participant 2 justified the patient's sexual orientation when she shared the opinion that the reason for his bisexuality was due to having been molested as a child. On the contrary, according to Nurse Participant 1, non-conforming sexuality was natural, and inherited from birth. She was of the opinion that people cannot pretend to be homosexuals. She asserted that it is a feeling that constituted the inner person and was not a choice that they made to be like others.

> *I don't think they can … pretend to be lesbians, maybe it's because of genetic or it is natural, it is not something that is inside … it's natural … there's*

> *something that they are born with, it is the feeling, it is not something that they do because they see other people doing* (NP1)*.*

Data revealed the way in which some nurse participants have learnt about the patients' sexual orientation in the clinical practice. Some nurse participants revealed that in most cases, they have confirmed patients' non-conforming sexual orientation when male patients presented with anal sores at the clinic, which, according to them, suggests that they had contracted infections through anal, male-to-male intercourse. Therefore, based on that observation, most of the nurse participants were found to relate the clinical findings to patients' sexual orientation. In the case of Nurse Participant 1, the patient came in with an anal STI, which suggested that he might be engaging in anal, male-to-male intercourse, which is regarded as a common sexual practice amongst gay couples. That observation prompted her to ask the patient about his sexual activities and sexual orientation, which led to him disclose his orientation.

> *… a patient who came to me, so that I can know … that person is a gay, is because of the condition that he came to my room for consultation, I asked that patient … what is the problem with you, and then the patient … gave the history that "Sister, I am here today because I have a problem". I said "What problem do you have?" He said "I've got … got the sores on, on the rectum (anus) … when I opened the rectum (anus), I found that this patient has got warts-like … sort of a cauliflower, that … protrudes through the rectum (anus) … and then I asked this … patient "What is wrong with you … what is happening here?" And then, he said to me, "Sister I've got … a partner that I'm sleeping with, and he is … a gay, I'm a gay …* (NP1).

At this point in the data analysis, the researcher noted that the perception of nurse participants relating clinical findings to sexual orientation held similar meaning with what emerged from LGBTI participants' data, where LGBTI participants perceived the relevance of disclosure of their sexual orientation to their health concerns. For LGBTI Participants 1 and 2, the circumstances under which disclosing their sexual orientation to the nurses became relevant,

was when they consulted the nurses with health concerns that they perceived to be related to their sexual orientation. Both participants stated that they only disclosed their sexual orientation to the nurses when they were undergoing HIV tests, because according to them, that's when the questions about sexuality became relevant. LGBTI Participant 1 asserted that he had to decide to disclose his sexual orientation when he was undergoing HIV testing, because he does not have visible traits identifying him as a gay man, and he wanted to be treated as a gay man. He wanted to make the nurse aware that he was gay, so that he could receive customised health care.

> *"… there are those people who really go like they do their testing, like I said in those outside tents … that's really one time where I actually disclosed* (P1).

LGBTI Participant 6 shared the same sentiment as LGBTI Participant 1, namely that he felt the need to disclose his sexual orientation to the nurse, as he wanted the nurse to understand his condition, ask him the right questions, and treat him accordingly. When asked how he felt about disclosing, he responded that he wanted to be helped, and when he disclosed his sexual orientation to the nurse, he wanted the nurse to consider his sexual orientation when providing him with treatment. He did not want to be treated the same way as heterosexual people, but to be given treatment that was specific for homosexual people. LGBTI Participant 6 alleged:

> *… It was just for me to get help, so when I disclosed, I wanted them to understand where I'm coming from, and actually gave me the right medication that I want, not treat me like … heterosexuals … they should consider the fact that I'm gay and probably there's specific meds that they use, that heterosexuals don't use …* (P6).

Data revealed that most nurse participants were developing perceptions about LGBTI patients when they related that they did not ask the patients about their sexual orientation. They relied on the patients' external traits that they had observed, which suggested that they could be LGBTI. For the nurse

participants, those patients whose physical traits were typical of the opposite sex were perceived as LGBTI. They perceived gay people as having more feminine looks than heterosexual males. For example, one nurse participant stated that, according to her personal experience of gay men's appearances, she could already assume that the patient was gay.

> *… I've already seen that this is a gay. Why? because of the way he dressed … the way he was talking even the … voice … the voice according to experience, it will tell you that … this one is not a woman, it is a male, but … it was highly pitched … the way he was stretching the hair … you can see the feature of a male, but it was a very beautiful boy, so that's … when I started to see … this is a gay …* (NP1).

On the same note, Nurse Participant 3 did not realise that her patient was gay until he disclosed his sexual orientation to her. According to her, the patient did not have external features that might suggest that he was gay, which she described as feminine looks.

LGBTI participants in this study shared the same sentiment as nurse participants when they revealed that they perceived being LGBTI to be a trait of the "inner self". This was revealed when some LGBTI participants decided not to disclose their sexual orientation to the nurses, due to the fact that they identified non-conforming sexual orientation as inherent, an inner being, and therefore should be kept discreet. Similarly, some LGBTI participants considered themselves to be covert LGBTI, because they did not have visible features that identified them as such. LGBTI Participant 1 referred to himself as a "masculine" gay, a gay man who does not have "feminine looks". Therefore, according to him, people around him were not able to detect his orientation.

A few LGBTI participants also shared similar views regarding being perceived by nurses as LGBTIs, based on their external traits. Some LGBTI participants indicated that they did not have to disclose their sexual orientation to the nurses because they realised that nurses had already assumed that they were LGBTI. In certain instances, the nurses did not ask the participants about their

sexual orientation. Rather, they relied on the external indicators, which meant that they presumed that patients were having non-conforming sexual orientation. For instance, with LGBTI Participant 5, the nurse referred to him as *chomi*, the term that LGBTIs use to refer to their gay or lesbian counterparts, at which point he realised that the nurse knew that he was gay. LGBTI Participant 5 raised the importance of how, the nurse's perception played a significant role in increasing the level of comfort on how he felt about his sexual identity and orientation. This participant's experiences revealed that nurses, who are able to identify the patients as LGBTI by using the terms that LGBTIs use, can be cues that facilitate disclosure in clinical practice.

> *I … think she … knew because … you know how you know that people know … in … Pretoria, they call you "chomi" … When somebody says "chomi" well you just know that I don't have to disclose my sexual orientation because this person know … so for her that word, she started by calling me that … so person is nice to you, you see the smile, the … attention they give you and with me it was … it was very nice* (P5).

When questioned as to whether he had ever disclosed his sexual orientation to the nurses, LGBTI Participant 4 shared the same sentiment as LGBTI Participant 5 had done, when he responded that there was no need for him to disclose his orientation since he noticed that the nurse had already detected that he might be a gay man based on his feminine looks. When LGBTI Participant 4 was asked how the nurses knew that he was gay, he said that some could detect from his voice, since it sounds *feminine* , while others have learnt from his feminine gait , and yet others from his looks. This concludes the discussion on the two emerging sub-categories, namely: 1) *developing awareness of own beliefs, values and attitudes;* and 2) *developing perceptions about others* of category 1: recognising personal subjectivity. Category 2: tackling and overcoming personal subjectivity will now be discussed.

4.2.2. CATEGORY 2: TACKLING AND OVERCOMING PERSONAL SUBJECTIVITY

Category 2 namely 'tackling and overcoming personal subjectivity' will be discussed in relation to its sub-categories. Relevant quotes from participants will be presented to expand the category and its properties.

Tackling and overcoming personal subjectivity became another category that emerged as comparative data analysis progressed. For the nurse participants, tackling and overcoming personal subjectivity followed the process of developing awareness of one's own values, beliefs and attitude. It became a reflexive response of re-establishing the self, in response to the tension of cultural shock. The nurse participants became aware that the self within the context of themselves as individuals and professionals, and the LGBTI patients were experiencing tension and therefore seeking various ways of resolving the tension and its effects. The nurse participants found themselves reflecting further on their personal and professional values, beliefs and attitudes, and were, over time, able to pursue personal and professional transformation in order to establish a good nurse-patient relationship. Two subcategories that described the processes of tackling and overcoming personal subjectivity were identified as: 1) *accommodating*; and *2) being open to change*.

Interesting information emerged which demonstrated the properties and dimensions of where, when and how the nurse participants were **tackling and overcoming their personal subjectivity**. Firstly, following self-awareness, they were able to be persuaded into a process of setting aside their personal values, beliefs and attitudes. Secondly, they became open to change in order to deal with the effects of their own prejudice and to meet the needs LGBTI patients. The category revealed how nurse participants, having realised the impact of their values on LGBTI patients, were willing to change their negative attitude, eliminate any forms of bias they might have towards the patients, and adopted a more patient-centred approach.

Blumer (1969:138) suggests that the 'self' is reflexive, which implies that the person is capable of becoming an object of her own reflection. The person experiences self indirectly from the perspectives of other individuals or members of the social group to which he belongs. He becomes an object to her/himself through being exposed to the attitudes of other individuals towards her/himself within a social environment. Blumer (1969:11-12) asserts that understanding others implies understanding the objects in the world of people. The meaning of objects are formed by people; taught by people, and can therefore be changed by people. Blumer's reasoning suggests that people form meaning about objects and thus, are open-minded to changing the meaning and perceptions about the object when they are presented with new facts and evidence. Thus, tackling and overcoming personal subjectivity, implies that the internal self has developed ways of dealing with the situations with which it is confronted, and is thus adaptable to it.

4.2.2.1. *SUB-CATEGORY 2.1: ACCOMMODATING*

The first sub-category, accommodating described the nurse participants' experiences on and of the process of: 1) setting aside own values, beliefs and attitudes; 2) acknowledging having limited knowledge; and 3) being related to an LGBTI person. In this study, accommodating became a concept that captured several of the responses from nurse participants. It became a common solution to settling internal conflict experienced during interaction with the self, others and the environment. '*Accommodating'*, in this study, was seen as an affective process that involved giving up part of the self in order to preserve the relationship with others. '*Accommodating'* meant being sensitive to the needs and feelings of others, including attending to those needs despite experiencing internal conflict.

Nursing care requires that individuals identify and use their values and beliefs to determine the choices of actions taken during their interactions with others, and to deal with the outcome of those interactions. In this study, setting aside own values and attitudes became a cognitive and affective process that was

constituted by a combination of personal values, professional values and ethics. As a cognitive process, the sub-category illuminated an understanding of the factors inherent in the conflict that nurse participants experienced when they were faced with values that collided with those of LGBTI patients. Nurse participants shared how they had learned to deal with conflicting values by developing new attitudes and skills. Participants described how, as nurses, they became more accepting of others' differences, and less judgmental. Fundamentally, they were required to priorities the objectives of the clinical interaction, which are patient-centred.

Data revealed that, for the nurse participants, setting aside own values, beliefs and attitudes became a process of suppressing and bracketing their own values, beliefs and attitudes and being open to change in order to meet their professional obligations towards LGBTI patients. One nurse participant expressed that she had, over time, learnt that having different Christian values to those of her patients, and ought not to be the cause of imposing judgmental and discriminatory attitudes towards LGBTI patients. When nurse participants put aside their personal values and beliefs to accommodate the needs of the patients, it became a demonstration of their moral commitment towards caring for LGBTI patients. Nurse Participant 1 uttered that she had learnt that people ought to be treated humanely, irrespective of their background.

> *… what I have learnt is that … if you're a human being … and then you told yourself that you are a Christian, being Christianity doesn't mean that you need to … judge the people or you have to discriminate … the people or what, yours is just to, you must learn that a human being is a human being …* (NP1).

During the interview, Nurse Participant 1 described how she became more open to the differences that existed between her and her LGBTI patients, and to efficiently managing her patients, despite holding values and beliefs that may be in conflict with their lifestyle. She described what has helped her to treat her patients efficiently as her nursing oath and her obligation to treat patients equally irrespective of their sex, colour and culture. Furthermore, she

disregarded all the allegations that were made against LGBTI patients and kept aside all the conflicting values that people held against them.

For Nurse Participant 3, when her patient disclosed his sexual orientation to her, she became shocked because she found that non-conforming sexuality contradicted her Christian values. However, she had to bracket her values and beliefs, by admitting her worldview to her patient. She was not sure about how to manage the conflicting values of upholding her Christian values and at the same time fulfilling her nursing obligations. She mentioned to her patient that she does not promote non-conforming sexuality, but was obliged to treat him with the greatest love, despite her values.

> *… I told him, "You know, I'm Christian, this is what the bible says, but for you as a person I have the greatest of love, but what you are doing … I don't always … condone" … I don't know if you can divorce the two or if I'm being a hypocrite now, I … really don't know but that is my personal feeling …* (NP3)*.*

Furthermore, on the same note, when Nurse Participant 3 was asked about her perceptions of LGBTI people, she confessed uncertainty over whether or not their sexuality was a choice. However, she believed that non-conforming sexuality contradicted her beliefs and was not something that she was able to support. The same nurse participant shared that as a nurse, despite not upholding non-conforming sexuality, she had learnt over time to set aside her values, beliefs and attitudes, not to letting her personal feelings affect her work. On the other hand, Nurse Participant 4 found that communication with her patient had improved following her attempt to reach out and exhibit certain openness.

> *… I was trying to reach out the reality that he need to face as a patient – how do you call it? – the clustered group that he falls in, it's not by his choice, nobody forced him to be there, just to accept it as it is; and this will also help other people to know how to tackle the problem, because once you start smiling and like,*

> *looking like you are amazed and let this person to be, like start to be a little comforting him* (NP4).

Acknowledging having limited knowledge about LGBTI health care was developed from the related concepts, which constituted the sub-category 2.1: *accommodating*. As an expression of being *accommodating*, nurse participants acknowledged that the lack of knowledge and formal education and training in LGBTI health care was a limitation towards efficiently accommodating the needs of LGBTI patients. In most cases, nurse participants verbalised that they lacked the basic competencies that were needed to provide optimum care to LGBTI patients. They had identified a lack of knowledge and understanding of LGBTI issues as a barrier in efficiently addressing issues that LGBTI patients are confronted with. For instance, Nurse Participant 3 acknowledged that there had been gaps in the skills of addressing LGBTI health issues, where opportunities for addressing those gaps were limited. She was of the opinion that if the lack of skills was being addressed, LGBTI patients-nurse interaction would improve. However, she still remained optimistic that there will always be room to improve the skills needed to facilitate LGBTI youth friendly services.

> *I think there's a gap, to be honest … I think it's something that we were taught, it's something that you learnt … the skill … if the skill is there, you find it … by interaction thing and I … still think today it's not really addressed … in that sense, I don't know if there are places that addressing it directly … I think … there's room for improvement and there's room to sharpen the skill …* (NP3).

On the same note, Nurse Participant 2 found it difficult to interact with LGBTI patients due to her lack of knowledge on LGBTI health issues. She acknowledged having limited knowledge in providing customised LGBTI health care. Based on her limited knowledge, she felt that she had compromised the care that she gave to her patient. She claimed that she gave her patient normal treatment, rather than customising LGBTI health care. According to Nurse Participant 5, LGBTI patients have unique health needs, which should be met by customising their health care in order to treat them holistically. Nurse

Participant 1 blamed her lack of knowledge and skills on the lack of training on LGBTI health care for nurses.

Another expression of the process of *accommodating* was demonstrated when some nurse participants revealed that being related to a person with non-conforming sexual orientation assisted their own sense of comfort and capacity for sensitivity in working with and *accommodating* LGBTI patients. They related how having a person with nonconforming sexual orientation as a family member or a friend has impacted on their positive attitudes towards LGBTI people. Nurse Participant 4 related that at first, she couldn't understand her male cousin, who always had intimate relationships with male partners. However, she had, over time, learnt more about LGBTI people when he started working at the university-based PHC clinics, where she had had an opportunity to meet LGBTI people first-hand. According to her, meeting LGBTI people has helped her to acquire an understanding of people with non-conforming sexual orientation. Consequently, she was able to coach other family members towards their acceptance. Again, Nurse Participant 4 mentioned that her experience with working with LGBTI people has helped her to help others in understanding and accommodating LGBTI relatives.

> *At home we've got my cousin, more or less 34 years old, I still now don't understand, until I came to* [name of clinic], *meeting all these LGBTI and the gay, lesbian things … my uncle before he passed on, he used to have a problem with that, until I sat down with him … I explained the story to him "That is how they are gonna live, whether he likes it or not, he will never see Tebogo having a girlfriend, but you will always bring in … a guy as a girlfriend to him, and then he would be the boyfriend …* (NP4).

Nurse Participant 2 shared the same sentiment as Nurse Participant 4 when she mentioned that what made her understand LGBTI people better was having a sister who was a lesbian. Nurse Participant 2 believed that what made her LGBTI patients feel free and relaxed during their interaction, was when she

reassured her patient that she had a sister who was a lesbian, and that she loved her sister as she was. She noted:

> *I think is because of the background … because … at first, I couldn't understand that my sister is a lesbian but because I love her and … you know and … her girlfriend will come and visit us and at first, we were not close but as time goes by we were close and we usually go to parties where we meet a lot of … LGBTI and I made friends, I think the background has … mould me to be what I am now so that I understand LGBTI better* (NP2)*.*

LGBTI participants in this study also shared the significance of having an LGBTI confidante in the health care system. During an interview with one LGBTI Participant 3, he suggested that gay nurses would help make patients feel more comfortable, especially to those patients with sexual health concerns. He would regard this as a mediating influence, and a buffer against negativity. LGBTI Participant 3 asserted that gay nurses would make LGBTI patients feel more comfortable, as they could easily relate to and understand their health care needs. He mentioned that the majority of nurses do not recognise the relevance of sexual orientation or gender identity to the health status. Furthermore, he is of the opinion that most nurses are still ignorant of or not interested in gaining knowledge and understanding of the health concerns of LGBTI patients, and therefore neglect to address them.

LGBTI Participant 4 also shared the same view when the nurse became curious to learn more about non-conforming sexuality, because of her suspicion that her son could be gay. LGBTI Participant 4 could determine that the nurse was sensitised to LGBTI issues, and as a result felt free to provide the nurse with the necessary information.

> *I could say she was inquisitive, 'cause she ended up telling me about doubting his younger child as of being gay or what 'cause … she can see the actions, how he plays, he doesn't play with boys … he plays with girls … it pleased me, from that day, that's where I said … I*

> *can see that people there have accepted me, others just want to know, not that they are not accepting us, they just want to know more information about us, so from today I must just be open enough and be transparent so that they may not judge, they … may know us, who we are really …* (P4).

4.2.2.2. *SUB-CATEGORY 2.2: BEING OPEN TO CHANGE*

The second sub-category emerging under the Category 2: 'tackling and overcoming personal subjectivity' was '*being open to change'*. '*Being open to change'* involved cognitive and affective process of empowering. To have an open mind means to be willing to consider or receive new and different ideas. It means being flexible and adaptive to new experiences and ideas. In this study, *being open to change* required that the nurse participants free themselves from certain of their own values, thoughts, biases and attitudes and be open to new experiences and new ways of perceiving things. The nurse participants pursued new ways of doing and looking at things, whereby they developed their intellectual capability and critical thinking. *Being open to change* has assisted nurse participants to be more open to diversity and to be less judgmental about others. It meant being receptive to the views that others should express themselves freely, noting that the value of others ought to be recognised.

In this study, for the nurse participants, *being open to change*, meant assuming a submissive role in order to view LGBTI issues from a different perspective than that to which they are accustomed. Nurse participants became aware of their limitations with regard to LGBTI care and how that impacted on the care they gave to LGBTI patients and subsequently improving on those limitations. '*Being open to change'* constituted the processes of: 1) 'understanding of LGBTI peoples' challenges'; 2) 'changing attitudes'; 3) 'establishing new and changing old values'; and 4) 'empathising'.

As comparative data analysis progressed, it became apparent that '*being open to change'* was fundamentally tied to the notion of 'understanding of others' challenges'. 'Understanding of LGBTI people's challenges' was discovered

during nurse-patient interaction and included emotional and social features. This kind of process was seen to be bringing nurse participants emotionally closer to LGBTI patients. For most nurse participants, 'understanding of LGBTI people's challenges' meant both being aware of and acknowledging the challenges encountered by LGBTI people in their families, communities and the health care system. They expressed their awareness of the fact that LGBTI people often experience rejection by their families, and are also being ostracised by nurse participants at the clinics. Nurse Participant 4 alluded to the fact that when the patient is supposed to relate her medical problem to the nurse, they are usually fearful to disclose their medical problems, where instead, they would focus on something else. She mentioned that the reason why LGBTI people do not feel free to disclose their sexual orientation is because firstly, they fear the nurses' negative attitude towards them and secondly, they find the clinical environment intimidating. Nurse Participant 4 raised a concern about how some nurses mistreat LGBTI patients at the clinic, advising her nursing colleagues to be vigilant when treating LGBTI patients. She advised her colleagues to be humble, and to commit towards caring for patients, according to their nursing ethics. She noted that LGBTI patients tended to be frustrated at the clinics and consequently suffer from mental health problems.

> *… because of their fears they are exposed to, immediately they start opening up, you will find you are so cold, and immediately they start telling you, how, what to, which … group do I fall in, you will always raise your eyebrows and then start like "Okay it's fine, okay sister, that's fine, can I go now?" You cut him, you let the patient to cut off, what he was supposed to tell you more because of what, remember that, the patient is the one who has to talk more, than the nurse … please humble yourself in front of the patients and provide your services according to the commitment of the nursing … the pledge otherwise, you will lose out and then our patients who are frustrated health wise and their mental state will be disturbed* (NP4).

Whilst exploring the category, it was interesting to note that some LGBTI patients shared the same sentiment as some nurse participants when they verbalised their fear of disclosing their sexual orientation to the nurses. In some instances, LGBTI participants found themselves anticipating homophobic responses from nurses. In some cases, this led them to feel intense anxiety, and an aversion to disclosing their sexual orientation, subsequently getting an accurate diagnosis from the nurses. LGBTI Participant 3 eloquently discussed how he went to the clinic with a preconceived idea that the nurses normally "shout at gay people", being reticent to disclose his sexual orientation for fear of the same.

When Nurse Participant 1 was asked about her perception of the services that LGBTI patients receive at the clinic, she responded that she was of the opinion that clinics were not yet LGBTI friendly. She expressed her dismay about the way in which LGBTI people are ostracised by the nurses at the clinics. She mentioned that she has observed how the nurses were passing judgmental remarks about LGBTI patients, rather than providing them with the necessary treatment. Interestingly, on the same note, Nurse Participant 4 revealed how her LGBTI patient visited different clinics for the same problem, because his health care needs were not met. Her patient alluded to the fact that he found it difficult to relate his medical problem to the nurses, due to the fear that the nurses might be judgmental towards him.

> *… because … when gathering the medical information … it was long term history. Initially he started consulting, three different clinics, but he never got help that he needed, instead of saying exactly or narrating the symptoms to the sister that he met or the doctor, he wouldn't go that deeper … and then, the patient was thinking about what is it that really brought him here; then the patient always, most of the patient will always not tell the exact reason for his visit to the clinic, but rather come up with something else. So for him it's because the service provider's attitude, and the environment was very interrogating to them* (NP4).

Nurse participants demonstrated that they were *being open to change* when they communicated that they understood the challenges that LGBTI people face. What nurses have shared as understanding of LGBTI people's challenges was found to be similar to what LGBTI participants have discussed during their interview. Most LGBTI participants reported that they experience stigma and discrimination in the health care system as a result of their sexual orientation. It emerged that some LGBTI participants had experienced implicit or explicit, intentional or unintentional forms of discrimination in relation to their sexual orientation when they consulted the nurses at the clinics. In some cases, LGBTI participants had either disclosed their sexual orientation to the nurses, or the nurses perceived them as LGBTI, based on their external appearance, which subsequently resulted in the nurses exhibiting negative attitudes towards them. Most LGBTI participants reported that they were being discriminated against, judged, disrespected and devalued, were routinely refused information, and accused of engaging in risky sexual behaviour. These forms of prejudices caused humiliation for LGBTI patients, whereas result they received substandard health care, lack of preventative information, became reluctant to seek care, or to seek alternate care at other health care facilities.

Most LGBTI participants shared how they had experienced discrimination in various forms including verbal to non-verbal communication, from speaking style to the use of body language, from obvious to more subtle ways, when they interacted with the nurses during consultation. LGBTI Participant 1's experience of discrimination was when he realised that as an openly gay man, the nurses were talking about him at the clinic, and therefore he felt that he was being judged and discriminated against, that those were the kind of issues that they had to deal with on a regular basis as gay people. Over and above this, LGBTI Participant 1 had also noticed with concern how openly gay men tended to be treated differently from other patients at the public clinics. He had noticed how nurses gossiped about other gay men, laughed behind their backs, and commented on their dress code. This type of reaction towards gay people caused LGBTI Participant 1 to wonder why the nurses reacted in that

manner towards the patients. For LGBTI Participant 1, the whole experience left him feeling disrespected and undignified, since he expected the nurse participants to be people who have been trained to know better about how to treat diverse people.

Evidence from the LGBTI participants' interview indicated that sometimes, LGBTI participants experienced being discriminated against when they were being perceived as heterosexuals by the nurses. For LGBTI Participants 1 and 3, the experience of being discriminated against emanated from when the nurses were asking him presumptive questions about sexual issues and relationship. When the nurses questioned them about their partners, they were always referring to a partner as being someone of the opposite sex. Again, LGBTI Participant 1 believed that gay people have special health needs that had to be addressed, which tends to be ignored LGBTI Participant 3 is of the opinion that the nurse was asking him presumptuous questions because she was not able to identify him as gay from his mannerisms or appearance. When questioned about how he might respond to the nurse's heterosexist preconceptions, he said he responded by avoiding confrontation, and deciding rather to pretend heteronormativity. LGBTI Participant 3 further expressed that the nurses were not aware that they had patients who were not heterosexual. He raised a concern that the nurses tended to neglect the possibility that a partner could be either be of the opposite sex and/or same sex. He mentioned that when the nurse asked him about his girlfriend, he resorted to concealing the gender of his partner by avoiding gendered pronouns. LGBTI Participant 3 felt that the clinics were not yet enabled or ready to be referred to as LGBTI friendly clinics, as they were still referring to a partner as a person of the opposite sex.

> *I just laugh it off and then say ok "O testile"* [have you tested?] *as I'm not here … to test for HIV or STI … but then I don't even say "my girlfriend", because they already referred to the boyfriend and the girlfriend, therefore I just say, "O testile"* [she has tested]; *and I run away from the she and he part that I tend to use*

> **Vernac language because there is no she or he in there* (P3).

Furthermore, LGBTI Participant 3 again alleged that the nurse gave him a wrong diagnosis for sexually transmitted infections (STI) when he consulted the clinic. He alleged that the nurse treated his STI as an *ordinary STI*, whereas according to him, *homosexual's STIs* should not be treated as *ordinary STI.* LGBTI Participant 3 regarded "gay sex" as very risky, where the mode of transmission of STI and the sexual parts involved as being different from that of heterosexuals. When LGBTI Participant 3 was asked about what his experience at the clinic meant, he expressed that it was unpleasant. However, he also expressed being optimistic when he mentioned that the public clinics would eventually improve.

Most LGBTI participants sensed being judged when they were noticing verbal and non-verbal expression of judgment from their nurses after deciding to disclose their sexual orientation to them. LGBTI Participant 1 noticed the nurse expressing her awe when she started questioning him about why he was "doing such things" (referring to being gay). Some LGBTI participants experienced being judged, relating that the nurses in relation to their sexual orientation, accused them of engaging in unsafe sexual practices. The nurses would suggest that LGBTI patients were sexually at risk. This perception was proven through the experience of LGBTI Participant 5 and 6 when they went to the clinic to test for HIV and to seek treatment for STIs, respectively. LGBTI Participant 5 raised noted that the nurse had presumed from his orientation that he would be promiscuous. He was concerned about the nurse's remarks and found them disturbing. When LGBTI Participant 5 was asked about what questions the nurse asked him in order for him to conclude that the nurse was judgmental, he responded:

> *… I remember the first … that she made when I got there was like, you guys sleep around a lot … I doubt they are very educated I think and … there's certain things that when a person says feel like okay I don't know if that is ethical, you know* (P5).

LGBTI Participant 5 said that he felt unethically discriminated against during this encounter. He regarded the nurse as someone who was educated, who should know how to empathize with her patients and treat them better.

Nurse Participant 4 revealed how her patient visited different clinics for the same problem because his health care needs were not being met because of fear of nurses being judgmental towards him. Data from LGBTI participants also shared similar meaning to that of Nurse Participant 4. Based on the negative attitude that LGBTI Participant 5 had experienced at the clinic, he found himself looking for alternative medical care at another clinic. He was dissatisfied with the care that he had received at the first clinic, and as result sought care at another clinic for the same medical problem. The same sentiment of seeking alternate medical care at another clinic was articulated by LGBTI Participant 3 when, after interacting with the nurse, he felt that he did not receive the quality of care that he expected. This is due to the fact that he did not feel comfortable to disclose his medical problem and sexual orientation to the nurse. Eventually, he resorted to seeking out medical care at another clinic with the hope that he would disclose his sexual orientation to the nurses there and get better treatment. However, to his amazement, he found that the nurses' attitudes at the other clinic were almost the same as the previous one, and therefore, he still could not disclose. Ultimately, he ended up having piles of medication from different clinics for the same problem. Sometimes LGBTI participants related the experiences of not being helped by the nurses when they needed attention. LGBTI Participant 5 related his encounter when he was not being helped, he felt that the nurses, most of the time, are in a hurry to help, and that they just do not care to give information as to how the diseases are contracted and how to prevent them. Sometimes they would give medication without explaining how to use it.

> *… you know most of the nurses, that's they are … like when you get there, they just wanna get done. They don't care, to explain it to you, how much you know it, because sometimes you have a certain sickness or you want to actually know ways of preventing it, ways*

> *of getting away from it, it's not necessary or protection most of the time … actually to explain the process, how it came about and how to treat it and what are the causes, so they just give me medication and sometimes they just give you medication and you just leave, get off …* (P5).

Nurse Participant 3 eloquently expressed that LGBTI youth are being rejected in their families. They fear to return back home, as they believed that they have brought shame to their families by being LGBTI. Nurse Participant 3 further alluded that LGBTI people are also vulnerable to abuse by their intimate partners. She raised a concern she had that for LGBTI people, due to the fear of being rejected and being subjected to intimate partner violence, they may tend to be submissive and conform to the demands of their partners, even if they are aware that they are predisposed to health risks. Nurse Participant 3 eloquently expressed how she felt sorry for her patient after realising that his family had rejected him because he was gay. She cited that LGBTI people were still frowned upon and still stigmatised. Similarly, Nurse Participant 2 also noted with concern about how LGBTI people are ostracised in the society, which could be the reason why they are not comfortable to disclose their sexual orientation to others.

Changing attitudes became another process that met the criteria for the sub-category 2.2: *being open to change* amongst nurse participants. The process accounts for the behaviours according to which the nurse participants demonstrated their commitment to changing their attitudes towards LGBTI patients. Changing attitudes towards LGBTI required the nurses to adopt and adapt to new experiences and ideas. One nurse participant raised a concern regarding how the nurses' attitudes might impact on patient care outcomes. She mentioned that the nurse participants' attitude could either act as a barrier or facilitator of health-seeking behaviour for the LGBTI patients. At the same time, Nurse Participant 1 insisted that the nurses ought to have a positive attitude towards LGBTI patients in order to enable them to feel free and comfortable to seek health care at the clinics.

> *So, we as nurses, we must have a very good attitude, we must have a very good attitude according … so that when they see us, they must never be afraid, they must feel that they are welcome in the clinic. So all the services must be free (from threats) for … these people* (NP1).

Nurse Participant 3 shared the same sentiment as Nurse Participant 2 when she said that nurse participants needed to change their attitudes, because LGBTI people perceive nurses' attitudes as the main barrier in their health-seeking behaviour. She asserted that LGBTI people ought to be treated with respect by the nurses, as their core responsibility is rendering an efficient service to the patients.

In this study, *being open to change* required that the nurse participants free themselves from their own values, thoughts, bias and attitudes, so as to be open to new experiences and new ways of perceiving things. Simply put, it meant changing attitudes. For the nurse participants, changing their attitudes ought to commence by acquiring new knowledge, experience and skills, and embracing new ideas. Data revealed that nurse participants demonstrated a strong sense of self, and showed a willingness to compromise their own values and beliefs, and therefore, to adopt and adapt to new attitudes. For nurse participant 2, changing attitudes towards LGBTI people for the nurses was seen as a process that required knowledge regarding values and attitudes, which will assist the nurses to change their attitudes towards LGBTI people, to accept them, and to treat them as human beings.

> *I think … we nurses, we need to change our attitudes towards gay people, I think it's very, very important for the nurses to have a very good knowledge and they need a thorough training about the attitudes, about … the values because, so I think it's very important for us nurses … to have good attitude towards these … youth, know that these people are they are people, they are our children, we must accept them …* (NP2).

Changing old values and establishing new ones became another conscious process in which nurse participants were able to reflect on changing their attitudes towards LGBTI patients. In this study, data revealed how some nurse participants became aware of their limitations with regard to providing efficient care to LGBTI patients. Significantly, one nurse participant echoed how she was prepared to change her attitude towards LGBTI people and adopt also a new way of treating them efficiently. At the same time, Nurse Participant 1 expressed the significance of treating LGBTI patients the same as any other patients. She expressed that she has learnt that they are equal to any other human being. For Nurse Participant 1, changing old values and establishing new ones was demonstrated when she shared that initially, she was of the opinion that having non-conforming sexual orientation was a deliberate choice. However, after learning from LGBTI patients that having non-conforming sexual orientation is inherent, she changed her negative attitude about LGBTI people to a positive one. She also shared her view that LGBTI people themselves, do not approve of who they were, meaning that they are also not comfortable about being LGBTIs.

On the same note, for Nurse Participant 3, changing old values and establishing new ones meant not finding any fault in her gay patients, because she had gone through a mind shift of not letting her personal feelings influence her clinical practice. Once more, the statement of Nurse Participant 3, of changing old values and establishing new ones, was confirmed when she initially admitted that she did not tolerate nonconforming sexuality. However, she later realised that as a health professional, it was incumbent on her to accommodate LGBTI patients and their needs. She wanted LGBTI patients to experience a friendly health service and not to feel isolated.

> *I might not condone it, but being a health professional I have to be aware of it, and I think I have to make room for it and I … have to provide for it, if … they do come and visit the facility … or if I want to make it a friendly facility for them as well and not refer them to a little corner there, where it is specifically just for them … but*

> *him as a person, er no fault in him as a person and I don't also think that's the way I work in … essence maybe … as a nurse, I have progressed past that … to bring personal feelings and things into account or into my work environment where I work. So ja, that's my account, quite fresh in my mind still … of a guy telling me that his sexual orientation is different from what is expected of the norm* (NP3).

Empathising was identified as another precept that reflects *being open to change*. In most cases, nurse participants had observed how the patients were going through challenges ranging from physical, emotional and psychosocial trauma. Therefore, for nurse participants, empathising with others became an affective process that involved adjusting one's behaviour, actions and emotions in order to make sense of what others are feeling and thinking. It involved "putting oneself in others shoes". Empathising enhanced some of the nurse participants' capability to critically think about their actions and reactions and how that impacted on others. Empathising required that the nurse participants engage in a new meaningful way of understanding the health care needs of LGBTI patients and responding to them in an appropriate manner.

In the context of this study, empathising emerged as a paramount process that allowed nurse participants to reflect on how one would act, react and think if faced with the similar challenges as LGBTI patients. Several nurse participants expressed empathising with LGBTI patients, by sharing that they were aware of the challenges that LGBTI people face in their families and in the health care system. Some reasoned that they were obligated to understand the behaviour of LGBTI people in order to understand the challenges that they encounter. Some nurse participants empathised by sharing with the patients their experience of interacting with LGBTI people, either as a friend or relative. They shared how being related to LGBTI people has increased their understanding and developing of empathy for LGBTI patients.

Data reflects the strategies that were employed by nurse participants while they were empathising with LGBTI patients. For example, one nurse participant

empathised by verbalising that she felt sorry for LGBTI people, due to the challenges that they had to face. She raised the point that LGBTI people still face stigma and ostracism in the community, particularly their own families. The nurse participant felt sorry for her patient when her patient revealed that his mother was not aware of his sexual orientation. However, her patient mentioned that he would like her mother to know about his sexual orientation.

> *… I think mostly, you feel for me as a person, I feel sorry for them, because … of what they have to go through … it's … still being frowned upon and they are still being ostracized especially by their family, because … he just told us "Look my mum doesn't know, she's not aware of the status and she should know though … about this* (NP3).

In addition, Nurse Participant 3 demonstrated empathy when she felt that she wanted to ameliorate her patient's suffering. She felt that, for her patients, having to deal with the fear of being rejected by his parents and at the same time, the responsibility of studying, was too much burden to bear. However, she mentioned that she felt helpless when her patient would come to her, and sometimes break down in tears.

For Nurse Participant 4, empathising meant listening to each patient's story and not only treating physical symptoms. She believed that most patients do not disclose all their problems when they come to the clinic, and that what they complain about is just a 'tip of an iceberg'. She believed that there was more than what they were disclosing and nurse participants do not empathise with their patients, a lot of patients' complaints might be missed during consultation. As a result, the patients' needs will not be met and the patients will seek alternative care elsewhere. The same nurse participant believed that LGBTI patients do not disclose their sexual orientation to the nurse participants for fear of being judged. She noted when LGBTI patients attempt to disclose their sexual orientation; they tend to be frowned upon. She raised a concern that nurses ought to allow the patients to engage in a relaxed conversation that will enable them to disclose their sexual orientation.

> *Because of their fears they are exposed to, immediately they start opening up, you will find you are so cold, and immediately they start telling you … which group do I fall in, you will always raise your eyebrows and then start like "Okay it's fine, okay sister, that's fine, can I go now?" You cut him, you let the patient … cut off, what was he supposed to tell you more because of what, remember that, the patient is the one who has to talk more, than the nurse* (NP4).

LGBTI Participant 3 is of the opinion that clinics like OUT, non-governmental organisations that provides health care service to the LGBTI community, is LGBTI friendly, as over and above the medical care they receive from nurses, they also have social workers and psychologist who provide specialised services even for those LGBTI who are still in the closet or are still in denial of their sexual orientation. He mentioned that at the OUT Clinic they are able to demonstrate empathy by offering psychological support to those who are in need of counselling.

Nurse Participant 2 expressed her empathy, where she wondered how it would feel if she had a child who was gay. She was of the opinion that being LGBTI is "something" that did not develop unexpectedly but was inherited from the ancestors who exhibited the same behaviour during their time.

> *… so I told myself, I said no, man … these people … there's something that is happening with them, so it's very, very, very sad because if I said to myself, what about if it was me, and then I've got a child who is … a gay and he start developing to this, so I said, I think this thing sometimes it's from the fathers. I think this is from our forefathers, children cannot just start and develop this thing, so it's just that our parents they … did, they don't tell us, you find that some of our forefathers were doing these things …* (NP2)

This concludes the discussion on the two emerging sub-categories, namely: 1) *accommodating*; and 2) *being open to change* of category 2: tackling and

overcoming personal subjectivity. Category 3: Seeking understanding about LGBTI people and their health care needs will then be discussed.

4.3. CATEGORY 3: SEEKING UNDERSTANDING ABOUT LGBTI PEOPLE AND THEIR HEALTH CARE NEEDS

Category 3: 'seeking understanding about LGBTI people and their health care needs' will be discussed in relation to its sub-categories. Relevant quotes from participants will be presented to expand the category. 'Seeking understanding about LGBTI people and their health care needs' was the third category that emerged during data analysis. According to Blumer (1969:53) people in interaction with the self and others are forming their respective lines of action by directing, checking, bending, and transforming their lines of action in the light of what they encounter in their actions with others which was consistent with the findings of this study. The meaning of the category was explored further through constant comparative data analysis, noting properties and dimension that exhibit how nurse participants acknowledged having limited knowledge about LGBTI health care, how they explored ways of acquiring new knowledge and understanding about LGBTI patients, and consequently how and why they were changing their attitudes and behaviour towards LGBTI patients. To Blumer (1969:13) a human being recognises himself as a student and acts accordingly by learning new facts and information, the notion of Blumer is consistent with the category: 'seeking understanding about LGBTI people and their health care needs'. The category demonstrated how nurse participants acknowledged having limited knowledge about: LGBTI health care concerns; why they needed to acquire new knowledge; and how they could acquire new knowledge about LGBTI people and their health care concerns. The category emerged from the sub-category: 1) 'acknowledging having limited knowledge about LGBTI health care'; and 2) 'recognising the need to learn about LGBTI people and their lifestyle'.

4.3.1. *SUB-CATEGORY 3.1: ACKNOWLEDGING HAVING LIMITED KNOWLEDGE ABOUT LGBTI HEALTH CARE*

Sub-category 3.1: 'acknowledging having limited knowledge about LGBTI health care' also belonged to sub-category 2.1: 'accommodating' and was discussed briefly under that sub-category. Therefore, it will be discussed further under the category: 'seeking understanding about LGBTI people and their health care needs'. In this study, 'acknowledging having limited knowledge about LGBTI health care' was defined by nurse participants as not having the necessary knowledge to provide LGBTI inclusive health care, and the expressions of a desire to acquire more information about LGBTI health care concerns.

Data from nurse participants' interview revealed how, through self-interaction, nurse participants acknowledged a lack of knowledge and formal education and training on LGBTI health care issues to be a limitation towards efficiently accommodating the needs of LGBTI patients. The results indicated how nurse participants identified and discussed different types of knowledge gap. They identified and discussed these knowledge gaps as: 1) "being uncertain about what being LGBTI meant"; 2) "feeling helpless in providing care and support to LGBTI patients"; 3) "being ignorant about LGBTI issues"; 4) "assuming a heterosexist stance when interacting with LGBTI patients"; 5) "not knowing about the behaviours and lifestyle of LGBTI people"; 6) "not knowing what the health care needs of LGBTI people are"; 7) "not knowing how the health care needs of LGBTI people should be addressed"; 9) 'being uncomfortable to talk about non-conforming sexuality"; 10) "lacking adequate knowledge and skills in treating and caring for LGBTI patients"; and 11) "not receiving adequate training about LGBTI people and their health care issues".

> *… that's very difficult, … and honestly it is something that I am still very uncomfortable with, to ask, … I haven't breached that yet, … and I don't always know how to … ask it forth right… I really don't know how to ask … "what is your sexual orientation"? (*NP3*).*

In this study, Nurse Participant 3 acknowledged that there were skills gaps in addressing LGBTI health issues, and opportunities for addressing those gaps were limited. She was of the opinion that if a lack of skills could be addressed, the LGBTI patients and nurse interaction would improve. However, she still remained optimistic that there would always be a room to improve the nurse participants' skills.

> *I think there's a gap, to be honest … I think it's something that we were taught, it's something that you learnt … if the skill is there, you find it … by interaction thing and I … still think today it's not really addressed … in that sense, I don't know if there are places that addressing it directly … I think … there's room for improvement and there's room to sharpen the skill that is that* (NP3).

In this study, LGBTI participants also shared the way in which they have observed that the nurses to have limited knowledge about LGBTI people and their health care issues during their interaction with them. They have identified the knowledge gap that they had observed on the nurses as nurses: 1) "providing care and support related to heterosexual people"; and 2) "lacking knowledge about what type of sexual activities LGBTI people engage in",3) "lacking knowledge about the challenges that LGBTI people face on daily basis"; and 4) "lacking interest in learning about LGBTI people and their health care issues". The lack of knowledge about LGBTI people and their health care needs on the part of nurses became an issue of concern for LGBTI participants, which suggests that they were not receiving suitable health care to address their needs.

> *….them lacking that information even considering it when they give health care to us, also …* (P3) and

> *… they are not, if they are not trained, they are not sensitised, how are they gonna deal with the whole, with the whole issues that relating to LGBTI* (P1).

Data revealed how LGBTI Participant 3 had noted with concern when LGBTI people went for HIV testing at the local clinics, the nurses provided them with counselling that was meant for heterosexual people. LGBTI Participant 3 expressed that the nurse asked him questions that were related to heterosexual people to the exclusion of others. LGBTI Participant 3 is of the opinion that nurses were not aware of the type of sexual activity that LGBTI people engage in therefore may not have the appropriate knowledge to understand what types of sexual risks to which they might be exposed. LGBTI Participant 3 thought that most nurses in the mainstream PHC are still ignorant of or not interested in gaining knowledge and understanding of the health care concerns of LGBTI people, and that they therefore neglect to address them. From the findings, it could be concluded that nurses tended to assume that all patients were heterosexual, since they were trained in a traditional culture of hetero-normativity.

4.3.2. *SUB-CATEGORY 3.2: RECOGNISING THE NEED TO LEARN ABOUT LGBTI PEOPLE AND THEIR HEALTH CARE NEEDS*

In this study, ‘recognising the need to learn about LGBTI people and their health care needs’ emerged from the data as a result of an interpretive process following the nurse participants acknowledging having limited knowledge about LGBTI people and their health care needs within the context of clinical practice. Data analysis revealed how some nurse participants; subsequent to ‘acknowledging having limited knowledge about LGBTI people and their health care’ they recognised the need to learn about LGBTI people and their health care needs. Data analysis demonstrated that once nurse participants have acknowledge having limited knowledge with regard to LGBTI health concerns, they seek ways of learning about LGBTI people and their health care needs. Nurse participants in the study discussed addressing the need to learn about LGBTI people and their health care needs as: 1) “raising awareness”; 2) “needing to understand”; 3) “needing education and training”; 4) “wanting to learn”; and 5) “wanting to be empowered”. Therefore, the nurse participants

identified and developed a number of strategies of addressing the need to learn about LGBTI people and their health care needs, as illustrated in Figure 4 which indicates: 1) the context that they would like to learn about; 2) the resources; and 3) support required; and 4) the expected competencies; and 5) outcomes to be attained.

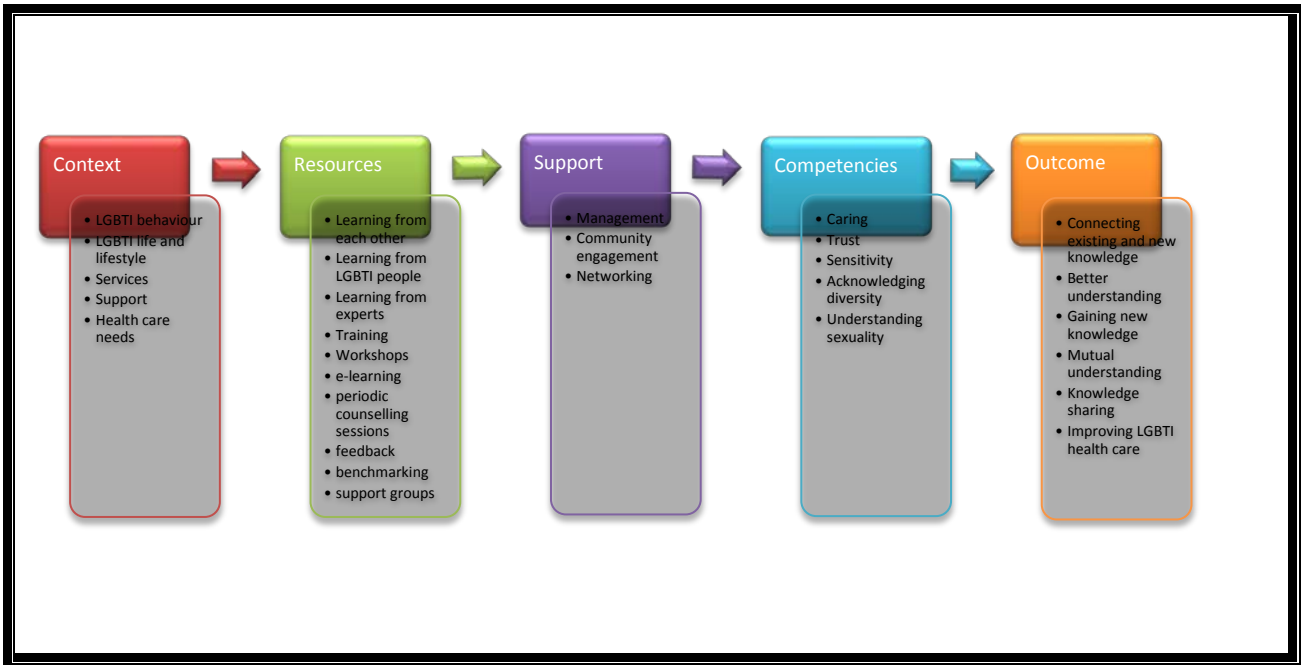

Figure 4: Recognising the need to learn about LGBTI people and their health care needs

The process revealed the eagerness of nurse participants to acquire a deeper understanding of LGBTI issues and the various mechanisms that they suggested to enable them to acquire more knowledge about LGBTI people and their health care needs. At the same time, *recognising the need to learn about LGBTI people and their health care needs* revealed the desperation of LGBTI patients to be treated by nurses who are competent in addressing LGBTI health care issues. LGBTI participants regarded competent nurses as facilitators of enabling LGBTI-friendly health care services.

> *Well … an update is always good … a face to face interaction … with other … professional nurses … working in primary health care and it also face what I'm*

> *facing and nowadays with technology, good database where you can maybe e-mail someone and say "Look, I'm sitting with this … even phone and say "… how do I handle the situation because I really don't have any idea what to do about this…* (NP3).

Furthermore, nurse participants suggested learning from others as a mechanism of addressing their need to learn about LGBTI people and their health care needs. Most nurse and LGBTI participants in this study provided a compelling narrative, which added a tone to the concept of 'recognising the need to learn about LGBTI people and their health care needs' as 'learning from each other'. Both LGBTI and nurse participants viewed learning from each other as an interactive process that takes places between people and results in connecting existing and new knowledge in order to obtain a better understanding of the phenomenon being addressed. Therefore, according the participants, knowledge is generated in action and interaction through sharing. They viewed learning as a mechanism of gaining new knowledge about each other and believed that social interaction provided a basis for the development of a mutual understanding, which allowed them to share knowledge and to better understand each other.

On that note, LGBTI Participant 5 suggested that both heterosexual and LGBTI people ought to engage in an interactive and collaborative process of learning from each other about sexual orientation and their different cultures or lifestyles. He suggested that nurses learn about LGBTI people and their lifestyle, and they also ought to learn about other people's lifestyle. He mentioned that for one to understand the culture and lifestyle of LGBTI people does not necessarily imply that one has to be in a personal relationship with an LGBTI person. However, he is of the opinion that being open-minded is the key to understanding other human beings.

> *They … need to be taught about this kind of things and I'm not only talking about, you know the entire gays, also we need to learn about other people as well, you know they need* [to be] *taught that listen … you have*

> *an experience with a gay person … I'm not saying that a person should go there and explain himself to say you see, I was born like this, leave me to understand, you know, you do not only have a personal relationship with a gay person to understand a gay, you only need to … be open minded and understand that the world ticks, so based on my experience I feel like awareness is very important, workshops …* (P5).

Nurse Participant 5 asserted that acquiring knowledge about LGBTI and their health care needs has helped her to understand her LGBTI patients better. One nurse participant uttered that she was always eager to seek greater understanding of the life and prospects.

> *I always wondered … what does life have got for them, so that they enjoy this part of being classified under … LGBTI …* (NP4).

In addition, some nurse participants identified LGBTI people as the source of their knowledge about LGBTI issues. They suggested learning from LGBTI people themselves either in an informal way, out of curiosity, or in a formal way and/or by forming alliances with people who are knowledgeable about LGBTI people and their health care needs. Learning from LGBTI people themselves was a mechanism which was also confirmed by LGBTI participants, when they suggested that nurses needed to learn from them about their health care needs, as experts on their own daily lives. Some nurse participants confirmed that for them to understand LGBTI patients better, LGBTI people ought to be involved in their training, as experts on their own health care needs and the way in which those needs should be met.

> *I think the nurse participants' training should include a … the LGBTIs … they know more about LGBTIs how to … their conditions and how to treat those conditions* (P5).

A few nurse participants in this study gave credit to LGBTI patients for teaching them about what they needed to learn about LGBTI people and their health

care concerns in order to be capable of caring for them. For Nurse Participant 4 and 5, whilst working with LGBTI patients, they have learnt from them that they were actually bisexual, and the meaning they attached to being bisexual. The patients revealed to them that as bisexual people, they have partners of the same and opposite sex and that their lives revolves around multiple partners. With Nurse Participant 4, she was curious to learn about what motivated her LGBTI patient to affiliate to LGBTI group. She was curious to learn from her LGBTI patient about activities that they engage in, their values, how they socialise in a group of LGBTI people, and where they source support from when in need.

> *… what enhanced you to join the group, and why is it so in … what are the interesting activities when you are together with the other people of the same group that you belong to? What exactly about, how … how do you socialise, the values, that you set up in your group, what are they, and then how do you end up to be … to interact with each other, are there some people that you can talk to, more about it?* (NP4).

For Nurse Participant 4, understanding LGBTI issues meant engaging in an interactive process with LGBTI people without being judgmental. She was of the opinion that interacting with LGBTI people can empower the nurses with the knowledge about their behaviour, and what they go through as LGBTI people. One nurse participant related that during the process of interacting with her LGBTI patient, she realised how she was still stuck in her old values and perceptions about LGBTI issues. She recounted that through her LGBTI patient, she was able to change her mind-set and learn about the importance of acknowledging diversity in people. She acknowledged that the nurses could learn from LGBTI people about LGBTI issues that they have been neglecting.

Nurse participants' views were therefore in agreement in this respect with to those of LGBTI participants, who believed likewise that nurses should learn from them about their sexual orientation and their health care needs. For some LGBTI participants, having nurses that are interested in understanding

sexuality and related issues is an indication of being LGBTI-friendly. LGBTI Participant 4 picked up cues that the nurse was gay-friendly when she started asking him more questions in a polite manner about LGBTI issues, to which he responded freely.

> … *she first asked … I need to ask you a question but if it offend you, you will forgive me … for me to know the truth, I said okay it's fine, she asked me if I'm gay and I said yes I am, then the questions began, she asked me about the lesbians and actually the LGBTI information* (P4).

On the same note, LGBTI Participant 3 affirms that LGBTI people ought to facilitate community engagement, raise awareness, and take responsibility to promote sensitivity and understanding of LGBTI people to the community by conducting workshops. This will enable the community to reflect on how their values, attitude and bias impact on the life of others who are regarded as having non-conforming sexual orientation. Furthermore, LGBTI Participant 5 believed that nurses ought to be interested in empowering themselves about LGBTI issues, and to have an understanding about what being LGBTI means.

> *… they need to … be taught about this kind of things and I'm not only talking about … the entire gays, also we need to learn about other people as well, you know they need* [to be taught] *… you have an experience with a gay person, you know, I'm not saying that a person should go there and explain himself to say you see, I was born like this, leave me to understand, you know, you do not only have a personal relationship with a gay person to understand a gay, you only need to open your mind … you just have to be open-minded and understand that the world ticks, so based on my experience I feel like awareness is very important, workshops …* (P3).

In addition, some nurse participants suggested learning from others about LGBTI issues and their health care concerns, for example, learning from other health care workers who have experience in working with LGBTI people. For

Nurse Participant 5, learning from others meant liaising with experts in LGBTI issues and their health care needs. On the same note, some nurse participants suggested one-on-one interactive and collaborative process of learning from others; e-learning methods where information could be shared through available electronic media like e-mails; a database on LBTI health issues; periodic counselling sessions; giving and receiving feedback; benchmarking with other institutions; and engaging in support groups. For the nurse participants, collaborating with others who are knowledgeable about LGBTI issues will assist those nurses working with LGBTI patients to bridge their knowledge gap. They acknowledged the importance of having special knowledge about LGBTI health care needs, such that they are able to improve the service that they provide to them.

> *Well … an update is always good … a face-to-face interaction maybe with other … professional nurses … maybe working in primary health care and it also face what I'm facing and nowadays with technology, good database where you can maybe e-mail someone and say "Look, I'm sitting with this" … or even phone and say "Look, I'm sitting … how do I handle the situation because I really don't have any idea what to do about this." I think … that can work* (NP3).

On the other hand, Nurse Participant 2 spoke to the importance of the role that clinic management ought to play in ensuring that nurses receive the quality of training that is necessary in addressing LGBTI health care concerns. Nurse Participant 5 suggested that, for nurses to be knowledgeable about LGBTI issues and their health care needs, they ought to receive either formal or informal training through in-service training.

> *I think it's very important to have the knowledge about these … type of people so that when they … come into the service … we need a special knowledge about them* (NP2).

At this stage of data analysis, addressing the need to learn about LGBTI people and their health care needs has helped some nurse participants to be confident in efficiently caring for LGBTI patients. One nurse participant indicated that having insight about LGBTI people and their related health care issues has improved her communication skills and the way she responded to her LGBTI patients. She mentioned that through her communication skills, she was able to let her LGBTI patients both disclose and communicate openly about his sexual orientation. She realised the significance of accepting and comforting the patient unconditionally. She is also of the opinion that accepting her LGBTI patients will further assist other nurses in dealing with LGBTI people and their health care needs, as they can learn from her about how to interact with LGBTI patients.

Data analysis has therefore demonstrated that gaining new knowledge about LGBTI people and their health care became a cognitive and affective process that followed from nurse participants' eagerness to address it as an acknowledged imperative. Data revealed how nurse participants were keen to acquire new knowledge about LGBTI issues. They became aware that LGBTI people exist in diverse settings, and that they are a diverse group of people. Nurse participants have learned about sexual orientation and sexual identity, their behaviours and challenges that they face in their families, society and the health care settings. They had acquired new knowledge about factors that hindered them from effectively providing care to LGBTI patients. They therefore realised the need to engage in learning activities that would empower them in developing an understanding of the health care needs of LGBTI people, as well as gaining competencies that will enable them to efficiently address LGBTI patients' health concerns. This concludes the discussion on the two emerging sub-categories 3.1 and 3.2 respectively, namely: 1) 'acknowledging having limited knowledge'; and 2) 'recognising the need to learn about LGBTI people and their health care needs', which fell under category 3: 'seeking understanding about LGBTI people'. Category 4: 'maintaining professional objectivity' will now be discussed.

4.4. CATEGORY 4: MAINTAINING PROFESSIONAL OBJECTIVITY

Category 4, ‘maintaining professional objectivity’ will be discussed in relation to its subcategories and its properties. Category 4, ‘maintaining professional objectivity’ emerged as the fourth category during data analysis. The category demonstrated how nurse participants reflected on their professional ‘self’ and their responsibilities towards others and therefore developed the strategies to enhance the care that they provided to LGBTI patients. The strategies were developed following having identified and reflected on the challenges that were posed as a result of imposing their own personal values, beliefs and attitudes on LGBTI patients, and their limited knowledge about LGBTI people and their health care concerns. The findings also reveal how their understanding of non-conforming sexual orientation and professional values influenced the way they perceived and interacted with LGBTI patients. There are three sub-categories in the category: ‘maintaining professional objectivity’ and they tend to occur concurrently and simultaneously, overlapping as causal conditions and as consequences of the process. In interaction with LGBTI patients, the nurse participants realised their professional ‘self’, and therefore: 1) developed awareness of their professional values; 2) developed ways of valuing human dignity; and 3) maintained their moral and professional obligations. Therefore, based on the findings during data analysis, three sub-categories that formed the category: ‘maintaining professional objectivity’ emerged as: 1) ‘establishing a therapeutic relationship’; 2) ‘valuing human dignity’; and 3) ‘acknowledging professional obligation’. It is interesting to note that most of the concepts that appear in the sub-categories could also be placed into other categories and sub-categories. For example, under the category: ‘maintaining professional objectivity’, the sub-category 4.1: ‘establishing a therapeutic relationship’ overlaps with the sub-category 4.2: ‘valuing human dignity’ and subcategory 4.3: ‘acknowledging professional obligation’. The latter sub-categories could be viewed as both the causal condition to and/or the consequences of establishing a therapeutic relationship.

Humans are the result of having a ‘self’ whose behaviour is a product of what takes place from the outside, the inside, and/or both. He acts toward his world, interpreting what confronts him, organising his actions on the basis of the interpretation (Blumer 1969:63-64). Therefore, humans are capable of self-interaction. When a protagonist is confronted with a situation in which he has to act; he initially takes into cognisance relevant factors in order to act. He is able to do this by interacting and communicating with himself; thereby constructing his line of action, while noting what is demanded of him before deciding what to do. Through self-interaction, he is able to set up the goals of his interaction, and anticipate the consequences of his actions (Blumer 1969:5556). This process of self-interaction helps the person to respond to a situation by either suspending, abandoning, transforming, reorganising and/or adjusting his anticipated actions to suit his norms, values, and group prescriptions for before implementing those actions. In essence, actions are the result of what the actor took into account; how he observed what happened; how he interpreted what happened; as well as what he anticipated to be the consequences of his actions. Therefore, actor’s actions are an interpretation of what led to the selection and execution of those actions (Blumer 1969:66).

Similarly, when nurse participants became aware of their own values and beliefs, this happened through interaction with themselves, and thus, with society. Thus, in this study, for the nurse participants, developing awareness of their professional values influenced their thoughts, decisions, actions and interactions with others. Data in this study revealed that the nurse participants’ responsibilities towards caring for LGBTI patients and treating every patient in a humane manner remained the main focus throughout the process of maintaining professional objectivity, as nurse participants realised their professional values. Nurse participants applied and maintained their professional values as a guide to effectively interacting with and meeting the health care needs of LGBTI patients.

4.4.1. *SUB-CATEGORY 4.1: ESTABLISHING THERAPEUTIC RELATIONSHIP*

The majority of the nurse participants in this study adopted a strategy of 'establishing therapeutic relationship' during clinical interaction with LGBTI patients, as they reflected on their professional values. In this study, nurse participants were able to recognise their professional identity and therefore adopted a stance of enhancing a therapeutic relationship during their interaction with LGBTI patients. Most nurse participants shared several strategies that they used in 'establishing a therapeutic relationship', whilst providing care to LGBTI patients. The strategies tended to occur concurrently and/or interchangeably as nurse participants provided a description of how they would enhance the care that they provide to LGBTI patients, under what conditions, and with what consequences. The strategies are described as: 1) establishing rapport; 2) increasing the patients' comfort level; 3) being available; 4) gaining patients' trust; 5) engaging in open communication; 6) reaching out to the patients; 7) having good communication skills; and 8) treating people with respect. The strategies identified overlap with one another; some occur as causal conditions whereas some occur as the effect of the consequences.

However, strategies that were common to most nurse participants throughout the process of 'establishing therapeutic relationship' were those of increasing the patients' comfort level and engaging in an open communication during their interaction with the LGBTI patients. It was interesting to note what "increasing the patients' comfort level" meant for the nurse participants, where they explained that this was followed in situations where the nurse participants realised that the topics or issues being discussed during clinical care were sensitive and might cause discomfort to the patients. In this study, increasing the comfort level of the patients meant creating an enabling environment in which the patient would feel safe and free enough to disclose his/her personal and sensitive information without being judged. Nurse participants in this study mentioned how they had attempted to make the patients feel comfortable and relaxed, which consequently assisted them in engaging in a more open mutual

communication. One nurse participant mentioned increasing her patient's comfort level by reassuring the patient of her availability whenever he needed someone to talk to. The nurse demonstrated shared humanity by attempting to know her patient better, extending their relationship beyond clinical practice by inviting her LGBTI patient to her home, as well as informing him that her door was always open, and that he was welcomed. Assuring the patient of a caring presence facilitated the development of trusting, healthy relationships.

> *… otherwise the patient was very calm and then, we had a very good relation together with that patient because he didn't … even hesitate to tell me the problem, then we even made the friendship, relation with the patient that when he comes … we'll make some talks and we'll make some relationship, I even gave him some my addresses that, "whenever you have anything or what if you want to talk to me, you can come and visit me even at the clinic, never be afraid, whatever that you want, come to the clinic and talk to me, you know my consultation." I gave him my consultation to come and see me and then … he must never hesitate, he must just ask … the clerks at the reception that I want to see sister Mary and then they'll tell … him … my consultation as long as I know what our relation is. So it was a very good … relation, together with … the gay patients* (NP1).

Nurse Participant 2 shared that what influenced her patient to feel comfortable during their clinical interaction stemmed from her acquaintance with LGBTI people. She mentioned that being acquainted with LGBTI people has, over time, taught her to love and accept people irrespective of their non-conforming sexual orientation. Nurse Participant 2 reassured her patient that in her view one can't pretend to be a lesbian. For Nurse Participant 1, she referred to increasing her LGBTI patient's comfort level by giving him a warm welcome when she greeted him, asking him about his personal details, and applauding him for being neatly dressed. Furthermore, she explained her role as mother to him, which encouraged her patient to freely engage in open communication. For Nurse Participant 1, being available and present has enabled the patient to find connection and meaning in his situation.

> *I think … what made this … patient to be open to me because first thing when the patient entered into my room, that warmly acceptance that he … received from me, you know first thing we greeted to each other and then I asked him where he is staying and the age, I even praised him for … being so beautiful … so I'm Sister Mary and then you are welcome into my consultation, you know I like people who are open, you know I've got so many children … I told him my social life and … this patient, what made him to be so open, not to fear is because I welcomed him, to my consulting room, I said he must never be afraid, I'm a human being like himself, I'm his mother …* (NP1).

For Nurse Participant 4, increasing the comfort level of her patient and establishing rapport was demonstrated when she attempted to ascertain from her patient whether he was comfortable to talk about what had brought him to the clinic. That question established trust for more open communication, where it became easier to discuss health concerns. On the same note, Nurse Participant 4 further reassured her LGBTI patient of confidentiality as well as her availability should there be a need for follow-up after treatment.

> *… I reassured my patient, that whatever we discuss, is confidentiality and then if he is not certain, or there's no improvement based on the treatment that I am going to offer on the table for him, he still needs to come back, it will be preferably highly advisable that he can come and make a follow-up with the same sister* (NP4).

In this study, nurse participants revealed that they were able to engage in open communication with LGBTI patients as a result of having established rapport with them. Therefore, developing rapport became another strategy for enhancing a therapeutic relationship. By developing a rapport, some LGBTI patients felt that they were valued by the nurses; that the service was available to meet their needs; and that as a result, they gained confidence in and developed the desire to return back to the health care service. At the same time, whilst establishing rapport with the patients, nurse participants developed

a connection with the patients in an attempt to develop and sustain a therapeutic relationship.

For most nurse participants, developing rapport with LGBTI patients was established by: 1) attempting to ascertain the comfort level of the patient; 2) having good listening skills; 3) assuring the patients of confidentiality and their availability; and 4) demonstrating an empathetic understanding. Nurse participant 3 established rapport with the LGBTI patient by making herself available to him and by assuring him of maintaining their good relationship, even beyond the clinical practice. On the same note, Nurse Participant 3 described the positive outcome she had following having established a rapport with the LGBTI patient. She asserted having observed that every time the patient visited the clinic, he wanted to be helped by her because the patient had trust in her, along with her reassurance that he will be treated appropriately.

> *… the outcome was good because every time when he comes to the clinic he wants to see me, he will wait there with the file then say "I'll want to see that, Sister." I think maybe because we … developed … a rapport with … him, then every time when he comes, he knows that if he comes to me I'll be able to-to treat him correctly* (NP5).

One nurse participant expressed the importance of making a conscious effort of reaching out to patients by: 1) having effective communication skills; 2) listening to them; and 3) allowing them time to vent their feelings and concerns as a means to establishing rapport. Having those important attributes had helped some nurse participants to take into cognisance the needs of LGBTI patients, and to respond to those needs accordingly.

With Nurse Participant 3, 'establishing rapport' was a process that involved group interventions with her patients. During the group interventions, she established and maintained good relationships with patients, as she delivered life skills programmes to them. As they interacted with each other, her patients

were able to gain her trust to the extent that some of them were able to disclose their non-conforming sexual orientation. For Nurse Participant 2, 'establishing therapeutic relationship' became obvious when the LGBTI patient started engaging in an open communication and consequently disclosing her non-conforming sexual orientation to her. She responded in a friendly manner and reassured her patient of confidentiality and her availability to assist him in addressing his health needs.

> *… he must be free for whatever he want to tell me, I'm here to come and help him, he must never be afraid that I'm going to say this and that, no … I said I talk to him very friendly and then he start to open, that is why I think he just judged me and said "no, this one is a woman, a mother, I'm going to tell him, I'm not going to lie, I'm going to tell her the problem that I'm having, I want help …* (NP2).

Encouraging open communication became another strategy that became obvious whilst 'establishing therapeutic relationship'. Encouraging open communication required the nurse participants' ability and desire to encourage LGBTI patients to freely engage in an open conversation during clinical interaction. Encouraging open communication became an attribute necessary to optimising and sustaining the nurse-patient interaction and service delivery. In the context of PHC, nurses are usually the initiators of the conversation during interaction with the patients, and as a result, patients perceive them as authority figures. Therefore, to bridge the power relational gap, nurses have to be sensitive during their conversation with LGBTI patients, and take into cognisance that LGBTI patients would not engage in conversations that threaten their comfort zones and/or that they perceive as not meaningful and relevant to their health care needs. For Nurse Participant 4, in order to gain trust and maximise patient's engagement, she became aware that probing into the patient's sensitive affairs could be a barrier towards engaging in an open communication. Therefore, she brought up the subject of encouraging her LGBTI patient to engage in open communication, "breaking the ice" before probing into sensitive aspects of health care with the patient. For Nurse

Participant 4, before she could ask her patient any questions, commenced the conversation by letting her patient know that she was aware that the topic they were discussing was sensitive. She wanted to ascertain that her patient was comfortable to relate his health concerns to her. Furthermore, she suggested asking open-ended questions, giving the patient room to vent, providing relevant information, and taking care not giving the patient solutions, but suggesting alternative solutions to his concerns where these may be valid. By so doing, she gave the patient the space to respond as a way of engaging in open communication, and deliberately liberated her patient from the discomfort of communicating sensitive information.

These approaches that the nurse participants reported are congruent with what was shared by LGBTI participants during the interview. From the data, it could be concluded that some LGBTI participants were looking for cues of an enabling environment before deciding to engage in open communication with the nurses. For them, engaging in open communication included sharing with the nurses their health concerns as well as disclosing their sexual orientation to them. It is important to note that LGBTI participants would scan the clinics' environment for clues of safety to avoid being emotionally hurt, should they decide to engage in open communication and disclose their sexual orientation. LGBTI participants in this study shared that the nurses' attitudes and behaviours towards them could either facilitate or hinder open interactive communication and consequently, the possibility of disclosing their sexual orientation.

According to LGBTI participants, nurses' words, tone of voice, and body language were perceived as creating either a safe or unsafe place for facilitating open communication and disclosure of sexual orientation. LGBTI Participants 4 and 5 shared how they were able to engage in open communication after the nurses used verbal cues that prompted that they were sensitised to LGBTI issues. LGBTI Participant 5 raised the importance of how the nurse's verbal cues played a significant role in how he felt about his sexual

orientation, and how it made him feel comfortable to engage in open communication. LGBTI Participant 1 and 3 shared the same sentiment as did LGBTI Participant 4 and 5, by stating that they were also seeking verbal cues and information that would cause them to feel safe and comfortable to engage in open communication with the nurses. For LGBTI Participant 3, what would make him feel free and comfortable to disclose his sexual orientation to the nurses is when he would interact with friendly staff members, who were non-judgmental about his sexual orientation. He would feel comfortable when the nurse were asking him gender-neutral questions and expressing a sense of humour when asking him questions.

> *… we have to see friendly staff members who would speak … not bias, who would ask you if you have a girlfriend or a boyfriend even if it is in joking manner, then you would feel comfortable and free, then you would see that this is a gay friendly clinic* (P3).

LGBTI Participant 3 asserted that he felt content and comfortable about the manner in which the nurse asked him questions, and therefore was able to further engage in open communication, whereby their conversation moved from discussing medical issues, to discussing psychological and emotional issues as well. The whole experience had taught LGBTI Participant 3 that there were nurses in the health care system that have an understanding of LGBTI issues. On the same note, LGBTI Participant 1 suggested that, if the nurses could provide him with the information that he required and asked him questions related to his sexuality, he would have felt much more comfortable to engage in an open communication, to actually talk about whatever he wanted to talk about, including disclosing his sexual orientation.

From the findings, it could be concluded that nurse participants ought to be sensitive with regard to the questions they ask that relate to the patient's sexuality, and how they ask these questions. The manner in which they pose the questions should be adapted to the LGBTI terminologies and the language used in a particular district. This can enable LGBTI people to feel free to

engage in open communication and to disclose their sexual orientation to the nurses. This means that when they pose questions around sexuality and sexual orientation, they should display an attitude of inclusivity, without being judgmental, and eliminate the possibility of assuming a heterosexual stance. By so doing, it will allow LGBTI people to feel that the nurses acknowledge that there is diversity in sexual orientation and gender identity.

4.4.2. *SUB-CATEGORY 4.2: VALUING HUMAN DIGNITY*

'Valuing human dignity' emerged as a fundamental process that supports the category: 'maintaining professional objectivity'. The sub-category developed from the data that demonstrated different ways of showing respect for human dignity. Data from the interview revealed the actions and processes of how nurse participants recognised their professional values and moral obligation of respecting human rights whilst interacting with LGBTI patients in clinical practice. 'Valuing human dignity' became a process of expressing professional values in clinical practice by rendering care to LGBTI patients in a humane manner. The indicators of 'valuing human dignity' were identified as: 1) "respect for others"; 2) "respectful communication"; 3) "treating everyone the same"; 4) "being sensitive to patients' unique circumstances and health needs"; and 5) "being non-judgmental", which resulted in a caring professional conduct and increasing the patients' sense of self-worth.

> *I think we need to give them benefits of … a doubt, to see themselves as human being amongst us, and to be treated with respect, and not to be judged* (NP4).

For nurse participants, 'valuing human dignity' was seen as a process of: 1) continuously identifying and reflecting on professional ethics and values; 2) changing personal values and attitudes; and 3) reorganising actions to demonstrate a professional attitude that is focused on caring for human beings with respect and dignity. In this study, nurse participants related to adopting a non-judgmental attitude, which demonstrated actions that relate to changes in both their thinking and behaviour.

Therefore, adopting a non-judgmental attitude by nurse participants was seen as a conscious and intentional process of respecting human dignity, in order to prevent doing any harm to the patients. A characteristic that was most distinct for nurse participants was caring for patients in a humane manner. Nurse Participant 2 has, over time, learnt not to use her Christian value to judge the patients based on their circumstances, but to treat all patients with respect.

Similarly, Nurse Participant 2 alluded that nurses have a duty toward treating all the patients in a humane manner and adopting a non-judgmental attitude. She described the indicators of treating patients in a humane manner as: 1) "showing love"; 2) "having a positive attitude"; 3) "addressing patients with their titles rather than their names"; 4) "treating patients comprehensively"; and 5) "effectively responding the health care needs of the patient", which will results in patients' satisfaction.

> *… we must admit our patients with love, and … not have … all these attitudes that we are having as nurses and treat them as human beings and … leave this thing of judging, when the patient comes we must never judge and say this is so and so … we must take everybody as human being and … when we see them we must address them as 'Mr.' and 'Mrs.' … then we must never … call these people by their names. So let's give them that love and treat them comprehensively and then give them … whatever the problem they came in with, let's solve those problems and forget … this thing of judging … So, I think that will help other and then we can get … a good nation and a proper nation…* (NP1).

Nurse Participant 4 attempted to bridge the power relation gap by distinguishing to her patient the different roles that she plays i.e. her personal role of being a mother and her professional role of being a nurse. She explained that, as a professional nurse, she has the moral obligation of being non-judgmental towards LGBTI patients. She declared this information to the LGBTI patient in order to gain his confidence and trust to enable him to revisit

the health service when the need arose. For Nurse Participant 4, educating the patients and being non-judgmental to them will not only help the patient to freely communicate their reasons to visit the clinic, but will also restore the dignity of the patients which she referred to as entailing:

> *… see themselves as human being amongst us, and to be treated with respect, and not to be judged* (NP4).

Furthermore, Nurse Participant 4 alluded that being non-judgmental to the LGBTI patients will also assist those that are close to LGBTI people to accept them and not to discriminate against them. She warned that being judgmental with the LGBTI patients could have negative consequences for their wellbeing, which she referred to as "total destruction" and "bringing sadness and agony" to them. On the same note, for Nurse Participant 3, being non-judgmental meant focusing on their professional values and prime responsibility of rendering services to the patients, putting personal feelings and values aside and accepting people as they are.

Another concept that was revealed by the nurse participants that demonstrated valuing human dignity was "treating everyone the same". Treating everyone the same implied applying the principles of human rights and of equality when treating patients. Data in this study revealed that the majority of nurse participants have internalised their professional values and therefore focused on the principles of equity and social justice. One nurse participant mentioned that she cared for all her patients equally, irrespective of their social background and circumstances. Most nurse participants in this study viewed caring for LGBTI patients as treating them with equanimity.

> *… they are human beings, given treatment in totality, they must be treated like everybody, they are supposed to be treated … as unique people of which they need special treatment because they are gays, they can't be … differentiated from other people, they are human beings, they … need to be treated in totality and equally, so I don't think their needs are unique … they must be treated in totality like everybody and get*

the full treatment like … every normal human being (NP1).

Nurse Participant 5 is of the opinion that treating LGBTI patients the same as other patients entails, for example, putting them in the same queue as any other patients in the clinic and not discriminating against them. She mentioned the importance of welcoming them and being friendly to them and making them feel comfortable. For Nurse Participant 3, treating LGBTI patients the same as others implied not viewing patients' sexual orientation as significant when rendering care to them. She is of the opinion that people's sexual orientation does not define who they are. She shared that she treated the LGBTI patient as she would treat any other patient. For Nurse Participant 3, treating the patient was guided by her professional values and ethical standpoint of having the moral obligation of respecting his humanity and uniqueness and not doing any harm to him. She warned that if nurses treat LGBTI patients differently from others, it would result in patients not returning for their follow-up treatment, which will have detrimental effect on their health outcomes.

On the other hand, Nurse Participant 4 asserted that LGBTI patients should be provided specialised health care services, because they have unique health care needs to those of their heterosexual counterparts. She indicated that they needed nurses who have good listening skills and are able to accommodate their unique needs. She believed that having specialised health care service for LGBTI people would promote their access, acceptability and affordability to health care, which would ultimately enhance the health care that they receive. Nurse Participant 3 shared a similar view to Nurse Participant 4 by regarding LGBTI people as having unique physical and emotional needs, due to the fact that they express themselves in a different sexual way. Therefore, according to her, LGBTI patients require specialised health care services.

4.4.3. *SUB-CATEGORY 4.3: ACKNOWLEDGING PROFESSIONAL OBLIGATION*

'Acknowledging professional obligation' became the third sub-category that formed the category 4: 'maintaining professional objectivity'. 'Acknowledging professional obligation' was a process that most nurse participants in this study discussed during their interaction with LGBTI patients. Data in this study revealed that what has helped most nurse participants to be able to attend to the patients' needs, was when they reflected on the nursing core value and the principles of care which they have learnt along their professional life. '*Acknowledging professional obligation'* has assisted the majority of nurse participants in this study to base their decisions and actions on professional values and principles whilst caring for LGBTI patients.

In this study, once nurse participants acknowledged their professional identity, being guided by the core values of the nursing profession, they adopted several strategies that demonstrated their moral and professional obligation towards LGBTI patients. Areas that demonstrated nurse participants' acknowledgment of professional and moral obligations involved: 1) the quality of interaction and actions with patients; 2) their being and presence during the interaction; and 3) the competencies that are required to conduct themselves in a professional and caring manner. Those areas were seen to be guided by professional values and served to direct and set boundaries on the actions and interactions that explain in some ways how nurse participants balanced and maintained their personal and professional selves whilst they undertook their professional nursing roles and obligations. By upholding their professional values, nurse participants are being guided to acknowledge the diversity of LGBTI patients, whilst at the same time, acknowledging that patients have the same rights as do others, being treated the same regardless of their circumstances. For the nurse participants, being guided by their professional values when providing clinical care has also helped most of them to understand LGBTI patients' circumstances so as to overcome the initial attitudes, beliefs and preconceived ideas that they had about LGBTI people.

In this study, the majority of nurse participants claimed that what has helped them most to be able to attend to the patients' needs, was when they reflected back upon the nursing core value of care. For most nurse participants, reflecting on their professional values has helped them to interact with the patients effectively. Some nurse participants referred to their nursing values as embedded in the "nurses' oath", "nurses' pledge of service"; and "nurses' code of ethics". Some referred to human rights principles, which in SA is called the "*Batho Pele*" principles, some referred to the "Nightingale's principles of care", whereas some referred to their motivation for becoming nurses, and others to their personal and professional commitment.

> *… colleagues must improve in their … career. Let it not be a downfall but … let it be … highly… reconsidered service like before during the Nightingale's time … let us comply with the Batho Pele principle that will help us a lot* (NP4).

One nurse participant mentioned that she reflected back on the nurse's pledge of service and asked herself about what had motivated her to become a nurse in the first place. Her nursing values, she noted, have enabled her to reach out to her patient's concerns and attend to them without being judgmental. She further alluded to the importance of listening to her patient, and to having deeper understanding of the reasons why the patient came to the clinic in the first place.

> *I looked back into the pledge of service: why did I choose to become a nurse, to help people, in accordingly, in appropriate to what are the symptoms, not to be judgmental? Because … you need … to put up your listening skill … upfront, and then you give the patient* [time] *to vent* [ventilate]*, the main reason, sometimes you see for … you reach out to the patient who's there for a certain main reason* (NP4).

Nurse Participant 3 mentioned that for her to add value in the way she cared for LGBTI patient was aided by the code of ethics. When Nurse Participant 2 was asked about what helped her to manage her LGBTI patients efficiently, she shared similar views as Nurse Participant 4, by giving credit to the nurses' pledge of service, meaning the nurses' oath that nurses undertake once they become registered. She alluded to the fact that the nurse's oath has helped her to acknowledge the difference in others, and to commit to treat her patient unconditionally and in a non-judgmental way. One nurse participant reflected on how whilst interacting with her LGBTI patient, she noted that as a nurse she acknowledged that people are different and therefore cannot judge them based on their sexual orientation.

> *… I explained to the patient that … I understand that … we are different and there are lesbians, there are gays and we cannot judge them, so … she's a lesbian, he's a gay or bisexual, he must feel free to tell me* [so] *that I can treat her … properly* (NP5).

Nurse Participant 4 articulated the moral aspect of her professional accountability in her statement that nurses should always refer to their primary purpose and obligations as nurses, which is to provide quality health care service to the patients. She is of the opinion that when rendering care to the patient, she always strives to render quality care, by putting the needs of her patients first, so that she can leave a legacy to be remembered with by her patient even when she had retired. This concludes the discussion on the three sub-categories, namely: 1) 'establishing therapeutic relationship'; 2) 'valuing human dignity'; and 3) 'acknowledging professional obligation'. The core category as informed by the four categories and their related subcategories will now be discussed.

4.5. *THE EMERGENT CORE CATEGORY: REFRAMING PERSONAL AND PROFESSIONAL VALUES*

The discussion that follows elucidates the epistemological stance of the participants, which informed the emergent core category of this study and demonstrates its relationship to all other categories and sub-categories. The categories and subcategories that emerged from the data informed the conceptualisation of the core category and subsequently the substantive theory of this study.

According to Birks and Mills (2015:12), a core category emerges when the researcher can trace connections between categories and sub-categories that occur frequently during data analysis. Furthermore, the core category must be central to the data and must relate to most other categories (Glaser 1998:115; Goulding 2002:88). Similarly, in this study, the core category that emerged from data analysis was that of: 'reframing personal and professional values' and was seen to be central to the data and related to most of the other categories. The core category emerged during theoretical coding, when the researcher moved beyond the coding stage to raising main categories (Charmaz 2006:138). During this process, the researcher reflected and cross-examined all the data sets i.e., transcripts, ATLAS.ti data analysis reports, field notes and memos, which assisted her in expanding the understanding of the participants' core concerns. This process has ultimately helped the researcher to realise that raising categories into theoretical concepts required identification of categories that occurred frequently and answered the research questions (Charmaz 2006:139), which in this study was: what are the basic social processes involved in facilitating LGBTI youth-inclusive PHC in Tshwane District, Gauteng Province, SA?

The core category revealed the meanings, processes and contexts for the studied phenomenon of facilitating LGBTI inclusive PHC. The core category that emerged was constructed based on the analysis and interpretations of both LGBTI and nurse participants whereby they provided a descriptions of

their experience as they were interacting with each other during clinical practice. Eventually, the interactions between four categories revealed the emerging core category: ‘reframing personal and professional values’. Therefore, the findings of this study were able to address the research objectives which were to:

- explore and describe the experiences of LGBTI youth regarding health care they received in PHC clinics;
- explore and describe the experiences of nurses regarding caring for LGBTI youth in PHC clinics; and
- explore and describe the basic social processes involved in facilitating LGBTI youth-inclusive PHC.

Category 1: ‘recognising personal subjectivity’, demonstrated the challenges that participants encountered as a result of having conflicting values. On the other hand, Category 2: ‘tackling and overcoming personal subjectivity’; Category 3: ‘seeking understanding of LGBTI people and their health care needs’; and Category 4: ‘maintaining professional objectivity’, demonstrated the processes that participants employed to attempt to overcome those challenges posed by having conflicting values, thereby enhancing health care utilisation by LGBTI people. The categories depict how participants understood, interpreted, and discovered their self-concepts through their experiences within the physical, psychological, social and structural contexts. Self-concept refers to “how people see themselves in society and is formed by an evolving vocational identity comprised of the individual’s work values, interests and abilities that change over time” (Piko 2014:36). Therefore, the central concept that shaped the core category remained the use of the notion of the self-concept, understanding it as shaping how people think and feel about themselves, others and the environment, and ultimately determining how they perceive others and how they respond to situations. Nurses develop a concept of self through personal and professional interactions with others. Therefore, it is through social interactions that individuals share symbols and create meanings of self, others and situations (La Rossa & Reitz 1993:149).

This notion of the self-concept is in line with the perspectives of Blumer's symbolic interactionism and the theory of Cooley of the "looking glass self", which assert that people tend to form an image of self mainly from reflecting on and responding to how other people perceive them (Cooley 1902/1983a:183-184). In essence, people's actions are influenced by the reflections of themselves through others.

All of the categories and sub-categories can be described as interdependent and interconnected, and therefore influenced one another and the core category: 'reframing personal and professional values'. Each category contained concepts that were located in sub-categories, due to their frequent appearance in the data. At the same time, it should be noted that most of the concepts that appear in the subcategories are intertwined, and overlap, and could also be placed into other categories. At some point of data analysis, participants' quotations were fitted into more than one category or sub-category. All the concepts were instrumental in developing and supporting the actions and processes of 'reframing personal and professional values' as a way of facilitating LGBTI youth-inclusive PHC. The categories and sub-categories that emerged from the data and informed the conceptualisation of the core category will be discussed in greater depth in the next chapter.

As Mead (1967:135-138) has suggested, people interact with themselves and become aware of their beliefs, values, and attitudes. They become objects to themselves. Their ability to interact with themselves is attributed to the development of the 'self', which develops over time in social interaction with others. The 'self' is an object to itself in the same way as other people are objects to the person. The person views him or herself in such cases as other people would have viewed him. The object that he or she becomes to his or herself represents not only how others (the society) react towards him, but also to how he as a member of society contributed to society views. The person as a member of society shapes the views of society, and when society interacts with him or her, they in fact interact with themselves. When they interact with

themselves and judge their own values and beliefs, it is in fact the society who interacts with them. The nurses are part of the nursing society and whilst in interaction between members of the society, their values and beliefs are shaped, and when nurses become aware of their own values and beliefs, this happens through interaction with themselves, and thus, with the society.

In this study, nurse participants were able to recognise and acknowledge how their values and beliefs influenced their thoughts and perceptions about oneself, others and the environment, how they differ from those of others, and how they influenced interaction with others. Being aware of their own values, beliefs and attitudes provided the nurse participants with the moral judgment of counteracting any prejudice and intolerance that they might have towards their LGBTI patients. The nurse participants were able to reframe their personal and professional values by adopting strategies to help them maintain their professional objectivity. People behave in a manner that is consistent with the perceptions that they hold of themselves, and interpret any experience inconsistent to their perception as compromising their self-identity (Blumer 1969:62). As a result of this process, the nurses became motivated to preserve their professional identity and their moral and professional obligations towards their patients, despite having realised that the culture of the LGBTI people was incongruent with their values and beliefs.

4.6. CONCLUSION

In this chapter, the findings were presented and discussed as four categories each with its related sub-categories. The categories were identified as Category 1: ‘recognising personal subjectivity’; Category 2: ‘tackling and overcoming personal subjectivity’; Category 3: ‘seeking understanding of LGBTI people and their health care needs’; and Category 4: ‘maintaining professional objectivity’. The findings reveal that the majority of nurse participants were reflecting on their personal and professional self and that has helped them in developing awareness of and applying their personal and professional values in clinical practice to influence the facilitation of LGBTI inclusive PHC. The core category: ‘reframing personal and professional values’ emerged through theoretical coding as a response to situations in which participants felt that their values and integrity were compromised. LGBTI participants were of the opinion that nurses imposed their values on them and lacked the necessary knowledge about LGBTI health care. That notion was confirmed by the nurse participants, where the nurse participants developed strategies of seeking understanding of patients, to treat them in a humane manner whilst preserving LGBTI patients’ dignity and maintaining their professional self. Data revealed how nurse participants constantly reviewed their personal and professional values and the causal conditions that facilitated the implementation of those values. The nurse participants found themselves reflecting further on their personal and professional values and were, over time, able to pursue personal and professional transformation of their values, attitudes and behaviours to establish an effective nurse-patient relationship.

CHAPTER 5:

DEVELOPMENT AND DESCRIPTION OF THE CORE CATEGORY

5.1. INTRODUCTION

In Chapter 4, the findings of the study provided a description of how the core category of this study emerged. The findings of the study were described in the form of a storyline, a colloquial term used to define the summary of the findings (Strauss & Corbin 1990:116; Birks et al. 2009:406), substantiated with quotations from the interviews and by making reference to the theoretical framework underpinning this study, which is symbolic interactionism. Symbolic interactionism provides a model where the 'self' is understood as developing out of interaction with the world, and focuses on how individuals interpret meanings and act in specific contexts (Mead 1967:135-138), which in this study, implies the meanings of LGBTI youth and nurses' actions and interaction within the context of PHC. This chapter will focus on the categorical and theoretical interpretations of the findings of Chapter 4, leading to the emergent theory. An overview of the core category and its related categories and sub-categories will be provided. The researcher endeavoured to ensure that the core category that developed from this study is generated from the participants' data, illustrating that it is positioned within a specific context, and discussing what participants view as the main concern of the phenomenon being investigated.

In this chapter, the core category will be further highlighted and theorised. Theorising is an interpretive process that involves constructing an explanatory scheme from the data that systematically integrates various concepts through various statements of relationships (Strauss & Corbin 1998:25; Goulding 2002:44). According to Charmaz (2006:10), theories serves as a means of engaging with the world, and of constructing abstract understandings about and within it, which in this study, was the result of identifying and describing four main categories from the emergent data, and linking them together. The phenomenon of interest in this study was the process of facilitating LGBTI youth-inclusive health care, during

interaction between nurses and LGBTI patients within the context of PHC. Charmaz (2006:130) asserts that "…theory depends on the researcher's view; it does not and cannot stand outside of it. Granted, different researchers may come up with similar ideas, although how they render them theoretically may differ." Therefore, in this chapter, a brief discussion of the researcher's perspective on the research method, data collection and analysis, the findings; and ultimately the development of the core category will be provided.

5.2. LOCATING RESEARCH METHODOLOGY

Grounded theory aims to develop substantive theories of social processes. Glaser and Strauss (1967:32) differentiate between substantive and formal theory by asserting that substantive theories are developed for a substantive or empirical area of sociological inquiry, such as patient care, race relations, professional education, delinquency, or research organisations. On the other hand, formal theories are developed for a formal or conceptual area of sociological inquiry, such as stigma, deviant behaviour, formal organisation, and socialisation. Because grounded theory seeks to discover the participants' perspective, the aim of the research had to be formulated in such a way that it incorporates the participants' perspectives on the problems they encounter and how they resolve those problems in clinical practice.

Thus, this study sought to gain insight into participants' perspective on experiences, actions, interactions and meanings on how they handle their situation during interaction in clinical practice. Discovering more about the concerns of LGBTI youth when accessing health care, and how the nurses could assist them in accessing LBTI youth-inclusive health care services was critical to this study. The purpose of grounded theory research is to uncover participants' main concern in a substantive area and to provide a conceptual account of the main resolution to their concern or problem. The main resolution is also known as the core category (Glaser 1998:115). Similarly, in this study, the term main concern implied the main problems that the participants discussed. The term main resolution implied strategies employed

by the participants to resolve the main concern and was used interchangeably with the term core category. In grounded theory methods conceptualisation is achieved through the process of constant comparative data analysis (Hallberg 2006:144). Codes are generated from asking about the main concern of participants, which in this study is:

- how do nurses and LGBTI youth experience their interaction in PHC in Tshwane District, Gauteng Province, South Africa?
- what are the basic social processes involved in facilitating LGBTI youth-inclusive PHC in Tshwane District, Gauteng Province, South Africa?

The first question focused on how the nurses and LGBTI youth experienced their interaction, how they interpreted the interaction, and what meaning they attached to the experience. The second question focused on unfolding how the basic social processes of facilitating LGBTI youth-inclusive care happened in the context of PHC, thereby theorising the process. Together, the research questions were more concerned with understanding the processes involved in human social interaction, and constituted the fundamental phenomenon around which the study evolved.

These questions are the starting point of the research process. Charmaz (2006:20) asserts that soliciting answers for such questions may not be as straightforward as the questions suggest. For example, what one defines as ‘basic’ is always an interpretation, even when major participants concur. Therefore, presenting the core category informing the substantive theory of the study in this chapter, such that it makes sense to the reader, was a difficult exercise. The researcher struggled to make a decision with regard to commencing with describing the categories, the subcategories and then concluding with an overview of the core category, or vice versa. The researcher examined how other grounded theory studies were structured and it was apparent that they were all structured differently depending on the researchers’ perspectives. Eventually, for the researcher, the most logical way, on behalf of the reader, was to commence with explanation of the key concepts that formed the core category and to conclude with providing an overview of

how the core category is related to the categories and their sub-categories. Therefore, the discussion will be presented under the headings of the core category, the categories and the subcategories that were discussed in Chapter 4, where connections within and between concepts that emerged during data analysis process will be put into perspective (Charmaz 2006:159). To simplify reading, the core category will be highlighted in bold italics, the categories in bold, and sub-categories in italics.

5.3. CONCEPTUALISATION

Conceptualisation is the core process of grounded theory, whereby the researcher discovers and generates new categories and properties from the data (Walker & Avant 1995:37). The purpose of conceptualising is to find new concepts for patterns, relating concepts to each other so as to give new understanding of what is happening, and generating a hypothesis of a substantive field. Therefore, the concepts represent categories of information that contain defining attributes (Walker & Avant 1995:37). Concept synthesis is a strategy for developing concepts based on observation or other forms of empirical evidence. As in all synthesis strategies, concept synthesis is based on observation or evidence. The data may come from direct observation, quantitative evidence, literature, or some combination of the three (Walker & Avant 1995:55). In this study, the process of conceptualisation involved collecting and analysing the data back and forth, and writing and exploring memos as described in Chapter 3, which resulted in the researcher engaging in several research stages at the same time. The following steps were applied in this study to collect and analyse the data:

a) initial purposive sampling of two target populations i.e. LGBTI and nurse participants;
b) initial process of data analysis was followed by theoretical sampling;
c) concurrent data collection and analysis;
d) coding and categorising;
e) memoing and theoretical sensitivity;
f) refining categories;

g) refining and connecting categories;
h) conceptualisation;
i) emergence of core category;
j) further refining and connecting categories through theoretical sampling;
k) theoretical saturation; and
l) emergence of substantive theory.

The purpose of concept synthesis is to generate new ideas. It provides a method of examining data for new insights that can add to theoretical development. Concept synthesis is useful in areas where observations of phenomena are available but not yet classified or named (Walker & Avant 1995:56). In order to generate a grounded theory, the researcher must be creative and be able to conceptualise. To facilitate the process of conceptualisation and to generate a theory, the researcher developed theoretical ideas, through writing down memos. Memos are the researcher's thoughts, ideas and writing, they can be short or long narratives, models or drawings, used to help the researcher to think at a higher conceptual level (Glaser 1978:83). Memos accomplish at least five important features of generating theory:

a) to raise the data to a conceptualised level;
b) to develop the properties of each category that define it operationally;
c) to present hypotheses about connections between categories and/or their properties;
d) to integrate these connections with clusters of other categories to generate theory; and
e) to locate the emerging theory with other theories for potentially more or less relevance (Glaser 1978:84).

5.3.1. NAMING THE CONCEPTS

The basic building blocks of a theory are concepts. Concepts are mental images of a phenomenon or an action; and are expressed by means of language, labels or words to enhance understanding. Concepts allow us to categorise our experiences in a meaningful way to ourselves and others, and prove even more useful when relationships can be drawn between two or more concepts to form statements (Walker & Avant 1995:24). A concept analysis may be rationalised for the purpose of theory development, understanding and operationalising of certain terms of which a variety of models exist (Walker & Avant 1995:24). Walker and Avant (2005:65) identify the eight steps of concept analysis which include:

a) selecting the concept;
b) determining the purpose of the analysis;
c) identifying the concept uses;
d) defining the attributes;
e) identifying model cases;
f) identifying antecedents;
g) consequences; and
h) defining empirical terms.

Re-examining preceding steps was necessary as the analysis progresses and deeper exploration occur (Walker & Avant 1995:37).

Statements are extremely important ingredients in any attempt to build a scientific body of knowledge. A statement in the context of theory building can occur in two forms, relational statements and non-relational statements. Relational statements refer to relationship between concepts which explain either association; correlation; or causality. A non-relational statement may be either an existence statement that asserts the existence of the concept or a definition, either theoretical or operational, and cannot be measured (Walker & Avant 1995:25). Theoretical definitions are used to describe the significant attributes of each concept. Operational definitions indicate the relationship between the dependent and independent variable or concepts (Walker & Avant

1995:25). Thus, a theory is an internally consistent group of relational statements that presents a systematic view about a phenomenon or process (action) and that is useful for description, explanation, prediction, and/or control. Associated with the theory may be a set of definitions, which are specific to concepts in the theory (Walker & Avant 1995:26). Theories encompass both concepts and statements; theory development frequently begins at the level of these latter two elements. The theorists starts with concept development; thereafter the statements get developed; and ultimately theory development (Walker & Avant 1995:27). Theories are developed in three ways:

a) Analysis: one clarifies, refines, or sharpens concepts, statements or theory when there is an existing body of theoretical literature (Walker & Avant 1995:28).
b) Synthesis: combines isolated pieces of information, where observations are used to construct new concepts, statements and theory (grounded theory manner) (Walker & Avant 1995:28).
c) Derivation: employs analogy or metaphor in transposing and redefining a concept, statement, or theory from one context to another (use concepts and statements from another discipline) (Walker & Avant 1995:29).

In this study, the concepts are placed within a theoretical context of symbolic interactionism, which added to their explanatory significance (Walker & Avant 1995:57). Once a concept is labelled and classified, it is substantiated through literature, field studies, and data collection, so as to discover whether the concept is empirically supported. The new concept should then be described in a theoretical definition that includes its defining attributes. The final step in concept synthesis is to determine, if possible, where the new concept fits into existing theory in the area (Walker & Avant 1995:58), which in this study is symbolic interactionism. The advantage of using concept synthesis as a strategy is that it provides a mechanism for creating something new from data already available (Walker & Avant 1995:61).

In this study, naming of the concepts was the key property of conceptualisation and a tedious trial-and-error process. In most instances, the words chosen were not necessarily appropriate with what one perceived and what one perceived changed constantly throughout the process of conceptualisation. However, the suitability of the name of the concepts chosen became refined as the patterns in the analysing process emerged (Glaser 2001:13). In this study, naming the core category followed as a result of understanding how the data developed and trying to fit different concepts together to form the core category. The concepts in the four categories that emerged through data analysis were examined and re-examined for similarities and differences. During that process, different combinations of abstract concepts emerged from the four categories that were described in Chapter 4. The concepts that describe the nurses shifting from having main concerns of 'having compromised values', 'experiencing conflicting values and tension', 'stereotyping others', 'being judgmental', 'feeling uncomfortable' to resolving the main concerns by 'changing values', 'shifting values', 'transforming the self', 'adapting to others' values', 'compromising own values', 'seeking knowledge', 'changing perception', 'empathising with others', 'accommodating' and 'valuing human dignity' were explored. All these suggested concepts combined, described the process of identifying and reflecting on own values and beliefs and then looking back into those values and beliefs to challenge and resolve irrational or maladaptive thoughts and behaviours that emerged as a result. This process resulted in naming the core category: ***reframing personal and professional values.*** It became clear that the core category: ***reframing personal and professional values*** has 'more explanatory power' (Glaser & Strauss 1967:70), and puts into perspective how the nurses resolved their main concerns in facilitating LGBTI youth-inclusive PHC.

As discussed in Chapter 3, the goal of grounded theory is to discover the core category as it resolves the main concerns of participants (Glaser 1998:115), which is the final stage of the process of theory development (Goulding 2002:88). The core category emerges through the process of coding and

abstraction of the data, until the data are finally incorporated into a higher level order, which requires that the researcher justify the basis for the emergent theory. A core category offers an explanation of the behaviour under study. It bears theoretical significance and its development should be traceable back through the data. This is usually when the theory is written up and integrated within existing theories to show relevance and a new perspective (Goulding 2002:88). Therefore, to generate the substantive theory, the researcher must first discover participants' main concern, which is then coded and condensed, to become the core category. The core category is the key point for the substantive theory, because most other categories relate to it, and it accounts for most of the variation in pattern and behaviour. Glaser (1998:115) has noted that "the prime function of the core category is to integrate the theory and to ensure that the theory is dense so that the relationships among the categories are comprehensive". The theoretical underpinnings that lies within the core category of this study, might explain the cognitive and reasoning processes that resulted in the nurses giving priority to facilitating LGBTI youth-inclusive care by overcoming their personal subjectivity. The core category provides a new insight into 'reframing personal and professional values', which is a complex and integrated process that involves personal and professional interpretation of the participants' situation and challenges. The core category: 'reframing personal and professional values' was central to the main concern of the nurses when they were experiencing value conflict and tension, and therefore developed ways of challenging those conflicting values and tension.

The purpose of this section is to present all elements of the core category. In this study, 'reframing' emerged as a conceptual term to explain the process i.e., series of actions of viewing and reflecting on values, experiences, ideas and emotions, and ultimately finding more positive alternatives to balance or mediate the care provided by nurses to LGBTI youth in PHC. This study initially revealed the nurses' main concern as actions of developing stereotypes when the nurses felt that their personal, social and religious values were inconsistent with those of LGBTI patients. In circumstances where nurses realised how their

personal, social and religious values impacted negatively on their interaction with LGBTI patients, they consequently developed ways that could facilitate care. The nurses developed strategies to ‘establish therapeutic relationship’ in response to some of the challenges posed by conflicting values. The nurses realised that they needed to change or compromise their personal values to be able to accommodate the diversity of LGBTI patients. Therefore, in this study, ‘reframing’ implies considering alternative frames, so that one can view things from a different perspective. Ultimately, the concepts that became apparent from the generation of the core category were ‘framing’, ‘reframing’ and ‘values’, which will be further elaborated upon in this section.

In this study, the process of ‘reframing’ commenced with a process that the researcher labelled as ‘framing’. As Walker and Avant (1995:51) discuss, the new concept should be described in a theoretical definition that includes its defining attributes. Frames structure peoples’ ideas and concepts, shape how people reason, and impact on how people perceive themselves and others (Mezirow 2009:22). As frames of reference, frames “provide criteria for judging or evaluating right and wrong, bad and good, beautiful and ugly, true and false, appropriate and inappropriate” (Mezirow 1991a:44). Framing is viewed as a cognitive and behavioural process that people use to help make sense of complex information by using frames (Lakoff 2004:iv,58; Crompton 2010:40). Similarly, in this study, the concept ‘framing’ explains the main concerns experienced by nurses when they used their values and beliefs as frames of references to stereotype and judge LGBTI patients and to feel uncomfortable and uncertain when caring for them. The process of ‘framing’ became apparent in the first category: ‘recognising personal subjectivity’, which will be discussed later in this chapter. “Framing” implied cognitive and behavioural processes that revealed how, for the nurses, making reference to their values and beliefs became a barrier to facilitating LGBTI youth-inclusive PHC. Furthermore, some nurses experienced cultural shock when they realised that their “frames”, which are their values and beliefs, were incongruent with those of LGBTI patients.

On the other hand, the concept ‘reframing values’ was identified as the main resolution of the nurses that explains personal and professional factors influencing the nurses’ traits and strategies that they applied to promote interaction with LGBTI patients. As previously mentioned, grounded theory provides a conceptual account of how the participants resolve their main concern, therefore, relating all the concepts to each other assisted in putting the participants’ main concern into a conceptual framework, which depicts the attributes of the core category. The core category is illustrated as a conceptual framework that identifies, defines, describes and examines the characteristics and variables of the concepts that indicate the basic social process of facilitating LGBTI inclusive PHC. The process of ‘reframing values’ which is the focus of the core category, followed that of ‘framing’ and is reflected in the second category: ‘tackling and overcoming personal subjectivity’, the third category: ‘seeking understanding of LGBTI people and their health care needs’ and the fourth category: ‘maintaining professional subjectivity’, which describe the main resolution of ‘*reframing personal and professional values*.’

Reframing implies “reshaping or redefining a perspective so as to bring others to a new point of view and new incentive to support that point of view” (Brown & Murti 2004:114). In this study, the researcher ultimately considered ‘reframing’ as the most suitable concrete concept (verb) that fitted the core category with the data, as it explained the basic processes involved in this study. For relevance of the theory, it was crucial to go through the process of naming the core category so as to ensure that the participants’ main concern and how they resolve it emerge from the data and is not forced. This study was able to let the basic social problems and the basic social processes of the participants emerge, and to fit the concepts with data to present what happens in the area being studied.

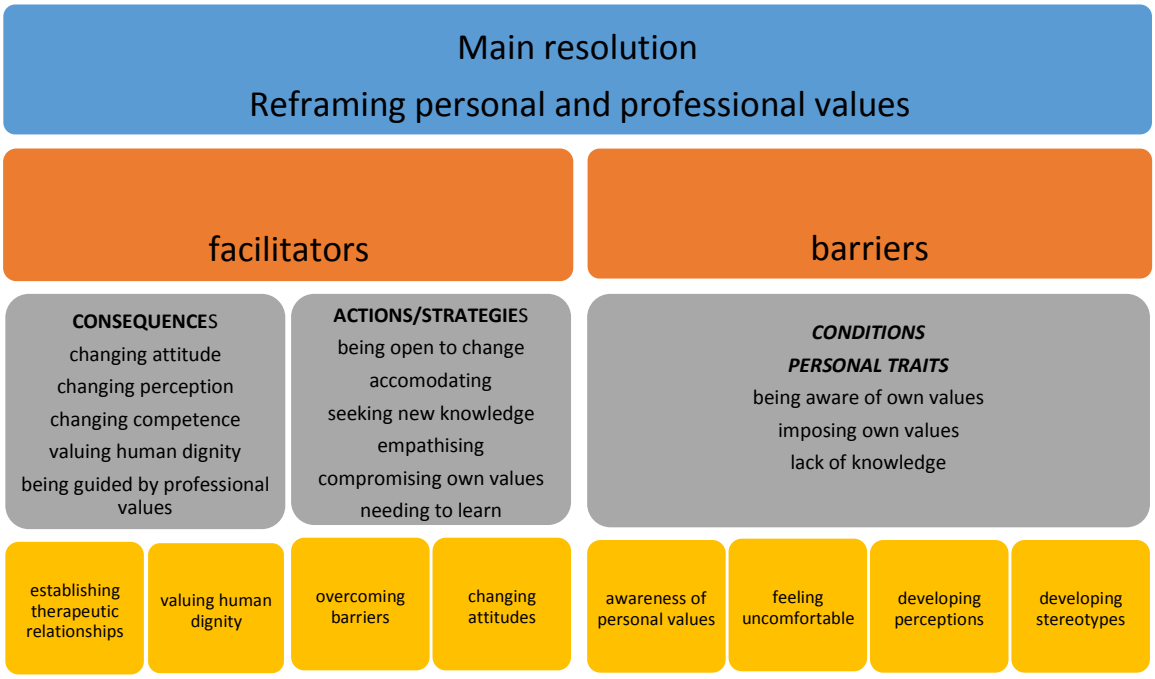

Figure 5: Attributes of the core category informing the emergent theory

Figure 5 above depicts attributes of the core category, '*reframing personal and professional values'* as the main resolution (as illustrated in the first row) towards addressing barriers or main concerns of care, which are illustrated in the second row and the right hand side column. Barriers of care are influenced by conditions in which the nurses' personal traits, such as having conflicting values with those of LGBTI patients, and imposing their values on the patients, and are illustrated in the third row and the right hand side column. As a result of realising the impact that their values have on patient care outcomes, the nurses engaged in actions and strategies to facilitate care ultimately changing their attitude and perceptions towards LGBTI patients, which are illustrated in the third row and left hand side column. The nurses' actions were influenced by professional and moral values of valuing human dignity, as illustrated in the fourth row.

'Reframing' was identified as the core variable which demonstrated the nurses shifting from using values and beliefs as frames to judge LGBTI patients to acknowledging that the perceptions and meanings that they held about LGBTI

people were no longer valid to them. The nurses were able over time to review their values, and made reference to those personal and professional values that enabled them to promote a therapeutic relationship. ‘Reframing’ is therefore conceptualised within this study as synonymous with ‘changing’, or ‘transforming’, which was a significant recurring affective, cognitive and behavioural process among the nurses.

The concept ‘values’ was also interrogated to determine how it fitted into the concept ‘reframing’. Dufresne and McKenzie (2009:36) assert that having a set of values would mean guiding individuals or groups’ actions and focus. Purtilo (2005:128) shares the same sentiment by describing a personal value system as a moral framework of how people think, feel and act in particular situations. Values form a frame that people use to act on their own principles in ways that are meaningful to them (Purtilo 2005:128). Several authors describe values as constructed fundamental personal, social, cultural, political, religious and professional value systems and experiences. Thus, values are used to define situations in which people find themselves, as well as to identify and interpret specific aspects that seem key in understanding the situation, and to communicate that interpretation to others (Mezirow 2009:22). This notion is supported by Wright (1987:7), who asserts that values influence ethical decision making in three ways: 1) values frame a problem, therefore, people view a problem based on the values they bring to the situation; 2) values supply alternatives as possible resolutions to consider during a problematic situation; and 3) values direct judgment or reasoning in resolving a problem, based on what a person wish to uphold or promote. Likewise, based on the analysis of this study, nurses assessed their attitudes and actions and reflected on the philosophies and values that guided those actions. In this study, it was revealed that nurses had values and beliefs acquired through socialisation, personal, religious and professional value systems that they used to guide their perception about others, their attitudes, their behaviour and interactions in clinical practice. For the nurses, personal, cultural and religious values formed barriers, and were therefore the main concerns of facilitating LGBTI youth-

inclusive PHC when the nurses discovered that their value systems were incongruent to those of LGBTI patients. However, as data analysis progressed, it was discovered that for the nurses, referring to their professional and moral values as their ethical frames of reference was what helped them to acknowledge the diversity of LGBTI patients and to treat them in a humane manner. However, the researcher acknowledges that there may indeed be some other factors that influenced nurses and LGBTI interaction in clinical practice and ultimately the facilitation of LGBTI youth-inclusive PHC that were not explored in this study. Therefore, further studies aimed at facilitating LGBTI youth-inclusive health care ought to be explored e.g., investigate social interactions and dynamics involved in the clinical care of LGBTI patients.

Some common actions of the nurses during the process of ***reframing personal and professional values*** involved reflecting on factors that hindered them from caring for LGBTI patients effectively. These factors were identified, as discussed earlier, as conflicting values and tensions; and the lack of knowledge and formal training about LGBTI people and their health care needs. The lack of knowledge and training on LGBTI health care made the nurses feel incompetent and uncomfortable in caring for LGBTI patients. Therefore, for the nurses, persuaded new strategies of: 1) changing attitudes, 2) gaining new knowledge, 3) having understanding and empathy for others; and 4) treating LGBTI patients the same as everyone else, became significant.

Reframing personal and professional values demonstrated the nurses' eagerness to change their attitudes in order to facilitate the care of LGBTI patients. For them, changing their attitudes implied: 1) changing their understanding; 2) changing their perceptions; 3) changing their practice and competencies; 4) establishing new and changing old values; and 5) becoming open to change after they have realised how their values, beliefs and attitudes impacted negatively on how they cared for LGBTI patients. These changes revealed that the nurses were explicitly aware of the changes that had to take place in order to facilitate LGBTI youth-inclusive PHC.

5.4. OVERVIEW OF THE MAIN CONCERN AND THE CORE CATEGORY

This section will provide an overview of how the core category unfolded by justifying how the core category is logically aligned to the main concern of the participants. The core category includes patterns of behaviour that reveal how participants resolved their main concern (Glaser 1978:93).

The core category that emerged from this study supports the argument that the theoretical basis for grounded theory originates from the social psychological theory of symbolic interactionism (Blumer 1969:1; Glaser 1998:12; Milliken & Schreiber 2012:693), which is regarded as a theory that explains human group life and conduct (Blumer 1969:12). Blumer's methodological approach depicts that gaining insight into social life of people requires an understanding of the process they use to interpret their situations and experiences, and how they construct their actions among others in the society (Blumer 1969:66; Strauss 1993:242).). Symbolic interactionists emphasise 'process' in interaction, and view behaviour as "purposive, socially constructed, coordinated social acts informed by preceding events in the context of projected acts that occur" (Katovich, Miller & Stewart 2003:122). The core category differs from other categories, in the sense that it describes processes, has more than one state of being, can vary over time, and is embedded in the actions of participants (Schreiber & Stern 2001:3; Katovich et al. 2003:122). In the same way, the core category that emerged in this study is that of ***reframing personal and professional values,*** and is a dynamic process that also varied in state and time as suggested by Schreiber and Stern (2001:3). For example, the experiences of both nurses and LGBTI participants was not static, since for the nurses, the experiences with one LGBTI patient may differ from those of another LGBTI patient, and vice versa. Therefore, it is difficult to provide a linear path from the beginning to the end of any experience.

In this study, the newly discovered core category: 'reframing personal and professional values' emerged from the four categories: 'recognising personal subjectivity', 'tackling and overcoming personal subjectivity', 'seeking

understanding'; and 'maintaining professional objectivity', which will be expounded further in this chapter. Blumer (1969:38) emphasises that any methodology that attempts to gain insight into social behaviour, the researchers must "get inside" of those that are affected by the phenomenon in order to understand the world from their point of view, rather than from obtaining statistical inferences. Therefore, the researcher asserts that to develop the grounded theory of facilitating LGBTI youth-inclusive PHC, it was appropriate to engage all those that were affected by the phenomenon in order to explore their experiences, ideas, emotions and strategies used to mitigate any ill effects experienced during their interaction. By drawing on the experiences and perspectives of LGBTI participants regarding how they were treated by the nurses at the clinics and of the nurses on how they perceived their interaction with LGBTI youth in clinical practice provided a new insight into the factors that affected their interaction, that which influenced how they engaged, and how they responded to the situations. Both the nurses and LGBTI participants shared specific, challenging experiences and noted how they dealt with those challenges. Therefore, the core category emerged, based on the analysis and interpretations of LGBTI and nurse participants' experience, and how they attached meaning to the process of facilitating LGBTI youth-inclusive PHC. The core category further indicates that the nurses used a process of giving primary consideration to adapting their values when responding to and dealing with situations that impact on their values and beliefs.

In this study, personal and professional values were conceptualised as having multipronged attributes, contributing to how the nurses felt, thought and behaved during their interaction with the LGBTI patients. The majority of the nurses discussed how reflecting on both their personal and professional 'self' has helped them in developing awareness of and applying their personal and professional values in clinical practice so as to influence facilitating LGBTI inclusive PHC. For this reason, the core category revealed the relationships between the development of personal and professional attributes, how those

attributes changed over time, and what influenced those changes. At some point of the analysis, personal and professional values were viewed as binary opposites. For example, for the nurses, being influenced by personal values constituted a hindrance towards facilitating LGBTI youth-inclusive health care, whilst the influence of professional values contributed towards facilitating LGBTI youth-inclusive health care. The core category suggests that participants' experiences were understood as an interaction between four variables: 1) the challenges that arose due to the diversity of LGBTI patients; 2) personal and professional traits of nurses; 3) intrinsic and extrinsic factors that influenced the nurses' traits and strategies; and 4) strategies employed by nurses to promote interaction with LGBTI patients, thus facilitating LGBTI youth-inclusive PHC.

5.4.1. HIGHLIGHTING AND THEORISING OF THE CORE CATEGORY

In this section, the core category informing the substantive theory of this study, will be further highlighted and theorised.

While framing entails a negative effect posed by nurses when they perceived LGBTI patients' values as contradictory to theirs, reframing has enabled the nurses to 'look back' and realise how that impacted on their professional and service principles. For the nurses, realising that their values were incongruent to those of the LGBTI patients and that this had a negative effect on the patient care provided, prompted them to change their mind-set and undertake strategies that would suppress, refute or remedy the effects of the tension that they experienced when interacting with the patients. Therefore, reframing became a responsive process in which nurses realised the importance of treating the patients in a humane manner, and to respect their human dignity without breaching professional values and principles.

The core category depicts a continuous interaction between three processes, i.e. cognitive, affective, and behavioural processes, which ought to be viewed as interrelated and interconnected entities during the process of 'reframing

personal and professional values'. In this study, cognitive processes demonstrate those processes whereby nurses apply the knowledge gained through personal and professional experience. This process has enabled them to make rational and critical decisions in encounters where they attempted to rationalise what being LGBTI meant for them, what LGBTI peoples' needs are, and what support they require from nurses. The affective processes became evident in situations where nurses acknowledged the challenges that LGBTI people undergo on daily basis in the society, the family and the health care environment. By acknowledging LGBTI people's challenges, the nurses were able to empathise with them and to accommodate them and their diverse needs. On the same note, the behavioural processes became apparent when nurses established rapport with LGBTI patients, showed them respect, and expressed a sense of value for their human dignity.

The nurses became motivated to preserve their professional identity and their moral and professional obligations towards the patients despite having realised that the culture of the LGBTI people was not congruent with their values and beliefs. Therefore, in this study, 'reframing personal and professional values' indicates the strategy that the nurses used to give primary consideration to the needs of LGBTI patients. From this explanation, it can be reasoned that 'reframing personal and professional values' emerged as a response, an outcome or consequence of the main concern of participants, where they responded to personally challenging situations. For the nurses, the concept of 'reframing' became significant in explaining the 'positive intention' of the actions and behaviour that needed to be changed. The actions involve discovering how the unpleasant behaviour can be replaced by an attitude and behaviour exhibiting more positive intentions. However, as mentioned earlier, in this chapter, though categories and sub-categories are discussed as distinct, they somehow intertwine and overlap as condition, process, strategy and consequence, and could also be placed into other categories.

5.5. OVERVIEW OF THE CATEGORIES THAT FORMED THE CORE CATEGORY

In this study, 'reframing personal and professional values' conceptualises the process that nurses used to change, alter, modify, transform or adapt their values, beliefs and attitudes in order to facilitate LGBTI youth-inclusive PHC. This section will elaborate on the attributes of the four categories, how they relate to each other and the core category.

Figure 6: Emergence of the core category

Figure 6 summarises the emergence of the core category, with its four related categories. It should be noted that for the purpose of reporting and to engage with the categories in all their complexity, categories are discussed distinctly. However, all of the categories and sub-categories can be described as interdependent and interconnected to the various experiences of the participants and influences one another and the core category as illustrated by the arrows between each category and sub-categories connected to each category as illustrated in Figure 6. Each category contains concepts that were located in the sub-categories, due to their frequent appearance in the data. It should be noted that most of the concepts that appear in the sub-categories are intertwined and overlap, and could also be placed into other categories. All the concepts were instrumental in developing and supporting the actions and processes of 'reframing personal and professional values' as a way of facilitating LGBTI youth-inclusive PHC. The four categories and the related sub-categories will be discussed.

5.5.1. CATEGORY 1: RECOGNISING PERSONAL SUBJECTIVITY

The first category: 'recognizing personal subjectivity' referred to behavioural process that explains how the nurses were able to identify and reflect on their values, beliefs and attitudes, and how that influenced their interaction with LGBTI patients. The first category initially described the barriers that hindered nurses in facilitating LGBTI youth-inclusive health care. The process of 'recognising personal subjectivity' incorporates two sub-categories namely: *developing awareness of own values, beliefs and attitudes'* and '*developing perceptions about LGBTI people'*. The sub-category: '*developing awareness of own values, beliefs and attitudes'* provides a starting point where personal, social and personal values became prominent in influencing how the nurses felt, thought and behaved during their interaction with LGBTI patients during the process of 'recognizing personal subjectivity'. The sub-category: '*developing awareness of own values, beliefs and attitudes*' makes explicit the ways in which the nurses experienced and understood their own values, beliefs

and attitudes and how those attributes were formed. They identified the source of their values and beliefs as emanating from their socialisation, culture and religion. This process resulted in the foundation of gaining insight into the 'self', and how their personal traits influenced and affected their interaction with the LGBTI patients.

Through the process of identifying and reflecting on their values, beliefs and attitudes, the nurses developed frames of reference that enabled them to better understand the factors that contributed to the conflict that they had experienced. It is within these interactions and influences that the nurses experienced the values of LGBTI patients as different from theirs, ultimately leading to the emergence of the second subcategory: 'developing perception about the LGBTI people'. Referring to their values and beliefs as their frame of reference, has prompted the nurses to perceive being LGBTI as 'a taboo object', 'unreal', 'immoral', 'exhibition of anti-Christian behaviour' and as an 'uncomfortable subject' to discuss. Most nurses affirmed that they were socialised in a Christian hetero-normative society, and as a result, felt uncomfortable to discuss issues of related to sexuality and sexual orientation with LGBTI patients. Realising that the patients were LGBTI, some nurses experienced cultural shock when they discovered that their own values and beliefs mismatched the culture of LGBTI people. One nurse was uncertain of the factors that made people to become LGBTI, however, irrespective of the cause, for her, being LGBTI still contradicted her beliefs. Having awareness of how values and beliefs influenced oneself and impacted on others prompted conditions that led to increased chance of miscommunication and misunderstandings between the nurses and LGBTI patients.

The second sub-category: '*developing perceptions about LGBTI people'* revealed that as nurses further interrogated their own beliefs and values against reality, in a subjective way, they '*developed perceptions about LGBTI patients'*. Nurses developed stereotypes and became judgmental about LGBTI patients. The nurses developed frames of reference or labels by which they

viewed the LGBTI patients against themselves and the world. The manner in which, the reason why and the factors that led nurses to *develop perception about LGBTI people*, were revealed when nurses indicated their uncertainty about what being LGBTI meant. For this reason, the nurses attempted to speculate about what being LGBTI meant, in order to make sense of LGBTI patients against their world, and as such, some nurses attempted to ask the patients what caused them to "become LGBTI". The patients' responses prompted them to perceive being LGBTI as an 'inner self' and/or as 'genetically inherited', an inherent factor over which people have no control. For some nurses, being socialised in a Christian hetero-normative society prompted them to perceive being LGBTI as a 'lifestyle choice', 'actions and behaviour of insanity', or 'Satanism'. At the same time, the nurses' professional experience made them judge LGBTI people based on the external traits and gestures, as well as on clinical findings that the patients presented with in clinical practice. For example, some nurses would refrain from asking patients about their sexual orientation, where instead, they assumed the patients' sexual orientation based on the physical appearance or mannerisms often based on generalisations or stereotypes of "how" gay or straight people ought to look. For the nurses, those male patients who have more feminine looks and gestures were perceived as being gay. Again, those male patients who presented at the clinic with anal region STIs were perceived as engaging in anal, male-to-male sex, and therefore, as being gay. Developing some perceptions about LGBTI patients for them seemed to provide a definition of what being LGBTI meant, therefore rationalising and making sense of LGBTI people and their way of being.

5.5.2. CATEGORY 2: TACKLING AND OVERCOMING PERSONAL SUBJECTIVITY

The core category: 'reframing personal and professional values' became apparent in the second category: 'tackling and overcoming personal subjectivity', the third category: 'seeking understanding about LGBTI people and their health care needs' and the fourth category: 'maintaining professional

subjectivity'. The second category: 'tackling and overcoming personal subjectivity' revealed strategies and actions that the nurses employed in order to balance personal, professional and service values.

For the nurses, 'tackling and overcoming personal subjectivity' followed the process of 'developing awareness of own values, beliefs and attitude'. It became a reflexive response, whereby the nurses reflected further on their personal and professional values, beliefs and attitudes, and were able to pursue personal and professional transformation in order to establish a positive nurse-patient relationship. The category: 'tackling and overcoming personal subjectivity' exhibited how nurses settled internal conflict experienced during interaction with the 'self' and others. 'Tackling and overcoming personal subjectivity' demonstrates that for the nurses, by virtue of giving up their personal values, and accepting their moral responsibilities, indicated their willingness to change their values and attitudes towards LBGTI and to be more accommodating of their health care needs. Therefore, 'reframing personal and professional values' was influenced by nurses implementing strategies which involved: 'changing personal values and attitudes', 'changing perception about LGBTI patients', 'understanding LGBTI people's challenges', 'empathising', 'changing old values and establishing new ones' and 'being accommodating', therefore adapting the personal 'self' to fit with personal and professional obligations.

'Setting aside own values and attitudes', in this study, illustrates the cognitive and affective processes that constitute a combination of personal values, professional values and ethics. The process illuminated an understanding of the factors inherent in the conflict that nurses experienced when their values mismatched with those of LGBTI patients. Consequently, the nurses developed new attitudes and skills, became more accepting to LGBTI patients' differences, and less judgmental to them. As evidenced by data in this study, for the nurses 'reframing personal and professional values' became relevant when they had to make decisions that involved setting aside their personal

values in order to fulfill their professional obligation of meeting the patients' needs. For the nurses, setting aside own values, beliefs and attitudes meant suppressing, bracketing and/or compromising their own values and beliefs and 'being open to change' in order to meet their professional obligations towards LGBTI patients. As part of this process, the nurses needed to consider which values was a priority when caring for LGBTI patients. Consequently, they compromised their own personal values and beliefs to accommodate the diversity of LGBTI patients, a process that occurred because the nurses believed they had professional or moral obligation to do so. One nurse reacted in shock when she became aware that the patient was gay, as this contradicted her Christian values. However, as a way of 'reframing personal and professional values', she bracketed her personal values and beliefs by letting the patient know about the predicament she had between the discomfort of interacting with LGBTI people and fulfilling her nursing obligations. She mentioned that she was uncertain if caring for the LGBTI patient was being hypocrite or not. However, by 'reframing personal and professional values' the nurse was able to put aside her own frame of reference and in order to understand the patient's frame of reference through empathising.

What was common amongst the nurses was when most affirmed their willingness to change their attitudes and perception about LGBTI people. The nurses acknowledged that the lack of knowledge and formal education and training on LGBTI health care was a limitation towards efficiently accommodating the needs of LGBTI patients. One nurse specifically mentioned that having knowledge about LGBTI people and their health care needs would allow nurses to change their attitude and perceptions towards LGBTI people**.** Therefore, the nurse anticipated that the greater the level of competence on LGBTI health care, the lesser the degree of uncertainty with regard to LGBTI people and their health care issues.

The category: 'tackling and overcoming personal subjectivity' is underpinned by the nurses' personal and professional understanding of LGBTI person as an

acquaintance. Those nurses that were comfortable and sensitised in working with and accommodating LGBTI patients attribute their comfort and sensitivity to being related to LGBTI people. Being related to an LGBTI person, as either a family member or a friend has impacted on the nurses' positive attitudes towards LGBTI people generally. Two nurses declared that they did not understand LGBTI people until they learned that their close relatives were homosexual. Having learnt about their relatives' homosexuality has helped them to acquire an understanding of LGBTI people, affording them the chance to change their perception and attitude towards them, and consequently, to feel comfortable to interact with them. One of those nurses mentioned that she always declares to the patients that she has a lesbian sister, in order to increase their comfort level during clinical interaction.

In this study, 'tackling and overcoming personal subjectivity' was seen as a process whereby the nurses shifted their focus from the personal to the professional 'self' when caring for LGBTI patients. The process of 'tackling and overcoming personal subjectivity' incorporates three sub-categories namely: 1) *accommodating*; and 2) *being open to change*.

A process of 'tackling and overcoming personal subjectivity' that affirms the core category: 'reframing personal and professional values' was that of accommodating LGBTI patients. Accommodating became apparent when nurses were empathising with LGBTI patients. Empathising became apparent when the nurses shifted their own values and beliefs in order to make sense of what LGBTI patients are feeling and thinking. It involved "putting oneself in others' shoes" when the nurses realised the challenges that LGBTI people go through in the society, their families and in the clinics. Empathising offered the nurses an opportunity to critically reflect on their actions, reactions and how that impacted on LGBTI patients. Empathising required that the nurses engage in a new meaningful way of understanding the health care needs of LGBTI patients, and responding to them appropriately. For the nurses**,** "putting oneself in others' shoes" allowed them an opportunity to reflect on how one would act,

react and think if faced with the similar challenges as LGBTI patients. For one nurse, she wondered how it would feel like if her child was gay. For another nurse, empathising meant giving patients attention by listening to each LGBTI patient's circumstances and not only treating physical symptoms. Empathising marked a shift from the personal to the professional 'self', which required changing attitudes towards LGBTI patients. A process which, for the nurses, should commence by acquiring new knowledge, experience and skills and embracing new ideas about LGBTI people and their health care needs. Nurses demonstrated a strong sense of 'self' and showed their willingness to compromise their own values and beliefs to adopt and adapt to new attitudes, accept LGBTI patients and to treat them as human beings.

The sub-category: 'being open to change' which is synonymous to being open-minded involves cognitive and affective process of how nurses were willing to consider new and different ideas about LGBTI people. 'Being open to change' meant nurses liberated themselves from their own values, thoughts, biases and attitudes and became open to new experiences and new ways of perceiving LGBTI people. 'Being open to change' has assisted the nurses to be more open to diversity, to be less judgmental about others and to be receptive to the views and values of others. For the nurses, being open to change constituted actions and interactions of: 1) 'understanding of LGBTI peoples' challenges'; 2) 'changing attitudes'; 3) 'establishing new and changing old values'; and 4) 'empathising'.

'Being open to change' was critical in signifying aspect of '**reframing personal and professional values'**. The process of 'being open to change' was fundamentally tied to the notion of 'understanding of LGBTI peoples' challenges', and integrates the actions of changing, adapting and modifying values and attitudes, once the nurses became aware of and acknowledged the challenges encountered by LGBTI people in their families, communities and the health care system. Dimensions of 'understanding of LGBTI peoples' challenges' by some nurses were validated in some of their narratives,

whereby they reflected on the challenges that LGBTI people experience. ‘Understanding of LGBTI peoples’ challenges’ therefore broadened the nurses’ understanding of the health care needs of LGBTI patients and prompted them to change their perception and attitude towards them. For instance, some nurses raised a concern about how other nurses treated LGBTI patients unfairly, negatively and unethically at the clinics and believed that such actions were immoral. Therefore, they urged the nurses to have an understanding, to show empathy, and to commit towards caring for LGBTI patients according to their nursing ethics.

5.5.3. CATEGORY 3: SEEKING UNDERSTANDING OF LGBTI PEOPLE AND THEIR HEALTH CARE NEEDS

‘Seeking understanding of LGBTI people and their health care needs’ was the third category that emerged during data analysis. Properties and dimensions that exhibit how nurses acknowledged having limited knowledge about LGBTI health care, as well as how they explored ways of acquiring new knowledge and understanding about LGBTI patients are outlined. Consequently, how and why the nurses were changing their attitudes and behaviour towards LGBTI patients was also delineated. The category emerged from the sub-category 1) ‘acknowledging having limited knowledge about LGBTI health care’; and 2) ‘recognising the need to learn’ about LGBTI people. ‘Seeking understanding of LGBTI people and their health care needs’ refers to the conscious process in which the nurses seek the knowledge and understanding of LGBTI people and their health and health care needs. For the nurses, ‘seeking understanding of LGBTI people and their health care needs’ required them to acquire specific knowledge and skills to facilitate LGBTI inclusive health care. ‘Seeking understanding of LGBTI people and their health care needs’ by the nurses revealed affective, cognitive and behavioural processes which emerged as responsive and adaptive processes of acquiring new knowledge about LGBTI issues and their health care concerns. Therefore, ‘seeking understanding of LGBTI people and their health care needs’ affirm the notion of ‘reframing personal and professional values’, as the nurses become eager to transform

their knowledge and attitude towards LGBTI people and their health care needs.

The nurses in this study were of the opinion that acquiring new knowledge about LGBTI people and their health care needs will provide them with necessary knowledge about the significance of sexual orientation in health care. Nurses identified and discussed different types of knowledge gaps they had as: 1) “being uncertain about what being LGBTI meant”; 2) “feeling helpless in providing care and support to LGBTI patients”; 3) “being ignorant about LGBTI issues”; 4) “assuming a heterosexist stance when interacting with LGBTI patients”; 5) “not knowing about the behaviours and lifestyle of LGBTI people”; 6) “not knowing what the health care needs of LGBTI people are”; 7) “not knowing how the health care needs of LGBTI people ought to be addressed”; 8) ‘being uncomfortable to talk about LGBTI issues”; 9) “lacking adequate knowledge and skills in treating and caring for LGBTI patients”; and 10) “not receiving adequate training about LGBTI people and their health care issues”.

In this study, the nurses consciously developed the active intention to bridge their knowledge gap. The nurses discussed addressing the need to learn about LGBTI people and their health care needs as: 1) “raising awareness”; 2) “needing to understand”; 3) “needing education and training”; 4) “wanting to learn”; and 5) “wanting to be empowered”. The process revealed the eagerness of nurses to acquire deeper understanding of LGBTI issues and the various mechanisms that they suggested so as to enable them to acquire more knowledge about LGBTI issues. In this study, the nurses and LGBTI participants added a new strategy of acquiring new knowledge about LGBTI people and their health care as ‘learning from each other’. Learning from each other was perceived by participants as an interactive process that takes places between people and results in connecting existing and new knowledge in order to obtain a better understanding of LGBTI people, their lifestyle, their needs and health care concerns. The nurses suggested: 1) learning from other health

care workers who have experience in working with LGBTI people; 2) one-on-one interactive and collaborative process of learning from others; 3) e-learning methods where information could be shared through available electronic media like e-mails, database on LBTI health issues; 4) periodic counselling sessions; 5) giving and receiving feedback; 6) benchmarking with other institutions; and 7) engaging in support groups. The nurses suggested that collaborating with others who are knowledgeable about LGBTI health care will assist those nurses working with LGBTI patients to bridge their knowledge gap.

5.5.4. CATEGORY 4: MAINTAINING PROFESSIONAL OBJECTIVITY

The fourth category: 'maintaining professional objectivity' revealed the affective, cognitive and behavioural processes of how for the nurses, having realised and applied their professional 'self' has assisted them in changing their attitude and practice in caring for LGBTI patients. Category 4: 'maintaining professional objectivity' provided insight into how the ethical guidelines, professional values, and the code of conduct of the nursing profession guided the nurses' decisions when interacting with LGBTI patients in clinical practice. Within the category: 'maintaining professional objectivity', 'reframing personal and professional values' signifies the personal and professional changes that occurred amongst the nurses as a response to the internal and external factors exerted by the need to overcome internal conflict that existed. The most significant driver for these changes was when the nurses referred to their prime role of committing to their professional and moral obligations when they justified how they managed ethically challenging situations. In this study, the nurses discovered their professional identity through constant interaction with the profession and society's expectations. Reflecting on their professional values provided an anchor for the nurses to work towards what is expected of them in their profession. Consequently, the nurses were able to connect with LGBTI patients emotionally, understanding what their health care needs were, rather than imposing their personal values on them. Professional values guided the nurses as to what should be done and what the expected outcome should be. Therefore, evidence in the data revealed that having to focus on doing

what is morally correct; the nurses became eager to give priority to treating patients the same as everyone else, that is, with respect, whilst valuing their human dignity. In this study, being guided by professional values remained significant for the nurses in order to achieve positive patient care outcomes. The category emerged from the three sub-categories namely: 1) '*establishing a therapeutic relationship'*; 2) *'valuing human dignity'*; and 3) *'acknowledging professional obligation'*.

Another factor underlying '***reframing personal and professional values'*** was apparent in the nurses' willingness to establish a therapeutic relationship during clinical interaction with LGBTI patients. Most nurses shared several strategies that they used in 'establishing therapeutic relationship' whilst providing care to LGBTI patients. The strategies are described as: 1) establishing rapport; 2) increasing the patients' comfort level; 3) being available; 4) gaining patients' trust; 5) engaging in open communication; 6) reaching out to the patients; 7) having good communication skills; and 8) treating people with respect. However, strategies that were common to most nurses throughout the process of 'establishing therapeutic relationship' were those of increasing the patients' comfort level and engaging in open communication. These strategies were employed in situations where the nurses realised that the topics or issues being discussed during clinical care were sensitive and might cause discomfort to the patients. In this study, increasing the comfort level of the patients meant creating an enabling environment in which the patient would feel safe and free enough to disclose his/her personal and sensitive information without being judged.

The nurses developed rapport with the LGBTI patients which became another strategy for enhancing a therapeutic relationship. The nurses reported that they were able to engage in open communication with LGBTI patients as a result of having established rapport with them. For most nurses, developing rapport was established by: 1) attempting to ascertain the comfort level of the patient; 2) having good communication and listening skills; 3) assuring patients of

confidentiality and their availability; and demonstrating empathetic understanding. Developing rapport with LGBTI patients facilitated positive health outcomes, where some LGBTI patients felt that they were valued by the nurses and that the health care service was available to meet their needs. As a result, LGBTI patients gained confidence in the nurses, the desire to disclose their sexual orientation, and to return to the health care service.

The sub-category: ‘valuing human dignity’ emerged as another fundamental process that supported the core category: ‘reframing personal and professional values’. Data from the interview revealed how nurses recognised their moral obligation of respecting human rights, by rendering care to LGBTI patients in a humane manner. The indicators of valuing human dignity were identified as: 1) “respect for others”, 2) “respectful communication”, 3) “treating everyone the same”, 4) “being sensitive to patients’ unique circumstances and health needs”; and 5) “being non-judgmental”, which resulted in a caring professional conduct and in increasing their patients’ sense of self-worth. For the nurses, valuing human dignity was seen as a process of continuously identifying and reflecting on professional ethics and values, changing attitudes and reorganising actions to demonstrate a professional attitude that is focused on caring for human beings with respect and dignity. One nurse in this study described the indicators of treating patients in a humane manner as: 1) “showing love”; 2) “having a positive attitude”; 3) “addressing patients with their titles rather than their names”’ 4) “treating patients comprehensively”; and 5) “effectively responding the health care needs of the patient”, which will result in patients’ satisfaction. The nurses adopted a non-judgmental attitude in order to prevent doing any harm to patients. The nurses were of the opinion that they have a role of valuing human dignity of patients, because in so doing, they believed that they were fulfilling their professional obligation. One nurse discussed treating LGBTI patients the same as others and not viewing patient’s sexual orientation as significant when rendering care to patients. For the nurse, treating LGBTI patient was guided by a moral obligation to respecting his patient’s humanity and uniqueness, and not doing any harm to him.

Data in this study revealed that what has helped most nurses to be able to attend to the patients' needs, was when they reflected on nursing core value and principles of caring which they have learnt along their professional life. Therefore, 'acknowledging professional obligation' was another sub-category that became the key strategy of 'reframing personal and professional values'. 'Acknowledging professional obligation' assisted the majority of nurses in this study to base their decisions and actions on the values and principles of their profession, whilst caring for LGBTI patients. Areas that demonstrated nurses' acknowledgment of professional and moral obligations involved the quality of interaction and actions with the patients, their being and presence during the interaction, and the competencies that were required to conduct themselves in a professional and caring manner. Those areas were seen to be guided by professional values and served to direct and set boundaries on the actions and interactions. 'Acknowledging professional obligation' explains in some ways how nurses balanced and maintained their personal and professional 'self' whilst they undertook their professional roles and obligations. For the nurses, being guided by their professional values when providing clinical care has also helped most nurses to understand LGBTI patients' circumstances and to overcome the initial attitudes, beliefs and preconceived ideas that they had about LGBTI people. Some nurses referred to their nursing values as embedded in the "nurses' oath", "nurses' pledge of service", "nurses' code of ethics"; some referred to the human rights principles, which in SA is referred to as the "Batho Pele" principles, some referred to the "Nightingale's principles of care", whereas some referred to their motivation for becoming nurses, and others to their personal and professional commitment. One nurse mentioned that she reflected back on the nurse's pledge of service and asked herself about what had motivated her to become a nurse in the first place. Her nursing values have enabled her to reach out to her patient's concerns and attend to them without being judgmental. One nurse mentioned that for her to add value in the way she cared for LGBTI patient was aided by the code of ethics. The nurse gave credit to the nurses' pledge of service, the nurses' oath that nurses

undertake once they are registered as nurses. This concludes the discussion of the core category: ‘reframing personal and professional values’, which informs the theory of this study and encapsulates the key features of all the categories.

5.6. CONCLUSION

This chapter concludes the presentation of the core category: ‘reframing personal and professional values’, which inform the emergent theory of this study. The chapter presented a theoretical overview of the core category, categories and related subcategories. The core category: ‘reframing personal and professional values’, which emerged from the data in this current study indicates the processes that nurses use to give primary consideration to adapting their personal and professional values when responding to and dealing with situations that impact on their own values and beliefs in order to facilitate LGBTI youth-inclusive PHC.

CHAPTER 6:

DISCUSSION AND INTEGRATION OF LITERATURE IN THE CORE CATEGORY

6.1. INTRODUCTION

In Chapter 5, the core category informing the substantive theory of this study and its related categories and sub-categories were discussed. In this chapter, the core category: 'reframing personal and professional values', which describes the process that nurses used to change, alter, modify, transform or adapt their values, beliefs and attitudes in order to facilitate LGBTI youth-inclusive PHC will be compared to relevant literature, discussing its practical implications within extant literature. In grounded theory studies, searching and reading literature is undertaken differently at different stages of the study, depending on the aim of the literature review. At some stage of the research, a literature review is done in an attempt to identify gaps in the knowledge of the phenomenon being investigated. During data collection, literature review related to grounded theory methodology, symbolic interactionism, coding, and writing of memos and other areas is done in order to improve credibility of the study (Annells 1997b:176; Strauss & Corbin 1990:57; 1998:101). In this chapter, a literature review will be undertaken to include the synthesis of the findings, with relevant nursing and social scholarship literature and theories. A literature review will also be done to reflect the researcher's interpretive perspectives (Chiovitti & Piran 2003:430), demonstrating how and where the findings fit or extend into those literature and theories (Charmaz 2006:169). Synthesising the findings to relevant literature and theories will therefore assist in positioning the emerged substantive theory in relation to those theories.

6.2. INTEGRATION OF THE CORE CATEGORY INTO LITERATURE

In this section, the core category presented in Chapter 5 will be related to the research literature, positioning and justifying its relationship to the literature and the chosen theories. The intention is to highlight how the core category that emerged in this study has supported, added to and/or challenged the

literature and theories as cited. Comparing the core category to extant literature seeks to enhance insight into the theory that emerged from this study and its concepts, and further highlights the contributions of this study towards new knowledge (Glaser 1978:32; Charmaz 2006:168.). In addition, the categories will be related to the concepts included in the conceptual framework constructed for this study.

A constructivist grounded theory approach that this study persuaded, has provided the conceptual framework that has helped to explore the core category informing the substantive theory of this study. The core category revealed the meanings, processes and contexts for the studied phenomenon of facilitating LGBTI youth-inclusive PHC, and has resulted in the theorising of this phenomenon. Engaging both LGBTI and nurse participants made this study unique, because it incorporated both groups of participants' perspectives, which proves to be rare in the available literature. During the literature review, it was discovered that there was limited research aimed facilitating LGBTI youth-inclusive health care, where the outcome was as frank as what emerged from the participants in this study. Studies by Röndahl (2009:151) and Dorsen (2014:2) revealed that previous studies on LGBTI patients and their health care issues mostly focused on their perceptions and experiences in health care, and neglected to focus on the nurses' or health care providers' experiences and perspectives on interacting with LGBTI patients in clinical care. Most studies that investigated the nurses' perspective with regard to caring for LGBTI patients have been obviously absent (Knight et al. 2014:662) or obsolete, with much of it being greater than 10 years old (Dorsen 2014:11-13). Only a few recent studies that focused on health care providers' perspectives on LGBTI health care issues has been conducted (Kitt 2010; Poteat et al. 2013; Yan 2014; Dorsen 2014). Therefore, it was critical to consider the LGBTI participants' experience of being cared for by the nurses, and the nurse participants' experiences of caring for LGBTI youth in PHC, as well as the meaning that they attached to those experiences.

A discussion on how the core category and the four categories relate to existing literature will follow. The discussion will commence with a discourse on the core category: '***reframing personal and professional values'***, which describes a complex and integrated process that involves personal and professional interpretation of the situation. According to Whetten (1989:490), the theoretical contribution of a theory should logically describe the factors of what, how, why, who, where, when, and which of the social or individual phenomena of interest is believed to be central to grounded theory methodology. Whetten (1989:490) further argues that these factors ought not to be predetermined, but should emerge as a progressive research process, reflecting the concerns of research participants and how they resolve them. These ideas appear to share some congruence with the core category: 'reframing personal and professional values', which emerged as a response to situations where nurses felt that their values and integrity were compromised. LGBTI participants were of the opinion that nurses imposed their values on them and lacked the necessary knowledge about LGBTI health care. That notion of lacking the basic knowledge about LGBTI health care was confirmed by the nurses during their interviews. Therefore, the nurses developed strategies of seeking understanding of LGBTI patients, to treat them in a humane manner, whilst preserving their dignity and at the same time maintaining their professional self. Data revealed how nurses constantly reviewed their personal and professional values and the preceding conditions that facilitated the implementation of those values. Data also revealed how nurses modified those values to accommodate LGBTI patients, changing their attitudes towards them and treating them in a non-judgmental way.

The core category: 'reframing personal and professional values' became apparent in the second, third and fourth categories and was consistent with Blumer's formulation, which suggests that the 'self' is reflexive, and implies that the person is capable of 'getting outside of himself' so that he can become an object to himself (Blumer 1969:138). Drawing on symbolic interactionism, the meaning of objects are formed by people; taught by people and can therefore

be changed by people (Blumer 1969:1112). Blumer's notion suggests that people consciously form meaning about objects, and thus, are open-minded to change the meaning and perceptions about the object when they are presented with new facts and evidence. The core category: 'reframing personal and professional values', resonates with Blumer's concept as data revealed that there were some commonality in the process of self-interaction amongst nurses as they developed awareness and appreciation of their own values, attitudes and beliefs. The process involved being self-aware and understanding of what influenced the development of one's personal values and beliefs. The nurses found themselves in circumstances that directly or indirectly challenged their values and belief systems. A variety of strategies were used by nurses to develop self-awareness. These included strategies such as identifying and reflecting on their own values, beliefs and attitudes in order to obtain a better understanding of themselves and how they perceive LGBTI people. For some nurses, by identifying their own values, beliefs and attitudes, they formed frames of reference that informed how they felt, thought and behaved during their interaction with LGBTI youth. Blumer's notion was congruent with the results of this analysis, which demonstrated how participants understood, interpreted and discovered their self-concepts (which in this study refer to personal and professional self-concepts) through their experiences within the psychological and social contexts. Therefore, the central concept that shaped the core category remained the use of the perception of self-concept, understanding it as shaping how people think and feel about themselves, others and the environment, and ultimately determining how they perceive and respond to situations.

Similarly, Mead (1967:135-138) suggests that people interact with themselves and become aware of their beliefs, values and attitudes. Their ability to interact with themselves is attributed to the development of the 'self', which develops over time in social interaction with others. The 'self' is an object to itself in the same way as other people are objects to the person. The person views him or herself in such cases as other people would have viewed him, becoming an

object to him/herself. A person can interact and act with himself, have perceptions about himself, and communicate with himself, thereby forming and guiding his conduct. Self-interaction enables the person to evaluate himself and his actions (Blumer 1969:62; Skovholt & Ronnestad 1992:141). Respectively, in this study, for most nurses, developing awareness of one's own beliefs, values and attitudes became a process that involved self-interaction, self-reflection and self-critique. Consequently, nurses were able to recognise and acknowledge how their values and beliefs influenced their thoughts and perceptions about oneself, others and the environment, how they differ from those of others and how they influenced interaction with others. Being aware of their own values, beliefs and attitudes provided the nurses with the moral judgment of counteracting any prejudice and intolerance that they might have towards LGBTI patients. The nurses were able to over time 'reframe' their personal and professional selves by adopting mechanisms that will help them to maintain professional objectivity.

As explained earlier in this chapter, the core category: 'reframing personal and professional values', describes the process that nurses use to change, alter, modify, transform or adapt their values, beliefs and attitudes in order to facilitate LGBTI youth-inclusive PHC. Data from the interview revealed how nurses recognised their moral obligation towards human rights by rendering care to LGBTI patients in a humane manner, and valuing human dignity. The indicators of valuing human dignity were identified as "respect for others", "respectful communication", "treating everyone the same", "being sensitive to patients' unique circumstances and health needs", "being non-judgmental", which resulted in a caring professional conduct, and increasing the patients' sense of self-worth. For the nurses, valuing human dignity was seen as a process of continuously identifying and reflecting on professional ethics and values, changing attitudes, and reorganising actions of demonstrating a professional attitude focused on caring for human beings with respect and dignity. The nurses were of the opinion that by doing so, they are fulfilling their professional obligation of applying the principles of equity and social justice

when treating LGBTI patients, which in most studies are referred to as demonstrating moral competence (Jormsri, Kunaviktikul, Ketefian & Chaowalit 2005:586). Moral competence is defined by Jormsri et al. (2005:586) as a combination of three dimensions: 1) moral perception as an affective dimension which requires the individual's awareness of values and the expression of those values; 2) moral judgment, as a cognitive dimension entailing the individual's choice of one value over another, based on logical reasoning and critical thinking; and 3) moral behaviour as a behavioural dimension involving the individual's application of values to actions by being willing to receive public affirmation for the choice. Correspondingly, the core category of this study depicts a continuous interaction between three processes i.e. cognitive, affective and behavioural processes, which should be viewed as interrelated and interconnected entities during the process of reframing personal and professional values.

The researcher has observed that theories that focused specifically on facilitation of LGBTI youth-friendly health services by nurses were limited. However, nursing literature has also suggested various systematic decision-making models to assist nurses in reasoning through ethically problematic encounters, irrespective of the theoretical approach which underpins their decisions (Bolmsjö, Edberg & Sandman 2006:342-343; Chally & Loriz 1998:17-18; Mew 2013:141-158; Johnstone 2016:3641). However, it should be noted that, it is beyond the scope of this chapter, to document the entire field of literature related to the concepts of the core category of this study. Therefore, those theories were considered which hold the perspective of social constructionism and an interpretivist approach adopted in this grounded theory study; as well as literature, theories and models of 'change', in particular those that emphasise 'cultural competence'. At the same time, those theories that are within the boundary of the core category of this study were acknowledged briefly in terms of their relative positioning within the core category. Stemming from this rationale, the researcher searched for literature and theories that best support, add to and/or challenged the core category of this study. For example,

those theories and literature that relate to ‘caring for vulnerable patients’, ‘managing diversity of patients’, ‘managing conflicting values’, ‘ethical decision making’, ‘values, beliefs and attitudes transformation’ and ‘moral reasoning’, which have similar connotations to cultural competence, were explored.

Cultural competence is defined as an ongoing interactive process of change in relation to other people (Dunn 2002:107), and includes fundamental change in the individual’s thinking, understanding and interacting with the world around them (Krajic, Strassmayr, Karl-Tummer, Noval-Zezula & Pelikan 2005:279; Dunn 2002:107). There are several theoretical premises for cultural competence theory. For example, Leininger (2002:192) emphasises that cultural care theory requires nurses to provide care based on the cultural uniqueness of each individual patient. Therefore, cultural competence models such as those of Leininger (1991:44), Campinha-Bacote (2002:181) and Dunn (2002:108-110) were considered, which denote a direct link between the level of health care providers’ competence and their ability to provide culturally responsive health care service. According to Leininger (2002:192), culturally competent care is not limited to individuals of racial or ethnic minority groups, but includes differences in age, religion, socioeconomic status and/or sexual orientation. Therefore, it is imperative for the nurses to recognise the impact of culture on health care and to learn about the culture of the people they provide care to. Nurses should be aware of cultural beliefs, cultural behaviours, and cultural differences of the patients and should avoid the temptation of impulsive generalisations. These assumptions of the cultural care theory allow nurses to be less judgmental and more accepting of cultures which promote holistic care for all cultures. Likewise, in this study, when the nurses realised the need to acknowledge the diversity of LGBTI patients, they adopted a non-judgmental attitude in order to prevent doing any harm to them.

However, as comparison to the literature progressed, Leininger’s transcultural theory was set aside; as the theory discusses that culturally congruent care occurs within the nurse-patient relationship, where the nurse and the patient

together develop a nursing care plan aimed at improving the lifestyle and well-being of the patient (Leininger 1991:44). The theory depicts that all care modalities require that the nurse work together with the patient in order to identify, plan, implement, and evaluate each caring mode for culturally congruent nursing care, which was not evident in this study. It was interesting to note that the nurses in this study made no references to any formal decision-making model or framework. This does not necessarily mean that they did not refer to a systematic process when they were interacting with LGBTI patients; however, the use of any formal procedure was not evident in the study data.

As discussed in Chapter 5, the core category of this study: 'reframing personal and professional values' relates to the process of identifying and reflecting on own values and beliefs and then looking back into those values and beliefs to challenge and resolve irrational or maladaptive thoughts and behaviours that emerged as a result. Therefore, as literature was further explored, it became apparent that in this study, values intensely influenced the patterns of decision-making and reasoning by the nurses in managing the tension experienced during their clinical interaction with LGBTI patients. Therefore, by making reference to the theories that relate to values, beliefs and attitudinal transformation made more logic for comparison with the core category of this study. Ultimately, the core category: '**reframing personal and professional values'** was found to resonate with the Mezirow's transformative learning theory (Mezirow 2003) for reasons that will be detailed later in this chapter. Transformative learning is "learning that transforms problematic frames of reference-sets of fixed assumptions and expectations (habits of mind, meaning perspectives, mind-sets), to make them more inclusive, discriminating, open, reflective and emotionally able to change" (Mezirow 2003:53).

Mezirow (1997:5) highlighted a view of learning as meaning making, and defined transformative learning as "the process of effecting a change in a frame of reference". Furthermore, Mezirow (2003:62-63) describes adults as autonomous thinkers who are able to make their own interpretations, rather

than act on the purposes, beliefs, judgments, and feelings of others. Mezirow's transformative learning theory was deemed to fit into the core category of 'reframing personal and professional values' which, like this study, is consistent with the tradition of grounded theory research (Glaser & Strauss 1967:238). The process of transformative learning is consistent with constructivism whereby people are active participants in the learning process and construct meaning from their own experiences, creating and interpreting knowledge rooted in their personal experiences (Mezirow 2009:62).

Mezirow (2009:22) describes transformative learning theory as a conceptual metaphor that explains the process of effecting change in a frame of reference. It is important to note that a frame of reference may also be, "a predisposition with cognitive, affective, and conative dimensions", which involves any aspect of a person's identity, and that any change in it may constitute transformation (Mezirow 2009:22). Frames of reference determine lines of action, and once they are set, people tend to reject ideas that fail to fit their preconceptions, labelling those ideas as unworthy of consideration, deviations, nonsense, irrelevant, weird, or mistaken (Mezirow 2009:22). Additionally, the core category of this study contributes a further dimension to Mezirow's (2009:22) theory, by explaining the ways in which nurses make thoughtful and situational adaptations to their practice when interacting with LGBTI patients in clinical practice. This notion became evident when the nurses in this study, looked through the lens of their personal, social, cultural and professional values that they had been socialised to hold. Those values and beliefs became contributory factors to how they behaved, as well as what motivated their responses and their perceptions about situations during their interaction with LGBTI patients. Data depicted that for the nurses, reflecting on personal and professional values has influenced how they created a therapeutic relationship in order to make LGBTI patients feel safe to utilise the PHC services. In order to cope with the tensions between their personal values and those of LGBTI patients, nurses developed coping mechanisms to resolve the tension and the effects thereof.

6.3. OVERVIEW OF MEZIROW'S TRANSFORMATIVE LEARNING THEORY AND ITS APPLICABILITY TO THE CORE CATEGORY

This section will provide an overview of Mezirow's transformative learning theory, demonstrating how the theory supports and validates the findings of the current study (Charmaz 2006:169).

Mezirow (1991a:152) views transformation as a form of development, and an outcome of the transformative learning process, such that "it is irreversible once completed; that is, once our understandings are clarified and we have committed ourselves fully to taking the action it suggests, we do not regress to levels of less understanding". Mezirow (1991a:7) asserts that "anything that moves the individual towards a more inclusive, differentiated, permeable (open to other points of view), and integrated meaning perspective, the validity of which has been established through rational discourse, aids an adult's development". Therefore, transformative learning, according to Mezirow, reflects a process and an outcome of adult development where meaning making develops greater clarity, although it does not have to follow clearly defined steps or stages (Mezirow 1991a:7). Mezirow's theory maintains that transformative learning is a form of learning whereby beliefs, attitudes, assumptions and meaning perspectives of the frames of reference that were previously embraced are questioned, changed and thoroughly validated (Mezirow 1978:13). Thus, adults tend to become transformation learners when they realise that their culture and their attitudes define and delimit their self-conception, lifestyle, and options in relation to a set of prescribed and stereotypic roles. As a result of recognising these cultural expectations and how they shape their thinking and feelings about oneself, the adults as transformational learners are able to identify their personal problem and perceive their traditional role as a constraint to personal development (Mezirow 1978:15). Adults come to recognise their culturally induced dependency roles and relationships, and take action to overcome them. When adult transformative learners interrogate their unexamined cultural assumptions and

attitudes into "critical consciousness", they become stuck in their own history, and this perception triggers a rigorous determination to disengage themselves from the self. As a result, they start to explore options for new roles and role models consistent with the broader perspective from which they now view their reality.

Mezirow (1976:12) identifies ten recognised steps in the transformative learning process namely: 1) a disorienting dilemma; 2) self-examination, with feelings of fear, anger, guilt or shame; 3) a critical assessment of assumptions; 4) recognition that one's discontent and the process of transformation are shared; 5) exploration of options for new roles, relationships, and actions; 6) planning a course of action; 7) acquiring knowledge and skills for implementing one's plan; 8) provisional trying of new roles; 9) building competence and self-confidence in new roles and relationships; and 10) reintegration into one's life on the basis of conditions dictated by one's new perspectives. According to the authors, when circumstances permit, transformative learners move toward a frame of reference that is more inclusive, discriminating, self-reflective, and integrative of experience. Although the core category that emerged from this study resonates with transformative learning theory, it merely revealed some of the steps of transformative learning process that did not occur sequentially and in a distinctive way, such as described by Mezirow. Mezirow (1991a:7) affirms that transformative learning does not necessarily have to follow clearly defined steps or stages. In this study, the core category suggests that facilitating LGBTI youth-inclusive PHC by nurses is a multifaceted process that involves interpretation of occurrences and adaptation to circumstances over time.

Mezirow's theory emerged from a grounded theory study within an educational philosophy (Mezirow 1971:135). However, recognising it as a conceptual metaphor or as a figure of speech, connecting different conceptual domains has enabled the theory to be applied in a wide variety of settings (Mezirow, 1997:11). The goal of transformative learning is not to present a manual, or recipes or strategies that can ensure transformative learning will take place,

since transformative learning not only happens in the classroom (Kroth & Cranton 2014:xv). In the same breath, Scott (1997:44) asserts that “transformation is not a rational process […] and cannot be pushed or planned for as in a goal-oriented, technical, rational process”. For this reason, the application of transformative learning should be situational and contextual. The theory is applicable in this study as it reflects on the behaviour and perspective transformation in adults. The researcher has observed that the theory has not been previously used to reflect on the behaviour and perspective transformation in the nurses caring for LGBTI patients. The theories that explain the processes used by nurses to facilitate LGBTI youth-inclusive health care were not always acknowledged or evident in the literature.

Transformative learning theory illustrates that the process of "perspective transformation" has three dimensions, namely: 1) psychological (changes in understanding of the self); 2) convictional (revision of belief systems); and 3) behavioural (changes in lifestyle) which can even occur informally in peoples’ lives, often without being recognised or named as transformative learning. In the same manner, the core category*: **‘reframing personal and professional values’*** emerged as affective, cognitive and behavioural responses of assessing, reflecting, enquiring, evaluating, rationalising and/or envisioning factors that could facilitate LGBTI youth-inclusive PHC. Further analysis of the work by Mezirow (1991a:104) suggests that transformative learning entails that an event triggers an individual to cognitively reflect on his/her knowledge, beliefs and values; and consciously reconstruct a new way of thinking. Emphasis here is on the word transformative, which is used to reflect any modification of assumptions (Brookfield 2000:139), and is commonly used as a synonym for any kind of learning (Tisdell 2012:22). Similarly, in this study, effecting change in a frame of reference that comprises cognitive processes (awareness, perception, reasoning, judgment), and affective processes (feelings) (Brookfield 2000:139) became evident in the second, third and fourth category, which will be discussed in the next section of the chapter.

6.4. INTEGRATION OF THE CATEGORIES AND SUB-CATEGORIES INTO LITERATURE

In this section, the categories and the sub-categories presented in Chapter 4 and 5 will be related to the research literature, positioning and justifying its relationship to the literature and the chosen theory.

6.4.1. CATEGORY 1: RECOGNISING PERSONAL SUBJECTIVITY

The first category: 'recognising personal subjectivity' referred to behavioural processes that revealed how the nurses were able to identify and reflect on their values, beliefs and attitudes and how that influenced their interaction with LGBTI patients. Through the process of identifying and reflecting on their values, beliefs and attitudes, nurses developed frames of reference that enabled them to better understand the factors that contributed to the conflict that they had experienced. The category also discusses conditions that were identified by nurses as barriers towards facilitating LGBTI youth-inclusive PHC. These conditions were also confirmed as barriers by LGBTI participants during their interview.

Though nurses are subject to the philosophical influence of their professional values and guidelines on the development of a moral professional identity (Varcoe, Doanne, Pauly, Rodney, Storch, Mahoney, McPherson, Brown & Starzomski 2004:320), they are at the same time also strongly influenced by their own socially-constructed values and beliefs that can influence nurse-patient interactions (MacDonald 2003:502). Values have both cognitive and affective features that "help to build a moral vocabulary by which we evaluate ourselves and others as praiseworthy or blameworthy" (Liaschenko 1999:36). Values influence how individuals live their lives both professionally and personally. They impact on their attitudes, their approach to life situations, their relationships, their interactions with people and within settings, and the meaning they assign to situations and the behaviours of others. Suar and Khuntia (2010:443) have stated that "values are, thus, prime drivers of personal, social, and professional choices". Similarly, in this study, 'recognising

personal subjectivity' revealed that the nurses had frames of reference, which guided their perception about others, their attitudes, behaviour and interactions in clinical practice. Those frames of reference were identified as values, beliefs, attitudes, experience which they have acquired through socialisation, personal value systems, and religion. Several studies have shown that nurses identified the main influences on their values and beliefs as derived from familial as well as religious backgrounds, and work experience in nursing. Therefore, the nurses' life experiences, nursing knowledge and practice are embedded in those beliefs, values and traditions that are learnt through personal, social and professional socialisation (Veins 1991:277, Jormsri et al. 2005:582).

According to Blumer (1969:62), people behave in a manner that is consistent with the perceptions that they hold of themselves and interpret any experience inconsistent to their perception as compromising their self-identity. Recognising differences that existed between their values and those of the LGBTI patients provided an opportunity for the nurses not only to know the other person, but also to gain a better insight into the 'self'. The nurses became motivated to preserve their professional identity and their moral and professional obligations towards the patients despite having realized that the culture of the LGBTI people was incongruent with their personal values and beliefs. The findings by Wilkinson (2008:211-21) regarding the processes that nurses use to deal with challenges to personal values and beliefs are contrary to the findings of this study. The study revealed that in situations where nurses identified certain core values or beliefs as determinant of how they ought to care for patients, they would not compromise their personal values; rather, they would rationalise their decisions as part of the duties (Wilkinson 2008:212).

A study by Dorsen (2014:63-64) sought to determine the attitudes of nurse practitioners towards LGB patients, revealing that nurse practitioners' values and beliefs became the source of conflict between their religious beliefs and their professional ethics that they often experienced, which impacted on the

way the cared for LGB patients. The findings of this study were congruent with findings of other studies that examined the relationship between religious values and attitudes towards sexual minorities (Dinkel, Patzel, McGuire, Rolfs & Purcell 2007:11-13; Yen et al. 2007:78). These studies discovered that health care providers, who self-identify as highly religious, harboured increased negative attitudes toward LGBTI persons. However, some nurse participants in the same study reflected that religion has positively impacted on their acceptance of diverse patients, despite realising that the values of their religion were incompatible with their personal values. Contrary to the findings, this present study revealed that the nurses' religious value system stood out as the major source of their values, beliefs and attitudes, which were seen to be contributing to the discomfort that the nurses experienced when interacting with LGBTI patients.

Authors like Constantine and Ladany (2001:491) highlight the significance of self-awareness among health care providers, which involves having an understanding of the impact of one's culture, how these variables impact interactions, understanding their areas of bias, and consequently, the desire to eliminate any harmful effects. A study conducted by Mewborn (2005:117-118) aimed at determining how school psychologists experienced working in diverse school contexts revealed similar findings related to self-awareness. The study discovered that school psychologists regarded having an understanding of one's own culture, along with skill in recognising the limits of one's competence in providing services to diverse populations, as essential multicultural competencies. The significance of self-awareness as revealed by Mewborn (2005:117-118) was consistent with the category: 'recognising personal subjectivity', which demonstrated that for the nurses, through developing awareness of personal beliefs, values and attitudes, they developed biased and contradictory understandings of LGBTI patients and their health care needs. In the same manner, Jormsri et al. (2005:586) are of the opinion that an understanding of ethical structure requires intense self-awareness, to enable nurses to make numerous ethical decisions in their practice.

The results presented in this study highlights the same dilemma experienced by student nurses in the study of Stanley and Matchett (2014:135-137), who sought to discover how they experienced morally distressing situations. The findings of that study indicated that student nurses experienced value system conflict when they were confronted with differing practices and beliefs, and found it difficult to take the right course of action in caring for patients (Stanley & Matchett 2014:135-137). Some student nurses struggled with values and cultural practices that contradicted their experiences, and as a result, found it difficult to make sense of the value systems that were different from theirs, especially those that emanated from different religious beliefs. The findings suggest that the distress experienced by student nurses occurred when they were confronted by differing value systems embedded in cultural practices, unfamiliar or contradictory to their own values (Stanley & Matchett 2014:135-137). Similarly, in this study, nurses found themselves in circumstances that directly or indirectly challenged their values and belief systems. It became apparent that based on their values, beliefs and attitudes, some nurse perceived being LGBTI as ‘a taboo object’, ‘unreal’, ‘immoral’, ‘exhibition of anti-Christian behaviour’ and as an ‘uncomfortable subject to discuss’ because they were socialised in a Christian heteronormative society.

Most nurses in this study felt uncomfortable when they were providing care to LGBTI patients as they believed that their own values and beliefs were incompatible with the culture of LGBTI people, and as a result experienced cultural shock. One nurse shared how uncomfortable she was to discuss issues pertaining to sexuality and sexual orientation with the patient. Similarly, the study of Dorsen (3014:74) demonstrated that health care providers experienced discomfort in discussing sexuality issues and sexual orientation to LGBTI patients (Dorsen 2014:74), a behaviour which some authors refer to as ‘sexophobia’ among health care providers (Kotronoulas, Papadopoulou & Patriraki 2009:479). Nathaniel (2006:419) emphasises the practical and relational features of nursing and the potential conflicts between personal and

professional values, using the term “situational bind” to describe the experiences of nurses whose core beliefs experience irreconcilable conflict with differing value systems. Equally, in this study, nurses experienced internal conflict within and between personal and social values which became a possible source of stigma and discriminatory behaviour towards LGBTI patients.

The category: ‘recognizing personal subjectivity’ resonate with Mezirow’s transformative learning theory, which describes an adult’s assumptions, beliefs, and expectations about the world, as part of a frame of reference through which individuals filter their incoming sense of impressions about the world. A person’s frame of reference, according to Mezirow (2000:16) selectively shapes and defines perception, cognition, feelings, and disposition, by influencing our intentions, expectations, and purposes. Echoing Blumer (1969:62), a person can interact and act with himself, have perceptions about himself and communicate with himself, thereby forming and guiding his conduct. The nurses in this study used their personal value systems as frames of reference, which formed the baseline of how they orientated themselves with regard to how they perceived LGBTI patients. Data revealed that as nurses interrogated their own beliefs, values and attitudes against reality, in a subjective way they developed perceptions about LGBTI patients. Nurses developed stereotypes and perceptions about LGBTI patients which seemed to provide a definition of what being LGBTI meant for them, and how LGBTI people made sense of their being, ultimately creating a frame of reference or a label by which they viewed them against themselves and the world. The findings of a study of physicians, who cared for LGBTI patients, showed that 65% have heard insulting remarks about LGBTI people and 34% had witnessed LGBTI patients being discriminated against by their health care providers (Eliason et al. 2011:1366-1367). Likewise, in this study, developing perceptions about LGBTI patients became a responsive process that reflected the nurses’ thoughts and feelings about LGBTI people. This process was formed through reasoning by nurses, as they attempted to explain or

rationalise for LGBTIs' behaviours, consequently developing biases and stereotypes about them.

This study revealed that values and beliefs have influenced the way nurses perceived and responded to LGBTI patients. The way in which nurses developed perceptions about LGBTI patients was revealed when they perceived being LGBTI as an 'inner self' over which people have no control, as 'genetically inherited', a 'lifestyle choice', actions and behaviour of 'insanity', or 'Satanism'. At the same time, being LGBTI was perceived by nurses based on the external traits and gestures and on clinical findings that the patients presented with in clinical practice. For some nurses, those patients whose physical traits were typical of the opposite sex were perceived as having nonconforming sexual orientation. For example, those males who have more feminine looks and gestures were perceived by nurse participants as homosexuals. Again, those male patients who presented at the clinic with STI in the anal region were perceived as engaging in anal, male-to-male sex, and therefore as homosexuals. A growing body of literature on the attitudes of nurses and other health care providers towards LGBT patients revealed that health care providers developed stereotypes of LGB patients. They defined LGB health exclusively in terms of sexual practices and increased risk for HIV and other STIs (Dorsen 2014:80-81; Dorsen & Van Deventer 2016:3717). The study conducted by Dorsen (2014:89-90) revealed that the nurse practitioners preferred to refrain from asking patients about their sexual orientation, rather they assumed the patients' sexual orientation based on the physical appearance or mannerisms, which are often based on generalisations or stereotypes about how gay or straight people should look.

6.4.2. CATEGORY 2: TACKLING AND OVERCOMING PERSONAL SUBJECTIVITY

Transformative learning is "based on constructivism - the notion that individuals construct meaning from their experiences in different ways and that different people see the same event in their own ways" (Kroth & Cranton 2014:16).

Perspectives are intensely rooted and remain unquestioned until the individual encounters a dilemma that questions them (Mezirow 1991). On the same note, when an individual encounters an experience which questions his or her meaning perspectives, this questioning can lead to critical reflection and critical questioning of the perspectives (Kroth & Cranton 2014:xiii). This experience of critical reflection consequently leads to the questioning of previously unchallenged values and assumptions (Kroth & Cranton 2014:xiv,3).

Similarly, in this study, the second category: 'tackling and overcoming personal subjectivity' reflects affective and behavioural processes of how nurses redefined the way they perceived the LGBTI patients and how they were eager to change their attitudes towards them. For the nurses, being aware of their own limitations in caring for LGBTI patients, they were able to pursue a process of changing their attitudes towards LGBTI patients by setting aside their personal values, beliefs and attitudes. This process is consistent with Mezirow's theory, which maintains that transformative learning is a form of learning whereby beliefs, attitudes, assumptions and meaning perspectives of reference frames that were previously embraced are questioned, changed, and thoroughly validated (Mezirow 2000:22). Consistent with the findings of this study, the nurses became open to change in order to deal with the effects of their own prejudice, to meet the needs of LGBTI patients, and therefore adopt a more patient-centred approach. When the nurses' realised that their values were vulnerable, they created opportunities for self-reflection and refinement of their personal value system, which according to Mezirow (1978:11) can lead to significant personal transformation. Consequently, they were able to implement coping strategies to deal with the threats to their values and to seek ways of accommodating and understanding LGBTI patients.

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The process of 'tackling and overcoming personal subjectivity' in this study involved transforming frames of reference through critical assessment and reflection of assumptions, validating challenged beliefs through discourse and taking action on one's reflective insight as Papastamatis and Panitsides

(2014:74) suggested. Papastamatis and Panitsides (2014:74) suggest that for transformative learning to happen, cognitive, physical, emotional, and spiritual dimensions ought to be closely interrelated, and all these parameters should be given attention in order to attain change in knowledge, understanding, attitudes, beliefs, skills and/or behaviours. Transformative learning is grounded on accumulative experience and a high level of cognitive functioning; it involves a way of resolving contradictions in a dialectical manner (Papastamatis & Panitsides 2014:74). For the development of a more philosophical outlook toward conflict, an increased ethical deliberation skills may be needed in nursing to prevent and alleviate moral distress in the clinical environment (Nathaniel 2006:419). Papastamatis and Panitsides (2014:75) assert that becoming critically reflective of own assumptions is the key to transforming one's frame of reference, and a crucial dimension of learning to adapt to change. Transformative learning can take several forms involving either objective or subjective reframing. It involves being: (1) aware of and critical in assessing assumptions, both own beliefs, values, judgments, and feelings and those of others; (2) aware of and gaining insight into the frames of reference and paradigms (collective frames of reference) and to envisage alternatives; and (3) responsible and effective at working towards assessing reasons and positions, solving problems, and making tentative best judgment regarding contested beliefs (Papastamatis & Panitsides 2014:75). Similarly, this study reflects nurses' eagerness to change the way they perceived LGBTI patients by seeking alternative ways of learning and increasing their understanding about LGBTI people and their health care concerns.

Nurses and other health care professionals take into cognisance the different voices within themselves and how each brings different perspectives of what actions should be taken in a given situation (Varcoe et al. 2004:320). Nurses are able to engage in a dialogue with the 'self' when they experience conflict between personal and professional values (Varcoe et al. 2004:320). Equally, in this study, what has helped the nurses to be able accommodate LGBTI patients were: 1) setting aside their own values, beliefs and attitudes; 2)

acknowledging having limited knowledge; and 3) being related to LGBTI person. In this study, accommodating LGBTI patients became a common solution to settling the internal conflict experienced during interaction with the self, others and the environment. Accommodating, in this study, involved compromising own values and beliefs in order to preserve the relationship with others and being sensitive to the needs and feelings of others despite experiencing internal conflict. However, contradictory results were found in the study of Stanley and Matchett (2014:137-138), where the authors sought to discover how student nurses experience morally distressing situations. The findings of that study demonstrated that student nurses had limited coping strategies, especially in situations where the tension was prompted by a conflict in value system. The most extreme response to this dilemma is when student nurses distanced themselves from challenging emotional situations, rather than attempting to resolve their inner conflict. Stanley and Matchett (2014:137-138) demonstrated that morally challenging situations may threaten nurses' sense of identity; where nurses need to develop coping strategies to preserve their moral integrity.

The process of transformation is fundamentally rational and analytical, as reflected in this study. Kucukaydin and Cranton (2012:11) suggest that "knowledge about transformative learning has been constructed by a community of scholars working to explain how adults experience a deep shift in perspective that leads them to better justify and to have more open frames of reference". Likewise, in this study, for nurses, setting aside their own values and attitudes became a cognitive and affective process that constituted a combination of personal values, professional values and ethics. The nurses shared how they had learned to deal with conflicting values by developing new attitudes and skills. Nurses in this study described how they became more accepting of others' differences and less judgmental. Nurses had to assess what ought to be achieved, which for them was meeting the needs of the patients, as opposed to what they had to give up, which in their case was their personal values, beliefs and attitudes during clinical interaction.

The study of Dorsen (2014:84-92) yielded similar results by revealing that nurse practitioners developed and implemented different strategies to ensure that, irrespective of their negative attitudes, they provided LGB patients with what they perceived as “best practices”. In the same study, nurse practitioners focused on acknowledging diversity by “bracketing” (a term commonly used in phenomenology studies to refer to the ability of researchers to contain their own biases when they are taking into cognisance the life experiences of others), and their personal values that were deemed to be in conflict with professional ethics, treating all patients “the same” and demonstrating their eagerness to learn more about LGB health over time (Dorsen 2014:87-91). In the same manner, in this study, for the nurses, they set aside their own values, beliefs and attitudes and became open to change in order to meet their professional obligations towards LGBTI patients. When nurses put aside their personal values and beliefs, in order to accommodate the needs of patients, it became a demonstration of their moral commitment towards caring for LGBTI patients. However, researchers assert that the inner tension experienced when personal and professional values are incompatible, is managed differently based on one’s ability or readiness to distinguish between personal moral views from professional duties (Hancock 2008:358). This was seen in the study by Hancock (2008:358), which had findings contrary to those of this study. The study of Hancock (2008:358) which studied evangelical social work students’ helping attitudes toward sexual groups revealed that only a few students are “able to achieve a clear and consistent awareness of their social location and are able to differentiate between their personal views and the needs of others”.

Another expression of ‘accommodating’ was exhibited when some nurses revealed that being related to a person with non-conforming sexual orientation contributed to their comfort and sensitivity in working with and accommodating LGBTI patients. The findings of this study were consistent with the findings of a study of Dorsen (2014:6970), which demonstrated that having a homosexual person as a family member or a friend has impacted on nurse practitioners’

positive attitudes towards LGBTI people. Nurse practitioners in that study indicated that having a homosexual relative, having contact with LGB community and having gay friends during childhood, adolescence and professional training has influenced their attitudes and experiences when caring for LGB patients. In the same way, LGBTI participants in this study also shared the significance of having LGBTI confidante in the health care system. One LGBTI participant revealed that having gay nurses at the clinic would make him feel comfortable to communicate freely. LGBTI participant alluded that the clinics lack gay nurses who could deal with issues of sexuality. However, on the other hand, the study of Dorsen (2014:68) revealed a contrary view, when one nurse participant revealed that merely being gay was not sufficient to help him understand his patients on a deeper and more therapeutic level.

As another way of 'tackling and overcoming personal subjectivity', nurses alluded that they were 'being open to change'. Being open to change is synonymous with being open-minded. To have an open mind means to be willing to consider or receive new and different ideas and being flexible and adaptive to new experiences and ideas. In this study, 'being open to change' required the nurses to free themselves from their own values, attitudes and bias, and to be open to new experiences and new ways of perceiving things. For the nurses, being open to change constituted: 1) understanding of others' challenges; 2) changing attitudes; 3) establishing new and changing old values; and 4) empathising. By being open to change, the nurses became more open to diversity and to be less judgmental about LGBTI patients. It has meant being receptive to the views that others should express themselves freely and that the value of others should be recognised. In this study, 'being open to change' was fundamentally tied to the notion of 'understanding of LGBTI peoples' challenges'. For most nurses, understanding of LGBTI peoples' challenges meant being aware of and acknowledging the challenges encountered by LGBTI people in their families, communities and the health care system. Similar results were found in the study by Dorsen (2014:68),

where nurse practitioners expressed that they acknowledged the struggles that LGB have to deal with and the emotional hardship of caring for LGB patients.

In this study, most nurses demonstrated their commitment towards changing their attitudes towards LGBTI people. One nurse insisted that the nurses should have a positive attitude towards LGBTI patients such that they might feel free and comfortable to seek health care at the clinics. She alluded to the fact that for the nurses, changing their attitudes should commence by acquiring new knowledge, experience and skills, and embracing new ideas. One nurse in this study echoed how she was prepared to change her attitude towards LGBTI people, and to adopt a new way of treating them efficiently.

Another way of 'tackling and overcoming personal subjectivity' became apparent when nurses empatihised with LGB patients. Swanson (1991:165) defines caring as "a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility". In this study, for the nurses, empathising with others became an affective process that involved adjusting one's behaviour, actions and emotions in order to make sense of what others were feeling and thinking. Empathising enhanced some of the nurses' capability to critically think about their actions and reactions and how that impacted on others. Empathizing required that the nurses engage in a new and meaningful way of understanding the health care needs of LGBTI patients and responding to those needs in an appropriate manner. Equally, Cooley (1902/1983a:152) asserts that by engaging oneself imaginatively in the circumstances of another person, the individual learns the human capacity of seeing the 'self'. Assuming the role of the other, is viewing the world from another's perspective and is significant in gaining insight into one's own behaviour in a situation. Assuming the role of the other makes it possible to anticipate and make sense of one's own behavior, because an opportunity and a perspective from which to view the 'self' has been provided (Chenitz & Swanson 1986:5).

Similarly, in this study, empathising allowed nurses to reflect on how one would act, react and think if faced with the similar challenges as LGBTI patients. Several nurses expressed empathising with LGBTI patients by sharing that they were aware of the challenges that LGBTI people face in their families and in the health care system. Some uttered that they had to understand the behaviour of LGBTI people in order to understand the challenges that they encounter. Some nurses empathised by sharing with patients their experience of interacting with LGBTI people either as a friend or relative. They shared how being related to LGBTI person has increased their understanding and developing of empathy for LGBTI patients. Nancy Eisenberg declares that in order to understand the reason why people care for others, she defined empathy in affective terms "an affective response that stems from the apprehension or comprehension of another's emotional state or condition, and that is similar to what the other person is feeling or would be expected to feel" (Eisenberg 2002:135). Therefore, the term empathy, as evident in this study, implies the ability to obtain knowledge of the subjective side of another person.

6.4.3. CATEGORY 3: SEEKING UNDERSTANDING OF LGBTI PEOPLE AND THEIR HEALTH CARE NEEDS

According to Blumer (1969:53), whilst people are in interaction with the 'self' and others, they form their respective lines of action by directing, checking, bending, and transforming their lines of action in the light of what they encounter in their actions with others. Blumer's notion is deemed to be congruent with the third category of this study, namely: **'seeking understanding of LGBTI people and their health care needs'**. The category: '**seeking understanding of LGBTI people and their health care needs**' emerged as a responsive and adaptive processes of acquiring new knowledge about LGBTI issues and their health care concerns, thereby transforming their lines of actions and behaviour. Mezirow's transformative learning theory focuses mainly on the process of personal transformation and empowerment (Mezirow 1978:7). According to the theory, disorienting

dilemmas, critical reflection, and rational discourse are viewed as experiences that could bring about transformative learning, with the application or experiencing of one or some combination of these elements. A disorienting dilemma is described as a dilemma that causes a significant level of disruption or disturbance in a person and where their frame of reference is deemed to be inadequate to explain their perceptions and experience (Mezirow 1996:163). Critical reflection, on the other hand, is described as a process whereby a person intentionally construes new meanings as a result of examining their own beliefs. Similarly, the category: '**seeking understanding of LGBTI people and their health care needs'** emerged when nurses acknowledged having limited knowledge about of LGBTI health care, seeking various ways of acquiring new knowledge about LGBTI people and their health care concerns.

Similar results were also found in the study by Dorsen (2014:99-102), where the nurse practitioners in that study affirmed that viewing LGB patients as a vulnerable population with special health care needs constituted a new experience for them. They affirmed that they lacked the necessary information about LGB health in their formal education, clinical training or continuing education experiences, which caused them not to acknowledge the presence of LGB patients in clinical practice. Many nurse practitioners in the same study shared that they lacked basic knowledge about LGB culture, the common experience of stigma and marginalisation that many LGB persons experience, and the effect that this may have on their health care access and utilisation, as well as on the health care needs of individual LGB patients (Dorsen 2014:98-99). As a result of the lack of knowledge in LGB health issues, nurse practitioners were uncertain about the significance of sexual orientation when it comes to health care, and how it might impact on the care provided to LGB patients. The study of Kitts (2010:739,742) on physicians' knowledge and attitudes towards LGB adolescents in the context of the increased risk of depression and suicide among LGB adolescents yielded similar results. A majority of participants in that study expressed that they did not have the

necessary skills to address the issues of sexual orientation/gender identity with the patients.

Taylor (2000a:292) identify the four processes of learning as follows: 1) to elaborate an existing point of view by seeking evidence to support our initial bias regarding a group and/or expanding the range or intensity of our point of view; 2) to establish new perspectives by encountering a new group and focusing on their perceived shortcomings thereby creating new negative meaning schemes for them; 3) to transform our point of view by critically reflecting on our misconceptions of a particular group and consequently changing our perception toward the group involved, becoming more tolerant and more accepting of members of that group; and 4) to become aware and critically reflective of our generalised bias in the way we perceive groups other than our own. The author asserted that such epochal transformations are less common and more difficult, since people do not make transformative change in the way they learn, rather, they learn what fits comfortably in their existing frames of reference. Correspondingly, in this study, '***reframing personal and professional values'*** for the nurses ought to commence with gaining more knowledge and understanding of LGBTI people and their health care needs. In this study, nurses critically reflected on their limited knowledge of LGBTI people and their health care issues.

A human being recognises himself and perceives himself as a student and acts accordingly by learning new facts and information (Blumer 1969:13), which is a resource in the adult learning process (Knowles 1990:57-63). Thus, to become meaningful, learning requires that new information be integrated by the learner into an already well-developed symbolic frame of reference, an active process involving thought, feelings, and character. At the same time, the learner may also have to transform his or her frame of reference to adequately understand the experience (Knowles 1990:57-63). Similarly, in this study, for the nurses to acknowledge the need to acquire new information about LGBTI people and their health care concerns was seen to be consistent with Knowles' (1996:253-

264) assertion that adults are motivated to learn by both extrinsic and intrinsic motivators. Adults respond to extrinsic motivators such as promotion and bonuses, as well as intrinsic motivators, such as the need for self-esteem, broadened responsibilities, power, and achievement. Thus, adults may only be motivated to learn when they perceive a need to learn. On the same note, people are able to become more 'inclusive, discriminating, reflective, open, and emotionally able to change'. Likewise in this study, nurses discussed addressing the need to learn about LGBTI people and their health care concerns as involving: 1) "raising awareness"; 2) "needing to understand"; 3) "needing education and training"; 4) "wanting to learn"; and 5) "wanting to be empowered". The process revealed the eagerness of nurses to acquire deeper understanding of LGBTI issues and the various mechanisms that they suggested to enable them to acquire more knowledge about them. At the same time, recognising the need to learn about LGBTI health issues revealed the desperation of LGBTI patients to be treated by nurses who are competent in LGBTI health care. LGBTI participants regarded competent nurses as facilitators of enabling LGBTI-friendly health care services. Similar results were found in the study by Dorsen (2014:100-101), which depicts that the nurse participants made a conscious decision to seek knowledge and experience that was essential for them to provide inclusive LGB care.

Brookfield (2012:131) views learning as the conceptual domain concerned with the acquisition of knowledge, skills and understanding which emerged through various processes e.g., reading, studying, being taught, teaching others, curriculum development, pedagogy, different ways of taking in, interacting, constructing, assimilating knowledge along with improving one's understanding of that knowledge, and social and community advancement. Likewise, most nurse and LGBTI participants in this study added a new strategy of acquiring new knowledge as 'learning from each other'. Both LGBTI and nurse participants viewed learning from each other as a mutual and interactive process that takes place between people and results in connecting existing and new knowledge in order to obtain a better understanding of the

phenomenon being addressed. Therefore, according to the participants, knowledge is generated in action and interaction through sharing. One LGBTI participant affirmed that LGBTI people ought to facilitate community engagement, raise awareness, and take responsibility to promote sensitivity and understanding of LGBTI people to the community by conducting workshops. This will enable the community to reflect on how their values, attitude and bias impact on the life of others who are regarded as having a non-conforming sexual orientation.

On the same note, Brookfield's (2012:131) view of acquiring of knowledge, skills and understanding through various processes were consistent with what the majority of nurses in this study suggested, viz. learning from other health care workers who have experience in working with LGBTI people; a one-on-one interactive and collaborative process of learning from others; e-learning methods where information could be shared through available electronic media; establishing a database on LGBTI health issues; periodic counselling sessions; giving and receiving feedback, benchmarking with other institutions; and engaging in support groups. For the nurses, collaborating with others who are knowledgeable about LGBTI issues will assist them in working with LGBTI patients to bridge their knowledge gap. A study by Dorsen (2014:117) yielded similar results when it discussed that once nurses have developed the intention to provide LGB inclusive care, most acknowledged the need to gain the required knowledge and experience to do so. They suggested formal professional educational activities, such as conferences or online educational modules, to fill in any gaps in knowledge regarding LGB and their health care concerns. Furthermore, they suggested formal or informal clinical experiences and/or mentorship within the LGB community as a way of gaining a deeper understanding of the culture and experiences of the LGB community that impact on access to health and social services.

6.4.4. CATEGORY 4: MAINTAINING PROFESSIONAL OBJECTIVITY

The fourth category: ‘maintaining professional objectivity’ demonstrated how the nurses reflected on their professional ‘self’ and their responsibilities towards others and therefore developed the strategies to enhance the care that they provide to LGBTI patients. The findings revealed how their understanding of LGBTI people, their health care concerns and their professional values influenced the way that the nurses perceived and interacted with LGBTI patients. The International Council of Nurses (ICN) Code of Ethics (2006:1) is explicit in its mandate that the nurses respect human rights and not discriminate against any patient, stating that “inherent in nursing, is respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect”. The (ICN) Code of Ethics (2006:1) and the Code of Ethics for Registered Nurses (CAN 2008:1) states that nursing care is respectful of and unrestricted by considerations of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status”. The Code of Ethics for Registered Nurses (CNA 2008:6) provides guidance for ethical nursing practice by identifying key professional values and the need to address inequities in health care, thus instructing the nurses to reflect on their professional actions and interactions when providing care to the patients. In the same manner, the nurses’ pledge of service and the Code of Ethics for Nursing Practitioners in SA mandate the nurses to respect human rights without consideration of age, colour, race, creed, disability, illness, nationality, gender, sexual orientation, or social standing. The nurses’ ethical values are embedded in the Code of Ethics, and therefore provide the framework for decision-making in clinical practice.

According to Shulman (1991:15), professional objectivity is valued as the quality that allowed the carer to separate him or herself from subjective feeling, attitudes and beliefs. Equally, the fourth category: ‘maintaining professional objectivity’ revealed the affective, cognitive and behavioural processes of how the nurses having realised and applied their professional ‘self’ by making references to their professional values have consequently assisted them in

changing their attitude and practice in caring for LGBTI patients. The category provided insight into how the ethical guidelines, as well as the values and codes of conduct of the nursing profession provided guidance to their decision-making. Parallel to the findings of this study, some authors have described professional values as standards for action that provide a framework for evaluating nurse's actions. In practice, when nurses make decisions, they make reference to professional code of ethics as a way of interpreting their professional obligations (Weis & Schank 2000:201). Likewise, in this study, by reflecting on their professional values, the nurses recognised the significance of not discriminating against LGBTI patients, and therefore treating them the same as heterosexual patients. In the same way, Dorsen's study (2014:95) yielded similar results to those of this study, where thenurse practitioners in that study, articulated that the core value in nursing, of caring for diverse groups of patients, has helped them in embracing LGB patients. Therefore, for those nurse practitioners, "treating everyone the same" and not discriminating against LGB patients in their clinical environments became crucial.

6.4.5. IMPLICATIONS OF THE STUDY

The discussion in this Chapter elucidates the epistemological stance of the participants, which informed the emergent core category of this study and demonstrates its relationship to all other categories and sub-categories. The categories and sub-categories that emerged from the data informed the conceptualisation of the core category and subsequently the substantive theory of this study. The implications of the study are that interactions between four categories revealed the emerging core category: 'reframing personal and professional values' which outlined the meanings, processes and contexts for the studied phenomenon of facilitating LGBTI inclusive PHC. The categories depict how participants understood, interpreted, and discovered their self-concepts through their experiences within the physical, psychological, social and structural contexts. The nurse participants were able to recognise and acknowledge how their values and beliefs influenced their thoughts and perceptions about oneself, others and the environment, how they differ from

those of others, and how they influenced interaction with others. Being aware of their own values, beliefs and attitudes provided the nurse participants with the moral judgment of counteracting any prejudice and intolerance that they might have towards their LGBTI patients. The nurse participants were able to reframe their personal and professional values by adopting strategies to help them maintain their professional objectivity.

6.4.6. CONCLUSION

In this chapter, the findings of the study were compared to research literature, positioning and justifying its relationship to the literature and the chosen theories like Mezirow's transformative learning theory. The discussion emphasised how the core category of this study has supported, added to and/or challenged the literature and theories as cited. Comparing the core category to extant literature has enhanced insight into the theory that emerged from this study and its concepts and further highlights the contributions of this study towards development of new knowledge.

CHAPTER 7:

THE SUBSTANTIVE THEORY OF FACILITATING LGBTI YOUTH-INCLUSIVE PHC

7.1. INTRODUCTION

In Chapter 4, the research findings were presented in the form of categories and subcategories that formed the core category: 'reframing personal and professional values'. In Chapter 5, the focal concepts of the core category were discussed and presented in a conceptual framework. In Chapter 6, the findings were discussed by extant theory and literature to enable the researcher to indicate the relationships between the focal concepts and other theories (Charmaz 2006:169). In this chapter, the process of theory synthesis is summarised and the theory is presented alongside the core category. The aim of this study was to develop a substantive theory focused on the basic social processes involved in facilitating LGBTI youth-inclusive PHC in Tshwane District, Gauteng Province, South Africa.

7.2. THE PROCESS OF THEORY SYNTHESIS

This section presents the process of theory synthesis, which informed the conceptual emergence of the substantive theory of this study.

A theory according to Saldaña (2013:250) "… is a condensed form of wisdom we formulate from our own experiences that we pass along to other generations", and occurs through the process of theoretical integration. Theoretical integration is the final stage of grounded theory and involves the elevation of concepts and categories from abstract to a conceptual level through the process of conceptualisation to become a working theory. Birks and Mills (2015:108) identify three factors that are essential in theoretical integration: 1) the identification of the core category; 2) theoretical saturation of major categories; and 3) gathering of theoretical memos. This process facilitates the relationship between the core category and the emergent theory.

The role of grounded theory is to facilitate the emergence of a theory from the participants' data that accounts for a pattern of behaviour which is relevant and problematic for those involved (Glaser 1978:83), as was the case with this study. The theory should also account for the variations in the participants' behaviour by using the least amount of concepts, at the same time ensuring parsimony and scope (Glaser 1978:93). The core category is the key variable identified in the data, and is related to, has explanation for, and forms the link between all the other categories included in the theory (Glaser 1978:93). The identification of the core category takes place through emergence and attempts to answer these questions:

a) what is the main concern or problem of participants?
b) what accounts for most of the variations in the processing of the problem or concern? and
c) what category or property does this incident indicate (Glaser 1992:4)? Therefore, the grounded theory method aims to identify the phenomenon, the causal conditions; contextual and intervening conditions; strategies; and consequences. The final product of grounded theory research is the emergence of the substantive theory, consisting of identification and explanation of the core category and its related properties, as well as categories (Glaser 1992:108). Therefore, in this study, linking the categories, sub-categories, and the core category to one another has assisted with finding the interrelationship amongst categories that support the emerging theory. The final product of substantive theory explains the major problems or concerns of the participants, as well as how they resolve these problems, which will be explained in detail later in this chapter.

A substantive theory is defined by Bryant and Charmaz (2007:610) as a "theoretical interpretation or explanation of a delimited problem in a particular area". The substantive theory of this study will provide a theoretical analysis of how meanings, actions and social structures are constructed (Charmaz

2006:151). The researcher endeavoured to ensure that the substantive theory that developed from this study has been generated from the participants' data, illustrates that it is positioned within a specific context, and discusses what participants viewed as significant issues in the phenomenon being investigated. The phenomenon of interest in this study was the process of facilitating LGBTI inclusive health care during interaction between nurses and LGBTI patients within the context of PHC.

The researcher may choose to select a core category that summarises and explains substantive theory comprehensively. Through further theoretical sampling and selective coding, the researcher may realise the core category in a highly abstract conceptual way. This is achieved through full theoretical saturation of both the core category and its related categories, sub-categories and their properties (Birks & Mills 2015:12). In addition, Glaser (2005:np) assert that, when describing the theory, only variables that are related to the core category ought to be included. The core category should be described according to: 1) its relevance; 2) explanatory power as reflected in the data; and 3) categories (gerunds) which highlight processes and changes which are the main properties of basic social processes. Pervasiveness, which is core process that gives rise to the word "basic" in the basic social process, as well as full variability and change over time, are some of the key properties of basic social processes of social life that people undergo (Glaser 2005:np). The basic social processes should uncover what condition or variables give rise to particular variations and therefore, ought theoretically to account for them (Glaser 2005:np). Meanwhile, process suggests a time-based dimension, where focus is placed on patterned lines of actions as they occur over time under different conditions to generate change. Thus, change is an inherent feature of basic social processes, as their stability and variability and contributes toward resolving and solving the problems of those involved. For example, in this study, "facilitating LGBTI youth-inclusive PHC" is the basic pattern or processes that occurred over time, regardless of variation in individual experiences. For this reason, the core category serves the purpose

of the substantive theory of facilitating LGBTI youth-inclusive, as it uncovers the relationships and the causal conditions (those factors that caused the phenomenon), identify strategies (actions taken in response to the phenomenon), identify contextual and intervening conditions (factors that influence the strategies), and outlines the consequences (outcomes from using the strategies) of the phenomenon of the substantive theory (Bluff 2005:161162).

Glaser (2005:np) describes two basic models for finding a basic social process: 1) by discovery and 2) by emergent fit. By discovery, the basic social process is unfolded by the researcher through observation and interviewing of the unit. The most significant social problem of those involved, and subsequently, the core variable (basic social process) that accounts for most of the variation in the behaviour about the problem, is discovered. The researcher therefore then shifts focus from studying the unit to studying the process and proceed to generate a substantive theory of the process by constant comparisons of incidents within different comparative groups in the same substantive area. Thus, in this study, by emergent fit, the researcher has discovered the basic social processes, and therefore wishes to extend it and present a substantive theory of facilitating LGBTI youth-inclusive PHC.

7.3. PRESENTATION OF A SUBSTANTIVE THEORY OF FACILITATING LGBTI YOUTH-INCLUSIVE PHC

In this section, the substantive theory and its application in this study will be presented as informed by the core category that was discussed in Chapter 5 and 6.

Goulding (2002:91) declares that there are no stringent methods for presenting the theory. The way in which theory is presented may be independent of the process by which it emerged. It may be presented in the form of a set of propositions, or it may consist of a theoretical discussion using conceptual

categories and their properties. However, the theory should be written in such a way that it demonstrates to the reader how concepts emerged and developed from the data, how the researcher moved from description through the process of abstraction, and how the core category was generated (Goulding 2002:90). This calls for a degree of creativity in writing up the grounded theory (Glaser 1978:22). Nevertheless, the researcher should still ensure that the reader understands the theoretical framework by providing an extensive abstract of the overall framework and its principal associated theoretical statements.

In this study, the substantive theory is presented in the form of a storyline, which provides an in-depth description of the categories, sub-categories, core category, and how they relate together to form the final theory. Authors like Birks and Mills (2015:114), Creswell (1998:57) and (Urquhart 2013:18,184) emphasise the significance of storyline as part of theoretical integration to create a narrative of the research process and the research outcomes and to guide the development of the final product, which is the theory. The initial integration of the substantive theory began during theoretical sampling of the nurse participants. The integration of the core category, categories and related concepts was used as a starting point and was continuously revised on the data to avoid the researcher's bias. Throughout data analysis, in this study, the mutual relationship between the core category: 'reframing personal and professional values' and the substantive theory: 'facilitating LGBTI youth-inclusive care' emerged. The core category emerges "when the researcher can trace connections between a frequently occurring variable and all of the other categories, sub-categories and their properties and dimensions", as Birks & Mills (2011:101) have suggested.

Following further constant comparative analysis the core category: 'reframing personal and professional values' was found to be adequate in explaining the basic social processes of facilitating LGBTI youth-inclusive PHC. The core category reveals that there were changes in the social phenomena being

investigated that occurred over time. It became clear that facilitating care encompasses looking back and reflecting on barriers towards care and tackling and overcoming those barriers so as to accommodate the health needs of LGBTI patients. The core category is therefore presented in the form of the 'gerund' "reframing", which provides a sense of movement, process or change (Glaser 1978:97). "Reframing" implies considering alternative frames, so that one can view things from a different perspective. In this study, 'reframing' means: 1) challenging the beliefs or other aspects of the frame; 2) standing in another frame and describing what you see; 3) changing attributes of the frame to reverse meaning; and 4) selecting and ignoring parts of words, actions and frame to highlight and moderate various elements. Therefore, facilitating LGBTI youth-inclusive PHC is a process that commences with nurses identifying the barriers to care as: 1) conflicting values; and 2) lack of knowledge about LGBTI people and their health care concerns, which are regarded as the main concerns for both LGBTI and nurse participants. Identifying the barriers of facilitating LGBTI youth-inclusive care is followed by nurses overcoming those challenges by changing, altering, modifying, transforming or adapting their values, beliefs and attitudes and recognising the need to acquire more knowledge about LGBTI people and their health care concerns in order to facilitate LGBTI youth-inclusive PHC.

Through theoretical coding, which is the final stage of coding in grounded theory, concepts of the core category were further refined and expanded into a theoretical structure (Stern & Porr 2011:70), leading to the emergence of a substantive theory (Birks &Mills 2015:13). According to Glaser (1978:72), "…theoretical codes conceptualize [sic] how the substantive codes may relate to each other as hypotheses to be integrated into a theory" and in accounting for resolving the main concern (Glaser 1998:163). Identifying theoretical codes is significant to the development of a substantive theory (Hernandez 2009:56). Furthermore, Hernandez (2009:54) explains that the "discovery of the ultimate theoretical code that integrates the substantive theory will probably occur during the selective coding phase, that is, after the core category has

emerged". Therefore, in this study, the selection of a core category became a guide for theoretical sampling, which focused on the collection of data that theoretically saturated the core category and other related categories and subcategories (Birks & Mills 2015:12; Glaser & Strauss 1967/2006:42-45). Theoretical coding enables the researcher to refine the properties and relationships of the emergent categories and the core category, which led to the conceptual emergence of the substantive theory (Glaser 1978:117; Birks & Mills 2015:13). This conceptualisation was theoretically enhanced through the application of the three basic tenets that underpin symbolic interactionism: 1) humans act towards things on the basis of the meaning they attach to them; 2) the meaning of things is derived from the social interaction with others; and 3) the meanings are modified through an interpretive process (Blumer 1969:2; Plummer & Young 2010:310), which provided a practical theoretical framework by means of which to explain this substantive theory. This process has assisted in the development of the properties of the emerging categories and the core category and ultimately the conceptual emergence of the substantive theory of facilitating LGBTI youth-inclusive PHC.

The discussion of the substantive theory explicates the different epistemological positions of participants, and demonstrates its relationship to all other categories and subcategories. In this study, the core category, which explains the basic social process is that of 'reframing personal and professional values', is a multivariate interplay of numerous features that contribute to the explanation of how the process of facilitating LGBTI youth-inclusive PHC unfold for the nurses. As a result, the substantive theory is linked to categories and sub-categories, which are clustered and presented as three phases of the process of facilitating LGBTI youth-inclusive care, as illustrated in the form of semi-circles linked together in Figure 7 to illustrate the interdependence of the three phases and are named:

a) Phase 1: Recognising barriers of facilitating LGBTI youth-inclusive care;

b) Phase 2: Recognising the need to change values and attitudes; and

c) Phase 3: Applying strategies to promote interaction with LGBTI patients. It ought to be noted that though the theory may be presented in the form of what might appear to be distinct phases, often times there have been between the different categories and sub-categories, as already explained in Chapter 5.

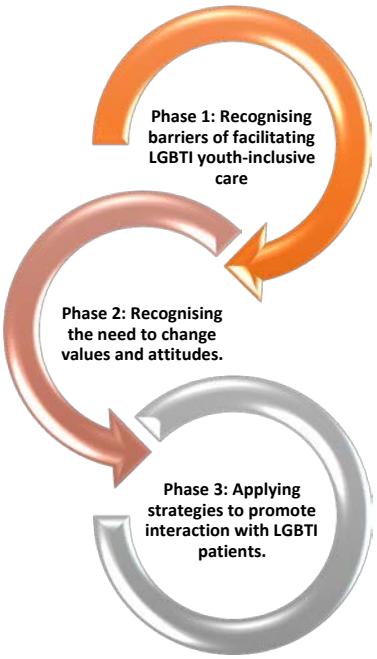


Figure 7: Phases of the process of facilitating LGBTI youth-inclusive PHC

Glaser (1978:95-96) asserts that the core category should be evident and have clear explanatory powers, which are reflective of the substantive theory. This is evident in Phase 1: Recognising barriers of facilitating LGBTI youth-inclusive care; Phase 2: Recognising the need to change values and attitudes; and Phase 3: Applying strategies to promote interaction with LGBTI patients, which explains what was happening in the analysed data. From the constant comparative method and substantive and theoretical coding procedures, it was possible to build up a picture of how participants identified and resolved their main concern. Different perspectives could be taken with regards to the core category developed within this study. Data from both LGBTI and nurse participants was used to understand and validate their main concerns during clinical encounters. However, since the substantive theory explains the basic social process of facilitating LGBTI youth-inclusive care by nurses, through

theoretical sampling of the nurse participant sample, only data obtained from the nurses was used to produce the core category and to explain the processes of facilitating LGBTI youth-inclusive care.

7.4. THEORY DESCRIPTION

In this section, a detailed description of concepts and statements, the attributes and properties of the concepts, as well as the theoretical definitions are outlined. The structure of the theory and its operationalisation are outlined.

In most instance the author prefer to use the theory guidelines of Walker and Avant (1995); Chinn and Kramer (1999); Duldt and Giffin (1985) are used. Walker and Avant's method involves: 1) concept synthesis; 2) statement synthesis; and 3) theory synthesis. The Chinn and Kramer's (1999) is:

a) describe the purpose of the theory;
b) define the concepts;
c) explain the relationship between the concepts; and
d) describe the structure of the theory; and operationalise the theory.

Duldt and Giffin's method (1985) is:

a) identify assumptions,
b) define concepts,
c) establish relationships; and
d) evaluate the theory.

The following headings for the theory description of this study are suggested:

a) purpose of the theory;
b) philosophical foundation of the theory;
c) context of the theory;
d) assumptions;
e) description of the concepts;
f) theory description;
g) relationship statements; and
h) synthesized theory.

According to Chinn and Kramer (1995:101) deliberative application of the theory has three subcomponents, namely:

a) selecting the clinical setting, which in this study is PHC;
b) determining the outcomes variables for practice, which in this study is optimising health care utilisation by LGBTI youth; and
c) testing the theory, which in this study will not be undertaken.

7.4.1. PURPOSE OF THE THEORY

The purpose of the substantive theory of this study is to improve access to and uptake of PHC service by LGBTI youth in Tshwane District, Gauteng Province. SA and to improve their health outcomes through the facilitation of LGBTI youth-inclusive PHC that is sensitive to their health needs. The substantive theory has, at its foundation, the basic social problem experienced by nurses during clinical encounter with LGBTI patients, and the basic social process used to deal with this problem. The nurses became involved in reframing their values according to their personal and professional life experiences when they experienced value conflict and tension. Therefore, the substantive theory of facilitating LGBTI youth-inclusive PHC is presented as the main resolution of facilitating care. The basic social problem explains how the nurses were able to identify and reflect on their values, beliefs and attitudes and how that negatively influenced their interaction with LGBTI patients, which is the main concern of participants. The main concern is both the cause and motivator for the resolution process. The basic social processes uncover what conditions or variables give rise to particular variations, and therefore, theoretically account for them. For example, in this study, “facilitating LGBTI youth-inclusive PHC” describes the basic pattern or processes, which occur over time, regardless of variation in individual experiences. Meanwhile ‘process’ suggests a temporal focus on patterned lines of actions as they occur over time, and under different conditions, to generate change. Thus, change is an inherent feature of basic social processes, as its variability contributes toward resolving and solving the problems of those involved.

7.4.2. PHILOSOPHICAL FOUNDATION OF THE THEORY

All theories must possess a philosophical basis underpinning the concepts and relationships articulated in the framework. The ontology of this study is concerned with meanings and interpretations between the participants' data, where the epistemological stance is constructivist in nature. This study is based on a constructivism philosophical foundation, which is adopted according to a grounded theory methodology, as well as symbolic interactionism, to develop the theory. Thus, symbolic interactionism is argued to be a theoretical framework underpinning this constructivist grounded theory research, as already discussed in Chapter 1 and 2.

Both symbolic interactionism and grounded theory focus on the studying of social processes (Bryant & Charmaz 2007b:21).

Symbolic interactionism depicts that, through social interaction, people learn the meanings of how others interpret their actions and interactions. Klunklin and Greenwood (2006:34) assert that interaction within the 'self' and with others allows people to understand a situation and make choice by deciding whether to change, adapt or maintain their course of action. This is relevant to this study, where the analysis suggest that the facilitation process is a dynamic occurrence involving actions, interactions, conditions and consequences of strategies employed by nurses to suppress, refute or remedy the effects of the value conflict and tension that the nurses experienced throughout the interaction process with LGBTI patients.

This grounded theory study interpreted data obtained from researcher-participant interaction, to explore the meaning of social reality to be discovered through social interaction (Moghaddam 2006:53), and analysed it in order to co-create and co-construct the theory (Watling & Lingard 2012:852). Early sensitisation to these aspects of the data underpinning theoretical advancement could explain how nurses linked together, their cognition and affection of the personal and the professional 'self', and how their perceptions and feelings positively influenced their interactions with the patients.

Categories such as 1) ‘tackling and overcoming personal subjectivity’, 2) ‘seeking understanding of LGBTI people and their health care needs’; and 3) ‘maintaining professional objectivity’ shed light on what motivated the nurses to facilitate care. Acknowledging the need to acquire knowledge and understanding of LGBTI people and their health care needs was an important feature that could provide a possible explanation of what being LGBTI meant, their lifestyle and health care needs, consequently changing the nurses’ attitudes and behaviour towards LGBTI patients. People who have insight into how similar or different they are from others are able to gain insight into the ‘self’, and therefore change. As people develop and change, they also develop new skills, abilities and understandings (Knowles 1996:253-264). In the same way, ‘seeking understanding about LGBTI people and their health care needs’ revealed how nurses intended to acquire new knowledge and understanding about LGBTI patients.

The nurses’ insight into their lack of knowledge, and having comprehension of the impact thereof on the outcomes of nurse-patient interaction, facilitated their interest in seeking knowledge and understanding of LGBTI people and their health care needs. Therefore, seeking more insight about LGBTI people and their health care needs was a conscious response to the lack of knowledge that was highlighted by the nurses as having negative effect on nurse-patient interaction, and emerged as meaningful facilitator of care. The ability of the nurses to seek new knowledge, and to elicit constructive attitudes and behaviour to acquire social skills and developing professional and social skills, has a positive impact on interpersonal and intrapersonal skills. Most commonly, nurses suggested that all patients ought to be treated with respect, and that LGBTI patients ought to be treated the same as other patients. This basic social process appeared to provide insight into the relationship between the nurses’ cognitive and affective processes, and social action and interaction.

7.4.3. CONTEXT OF THE THEORY

Strauss and Corbin (1998:106) explicitly state that “by context [they] mean the conditional background or situation in which the event is embedded”. The substantive theory of facilitating LGBTI youth-inclusive PHC is situated in the local and interactional context of the area of this study. The substantive theory assist in making meaningful theoretical connections between basic social problems and basic social processes, providing insight into the role that the core category played in the process of facilitating LGBTI youth-inclusive PHC during nurse-patient interaction. PHC is regarded as the first entry point into the health care system, and is geared towards health promotion, disease prevention, early diagnosis and treatment of diseases, and referral to secondary and tertiary health care (Fairman, Rowe, Hassmiller, & Shalala 2011:193; Dookie & Singh 2012:2). In most countries, 70-80% of nurse practitioners man the PHC services at a lower cost (Naylor & Kurtzman 2010:893; Fairman et al. 2011:193). In the USA, more than 16 million people are receiving PHC provided by nurse practitioners, who fulfill roles related to primary care, prevention, and care coordination with continued health care reform in large and small private and public practices (Fairman et al. 2011:193; Naylor & Kurtzman 2010:893-894). Studies have shown that primary care services provided by nurse practitioners are as safe and effective as those services rendered by physicians, and that in most cases, nurse practitioners, provided longer consultations and more information to clients than physicians (Fairman et al. 2011:193; Naylor & Kurtzman 2010:893-894). With this increased presence of nurse practitioners within PHC, it is anticipated that nurses will provide care to a more diverse client population, including those from the LGBTI community. It could also be proposed that the theory could potentially be used in other health care settings, or may possibly contribute to a formal theory.

7.4.4. ASSUMPTIONS OF THE SUBSTANTIVE THEORY

Polit and Beck (2010:4) refers to assumptions as “a basic principle that is believed to be true without proof or verification”. Assumptions are “embedded in thinking and behavior [sic] and therefore influence the development and implementation of the research process” (Burns & Grove 2009:40). The key assumption of the substantive theory is that the facilitation of LGBTI youth-inclusive PHC is an interactive and sensitive process to address the health needs of LGBTI youth. Personal and professional values of nurses are an important process and determinant for the achievement of effective access to and uptake of services among LGBTI youth. Therefore, the substantive theory of facilitating LGBTI youth-inclusive PHC serves as a point of departure for the assumptions of optimising of access to and PHC utilisation by LGBTI youth.

The assumptions of Blumer’s (1969) symbolic interactionism were adapted to this substantive theory. Symbolic interactionism suggests that the ‘self’ is reflexive, which implies that the person is capable of ‘getting outside of himself’ so that he can become an object to himself (Blumer 1969:138). Blumer’s notion was congruent with this theory, which demonstrates how participants understood, interpreted and discovered their self-concepts (which in this study refer to personal and professional self-concepts) through their experiences within the psychological and social contexts. Therefore, the central concept that shaped the substantive theory remained the use of the perception of self-concept, understanding it as shaping how people think and feel about themselves, others and the environment and ultimately determining how they perceive and respond to situations. Drawing on symbolic interactionism, the substantive theory of this study is based on the following assumptions about nurses:

a) the concept of the ‘self’ develops through a person’s lifespan and depicts that as a person gains insight into his/her identity, he/she develops an awareness of the ‘self’ and how the ‘self’ is similar or different from others.

b) self-awareness develops through self-interaction, self-reflection, and awareness of one's values, attitudes and beliefs.
c) acknowledging one's personal and professional identities and factors that contribute to the formation of those identities evolves over time.
d) the recognition of the self-concept impacts on the ability to change and adapt to situations.
e) the ability to change and adapt to situations facilitates understanding and regulates perceptions, behaviours and responses towards others.
f) changing perceptions about others demonstrate acceptance of differences and a sense of competence in caring for diverse patients.
g) for a therapeutic nurse-patient relationship to take place, one must develop the ability to 'put oneself in the patient's shoes', and see the world through his/her eyes.
h) being competent in caring for diverse patients enables the development and implementation of strategies that will optimise nursing care and health care outcomes of diverse patients.
i) exploring and applying strategies to learn about others demonstrate willingness to understand others' situations and challenges.
j) the therapeutic use of the 'self' in the context of being a nurse and in the profession of nursing is the key element of therapeutic nurse-patient interaction.

7.4.5. DESCRIPTION OF THE CONCEPTS

Grounded theory research is adequate for conceptual framework building due to its primary characteristics. It is a specific paradigm of inquiry that includes a number of distinct features, and involves the use of coding paradigms to ensure conceptual development, which facilitates "the generation of theories of process, sequence, and change pertaining to organizations, [sic] positions, and social interaction" (Glaser & Strauss 1967/2006:114). Therefore, it is imperative to develop concepts, each of which has its own attributes, characteristics, assumptions, limitations, distinct perspectives, and specific

function within the conceptual framework that shed more light on the phenomenon represented by the concepts themselves. Deleuze and Guattari (1991:15-21) assert that “every concept has components and is defined by them.” Using this definition, we can point to a number of aspects of the term “concept”. For example:

a) every concept has an irregular contour defined by its components;
b) every concept has a history;
c) every concept usually contains “bits” or components originating from other concepts.
d) all concepts relate back to other concepts;
e) a concept is always created by something;
f) every concept is “considered as the point of coincidence, condensation, or accumulation of its own components”; and
g) every concept must be understood “relative to its own components, to other concepts, to the plane on which it is defined, and to the problem it is supposed to resolve”.

Concepts are expressed through language, which is a means of both communication and interaction (Walker & Avant 2011:59). The synthesis was used as the approach of choice as it matched the research activities of the undertaken study. The rationale to select synthesis as the approach for theory-building type of research questions and aim of the study; which led to the use of constructivist grounded theory methodology, which required following the basic process of the study, without giving over to any preconceived ideas (Charmaz 2006:17).

A conceptual framework provides not a causal/analytical setting but, rather, an interpretative approach to social reality; therefore provide understanding, rather than offering a theoretical explanation, as do quantitative models. For the nurses, facilitating care involves the processes of identifying and reflecting on barriers that hinders nurses from facilitating LGBTI inclusive health care, and therefore, developed problem-focused strategies of seeking knowledge and

understanding, empathising, changing values, accommodating, valuing human dignity and establishing nurse-patient interaction. Strategies were aimed at mediating those factors identified as barriers of facilitating LGBTI youth-inclusive care. Facilitating care is influenced by a few concepts, viz.: 1) care; 2) facilitating care; 3) barriers to care; 4) nurses; 5) applying strategies; and 6) promoting nurse-patient interaction. For this reason, the relationships and interactions that occurred between the viewpoints of facilitating care are based on these concepts. Only the concepts related to the development of the emergent theory are defined below.

7.4.5.1. CARE

The term “care” is highly connected to nursing and is defined by Leininger (2001:4647) as an action of assisting others in meeting their real or perceived needs in an effort to improve their health conditions. Likewise, Swanson (1991:165) defines caring as “a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility.”

7.4.5.2. BARRIERS TO CARE

Barriers to care include intrinsic and extrinsic factors that limit or prevent people from accessing or receiving adequate health care (Carrilo, Carillo, Perez, Salas-Lopez, Natale-Pereira & Byron 2011:562). Among others, factors that are commonly associated with barriers to health care include: biological, economic, social and cultural factors (Phillips, Mayer & Aday 2000:66). In order to facilitate care, root-cause analysis should be undertaken by means of which to identify measurable and modifiable barriers and design interventions to address those barriers (Carrilo et al. 2011:563).

7.4.5.3. APPLYING STRATEGIES

Applying strategies refers to intentionally making means to attain a particular purpose. It refers to the implementation of plans and the application of forces and resources towards rendering quality patient care (John 2006:12).

7.4.5.4. FACILITATION OF CARE

Facilitation is a concept frequently used to refer to a strategy for enabling the process of developing nursing practice (Simmons 2004:36). Facilitation means to “make things easier” (Concise Oxford English Dictionary 2004:509). Therefore, facilitation of care implies applying strategies that enable nursing care.

7.4.5.5. NURSE

A nurse is a person who has obtained the necessary qualification at a tertiary institution and is registered or enrolled with the South African Nursing Council (SANC) that permits them to work in health care facilities and render nursing care to patients (Nursing Act No. 33 of 2005 as amended). A nurse is a person who possesses personal abilities and professional knowledge and skills to effect and affect positive outcomes for patients and self through a therapeutic nursing relationship.

7.4.5.6. NURSE-PATIENT INTERACTION

The relationship between the nurse and the patient is the key of nursing care and an interactive process between the nurse and the patient. In this relationship there is a mutual exchange of skills and personalities, which are equalised to establish mutual goals and pathways for satisfactory outcomes. The terms "nurse-patient relationship" or "nurse-patient interaction" are used synonymously to indicate a beneficial relationship wherein activities are directed to achieve beneficial outcomes for both patient and nurse (Travelbee 1966:125;155).

7.5. THEORY DESCRIPTION

The structure of the theory is described below. Table 9 defines the terms used in theoretical integration and theory building in the context of the substantive theory of this study. According to Strauss and Corbin (1998:166), process demonstrates the ability of individuals to respond to and/or shape the situations in which they find themselves. The theoretical model through which the

theoretical concepts were found to link together revealed a three-phase process. These three phases describe the phenomenon, conditions, actions, and outcomes of the process of facilitating LGBTI youth-inclusive PHC by nurses.

Table 9: Definition of the elements used in theory building

Term	Definition	Source
Basic social processes	Occurs around a core category or variable, accounts for patterns of behaviour and actions that are relevant and attempt to resolve problematic areas for those involved.	Glaser (2005:np)
Category	Concepts and properties that are generated from the data during data.	Hallberg (2006:143)
Concepts	Basic building blocks of a theory.	Walker & Avant (1995:37)
	Represent categories of information that contain defining attributes.	
Core category	Formed by identification and verification of relations between emerging categories and between categories and their properties in the data. Identification of a core category is central to the integration of other categories into a conceptual framework or theory.	Hallberg (2006:143)
Operational concepts	Indicates the relationship between the dependent and independent variable or concepts.	Walker & Avant (1995:25)
Substantive theory	An emergent theory developed inductively from interpreting the data generated within the context of the phenomena that the theory represents.	Baker, Norton, Young & Ward (1998:548)
	Predicts, explains and interprets phenomenon and enhances understanding and inform actions.	
Theory	An internally consistent group of relational statements that presents a systematic view about a phenomenon or process (action) and that is useful for description, explanation, prediction, and/or control.	Walker & Avant (1995:25)
Theoretical concepts	Describes the significant attributes of each concept.	Walker & Avant (1995:25)

The substantive theory describes three phases of integrating the basic social problem, so as to resolve the problem by unpacking how the nurses integrate

the personal ‘self’ and professional ‘self’, which is manifested in a person’s way of thinking, being, and acting (Hernandez 1995a:19). The personal ‘self’ refers to a person who is a member of a society and hold personal, social, cultural and religious norms, beliefs and values that have been acquired through socialisation. The professional ‘self’ refers to a person who is a member of a certain profession and has acquired norms, values and ethics of that profession. The nurses are central to the theory and they are actively involved in facilitating LGBTI youth-inclusive PHC, as evident in all the phases of the substantive theory.

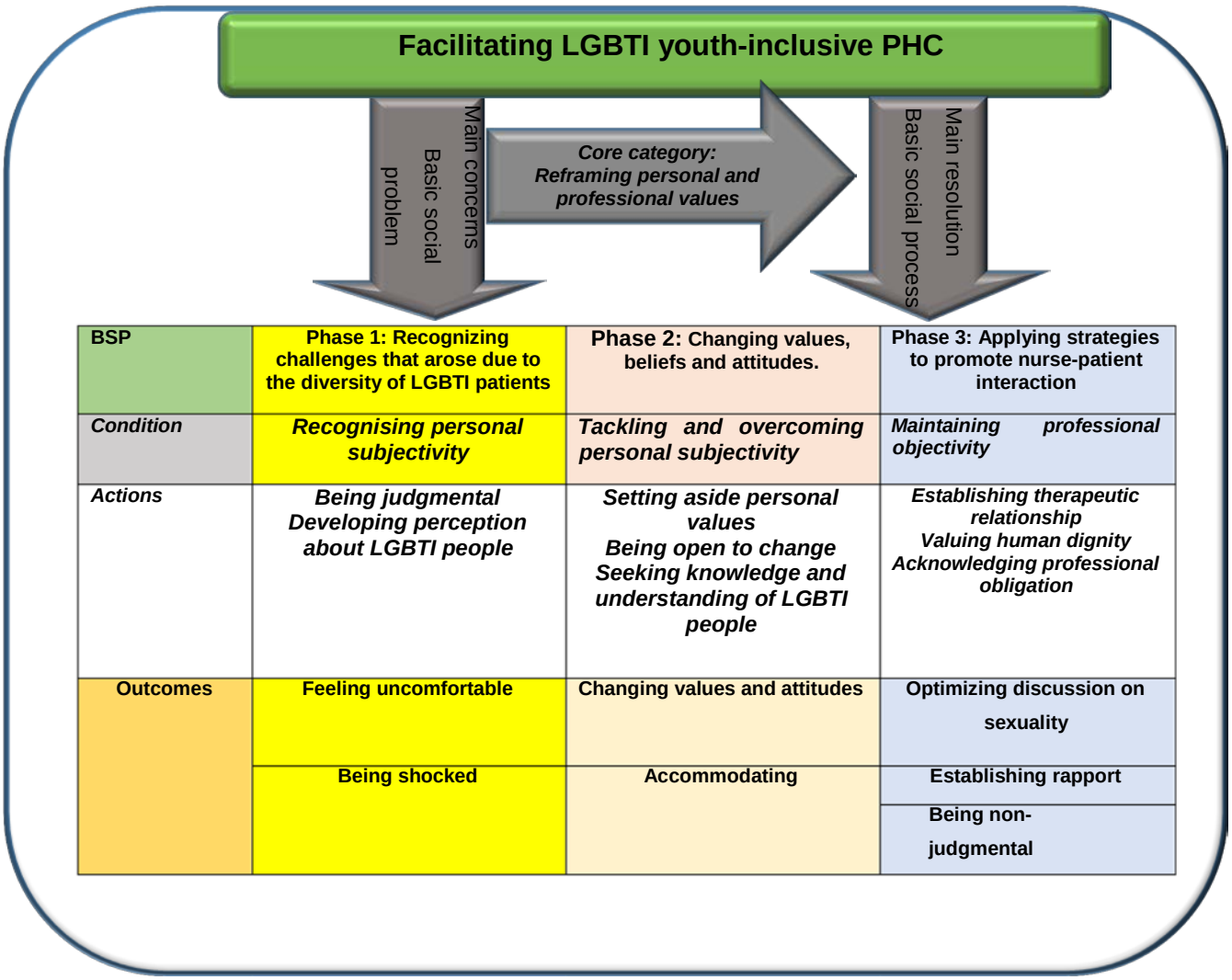
The substantive theory depicts that despite experiencing barriers that hindered nurses from facilitating LGBTI youth-inclusive health care, nurses are able to tackle and overcome their personal subjectivity as a way of resolving their main concerns. Those barriers are identified as the nurses’ personal values, beliefs and attitudes, which are perceived to be in conflict with those of LGBTI patients. The theory depicts that the personal and professional values are viewed as binary opposites.

For the nurses, being influenced by personal values contributes as a barrier towards facilitating LGBTI youth-inclusive health care, whilst being influenced by professional values and moral obligations that contribute towards facilitating LGBTI youth-inclusive health care. In some instances, nurses needed to change their self-concept by altering the personal self, by compromising their own values, beliefs and attitudes, and consequently altering perception about others. Baumeister (1998:680) asserts that the most significant feature of being interpersonal is self-presentation, which implies that self-identity is not an identity until it is recognised and accepted by others. Interpersonal relations always bring out emotions in people, where negative emotions are due to a threat or damage to a relationship; reported in this study, nurses experienced value conflict and tension; cultural shock; and feeling uncomfortable to discuss issues of sexual orientation. However, an increased affection in general conveys positive emotional outcomes (Baumeister, Campbell, Krueger & Vohs

2003:2), which in this study was reported as empathising and understanding of others' challenges. Baumeister (1998:713-714) reveals that the 'self' has the ability to control both the 'self' and the environment and can make decisions and initiate actions. This implies that if the 'self' did not have these capabilities, then people would be passive observers, who are just aware of themselves and their relation to other people, but without the ability to change any situation.

Baumeister (1998:713-714) assumes two kinds of control, viz. primary and secondary. Primary control refers to when a person is in need of a change to the environment, while secondary control is about a person changing the 'self' to adapt to the environment or challenging situations. Likewise, nurses in this study adopted both the primary and secondary control, by expressing their willingness to establish an enabling environment that promotes nurse-patient interaction, and establishing strategies to create a therapeutic environment for LGBTI patients, respectively.

Nurses adapted to their professional 'self', being guided by professional values and moral obligation to show respect and value the diversity and dignity of the patients. Despite the fact that this research did not set out to explore solutions, participants stated their opinions and persisted in offering their perceived strategies and recommendations as related to facilitating LGBTI youth-inclusive PHC. Therefore, the use of grounded theory here has successfully demonstrated how the theory may creatively inform practice and not only practice, but also nursing research and education.



BSP	Phase 1: Recognizing challenges that arose due to the diversity of LGBTI patients	Phase 2: Changing values, beliefs and attitudes.	Phase 3: Applying strategies to promote nurse-patient interaction
Condition	***Recognising personal subjectivity***	***Tackling and overcoming personal subjectivity***	***Maintaining professional objectivity***
Actions	***Being judgmental*** ***Developing perception about LGBTI people***	***Setting aside personal values*** ***Being open to change*** ***Seeking knowledge and understanding of LGBTI people***	***Establishing therapeutic relationship*** ***Valuing human dignity*** ***Acknowledging professional obligation***
Outcomes	**Feeling uncomfortable**	**Changing values and attitudes**	**Optimizing discussion on sexuality**
	Being shocked	**Accommodating**	**Establishing rapport**
			Being non-judgmental

Figure 8: The substantive theory of facilitating LGBTI youth-inclusive PHC

Figure 8 provides a visual model of some of the key concepts that led to core identification of the proposed basic social process theory of this study, viz. facilitating LGBTI youth-inclusive care. The model is set out as a series of rows, which represent attributes of each phase as informed by the categories. The uppermost block contains the title of the substantive theory or the main phenomenon, which sets the scene of the basic social process involved in this study. Linking the block to the columns are downward arrows, which depict the relationship between the main concerns, or the basic social problem, and the main resolution, or the basic social process, as expressed in the first three rows as phases of the theory. The directional arrow between the two downward

arrows illustrates the core category: ‘reframing personal and professional values’, which demonstrate a shift from nurses being influenced by personal values to changing their values and perceptions about LGBTI patients to being guided by professional values. The second rows depict phases of the theory, each phase is depicted as a step and the implication is that one is moving from one phase to another. This is an attribute of transforming from one level to the other. The second row on the left side of the Figure illustrates Phase 1: Recognising barriers of facilitating LGBTI youth-inclusive care, illustrates the barriers of facilitating LGBTI inclusive care as identified by participants.

The second phase is illustrated in the middle row and was labelled as Phase 2: Recognising the need to change values and attitudes, captures and defines actions and response to recognising barriers of facilitating LGBTI youth-inclusive care by the nurses. Phase 3: Applying strategies to promote interaction with LGBTI patients, which relates to actions and interactions employed by the nurses to facilitate LGBTI inclusive care, is followed by a row that shows the examples of code groupings of what motivate nurses to facilitate LGBTI youth-inclusive care. The third rows show examples of code groupings of actions of what nurses do in each phase facilitate LGBTI youth-inclusive PHC. The last rows indicate the outcomes or consequences of each phase, and are regarded as the goals of facilitating LGBTI youth-inclusive PHC. According to this theory, the nurses are viewed to be providing support and facilitating care in these phases.

The categories and sub-categories were theoretically coded as sub-processes of the substantive theory are discussed in greater depth in the three phases. The phases of the process will be outlined in greater details as follows:

7.5.1. DESCRIPTION OF THE PHASES OF THE SUBSTANTIVE THEORY

In this section the phases of the substantive theory will be discussed in detail.

7.5.1.1. PHASE 1: RECOGNISING BARRIERS OF FACILITATING LGBTI YOUTH-INCLUSIVE CARE

Phase 1: Recognising barriers of facilitating LGBTI youth-inclusive care will be outlined. The process of recognising barriers of facilitating LGBTI youth-inclusive care by the nurses has a set of essential variables of the sub-processes: recognising the influences of personal values and acknowledging the possession of limited knowledge, which represented the manifestations of problems and consequences of problems which did not occur in a sequential manner.

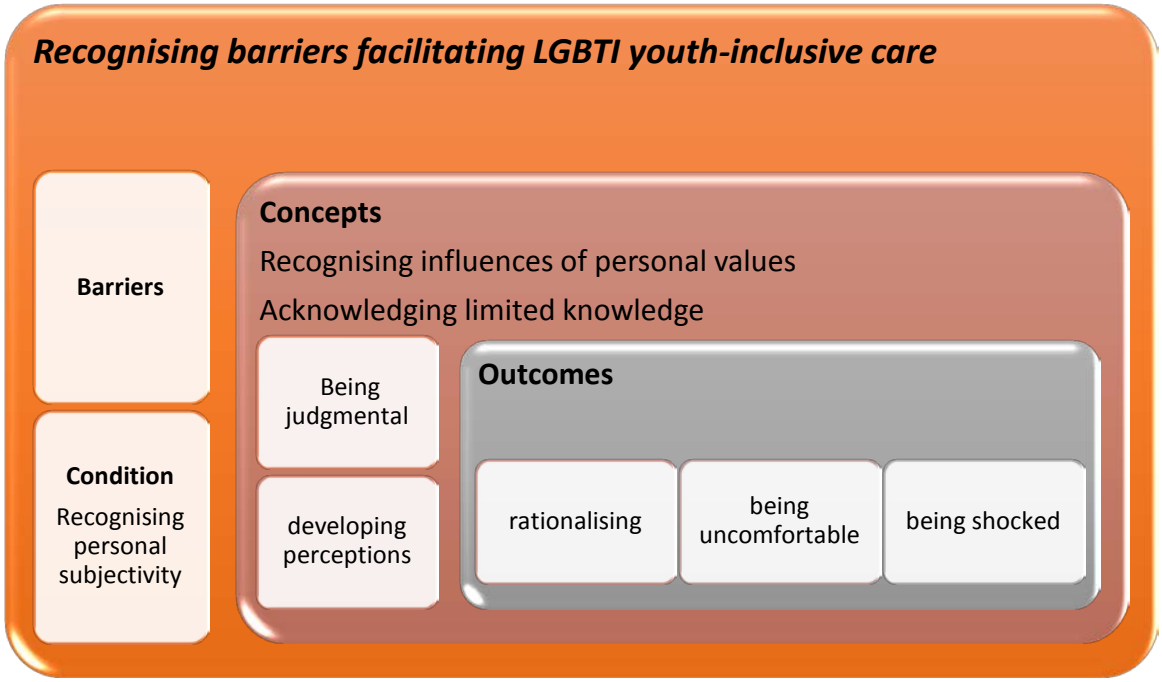


Figure 9: Phase 1: Recognising barriers of facilitating LGBTI youth-inclusive care

Phase 1: Recognising barriers of facilitating LGBTI youth-inclusive and its sub-processes are presented in a diagrammatic presentation in Figure 9, which depicts conditions, actions and outcomes of Phase 1. The interplay between actions and interactions of the sub-processes differs along the

process of recognising barriers of facilitating LGBTI youth-inclusive care by nurses and takes place at different levels of the process. This phase occurs under the conditions where nurses the nurses were able to recognise their personal subjectivity by identifying and reflecting on their values, beliefs and attitudes and how that influenced their interaction with LGBTI patients. The nurses initially described the barriers that hindered them from facilitating LGBTI youth-inclusive health care, which were identified as incongruent values, and were therefore regarded as the basic social problem or the main concern of the substantive theory. During this phase, the focus for the nurses was mostly on the personal 'self', where there were different personal factors that inhibited the nurses from facilitating LGBTI care ranging from personal, social, cultural and religious values and the lack of knowledge about LGBTI care. Among those factors, cultural and religious values stood out as influencing the attitude and behaviour of the nurses towards LGBTI patients. Based on their values they developed some perceptions about LGBTI patients. Phase 1 will be followed by a discussion of sub-processes related to the phase.

7.5.1.1.1. SUB-PRCESS 1.1: RECOGNIZING THE INFLUENCES OF PERSONAL VALUE

Sub-process 1.1: Recognising the influences of personal values emerged when the nurses were reflecting and identifying their values and beliefs, and considering how that affected their interaction with LGBTI patients. The process enabled the nurses to identify their biases and the source thereof, which were identified as personal values and beliefs emanating from socialisation, culture and religion. This process was the foundation of self-reflection, self-awareness and self-interaction therefore gaining insight into the 'self', and how the personal 'self' influence and affect their interaction with the LGBTI patients.

It is by means of these actions and interactions that nurses experienced the values of LGBTI patients as different from theirs, ultimately making clear the misunderstandings, tension and conflict that they experienced when they interacted with them. As the nurses gained insight into the 'self', in a subjective way they used their values, beliefs and attitudes to develop frames of reference about LGBTI people, and consequently, used those frames of reference to judge and developed certain perceptions about them. For the purpose of trying to understand how and why nurses often perceived their personal 'self' with regard to their values, beliefs and attitudes during the nurse-patient interaction, different theoretical approaches about 'self' and identity were compared to different aspects of the emerging theory about the process of facilitating LGBTI care.

Most nurses affirmed that they were socialised in a Christian hetero-normative society, in and according to which they developed negative perceptions about, as well as attitudes and behaviours towards the LGBTI people. Nurses were of the opinion that a man ought to be in a relationship with a woman, and vice-versa. Nurses became judgmental about how LGBTI people live, their lifestyle, their sexual relationships, risk activities they engage in, and their perceived health needs, which most definitely relied on stereotypes. At some stage, being LGBTI was perceived as a defence mechanism or a coping mechanism, a way of escaping from lives unpleasant experiences e.g., molestation during childhood. At some point, being LGBTI was perceived as a way of 'fending for oneself', especially among gays, who perceive male figures as providers of financial and material resources.

Being socialised in a heteronormative society has prompted the nurses to perceive being LGBTI as 'a taboo object', 'unreal', 'immoral', 'exhibition of anti-Christian behaviour'. Subsequent to having those perceptions about LGBTI people, the nurses felt uncomfortable discussing issues related to sexuality and sexual orientation, and in most cases, avoided discussing those issues. Nurses reacted in shock when they discovered the patients' sexual orientation

unexpectedly, and therefore found themselves not prepared or comfortable to discuss it. Some nurses reacted with shocked when they learnt about the non-conforming sexual orientation of the patients, due to the fact that: 1) they have never been face-to-face with LGBTI person before, but have only learnt through media about their existence; 2) the patients did not have external traits which might suggest a non-conforming sexual orientation; 3) culturally, being LGBTI is regarded as a taboo; and 4) in their view, being LGBTI contradicted their values and beliefs.

Developing perceptions about LGBTI patients prompted the nurses to rationalise what being LGBTI meant, in order to seek deeper understanding and to make sense of factors that contribute to people being LGBTI. The nurses used their perceptions to explore the reasons why people become LGBTI. Among other reasons, they perceived being LGBTI as an ‘inner self’, over which people have no control, or as ‘genetically inherited’, a trait with which a person is born. Some nurses perceived being LGBTI as a ‘lifestyle choice’, ‘actions and behaviour of insanity’ or ‘Satanism’. At the same time, the nurses’ professional experience made them perceive LGBTI people based on the external traits and gestures, as well as on clinical findings that the patients present within clinical practice.

The nurses were able to discuss sexual orientation with LGBTI patients in circumstances where a male patient presented with anal sores, which suggested that they had contracted an anal STI. According to the nurses, such ailments suggest that the patient could be homosexual, or engaging in a male-to-male sexual relationship. When the patients present with those conditions, the nurses realise the significance of discussing issues related to homosexuality with the patients. In the same manner, some nurses would perceive the patients as being LGBTI, based on the physical appearance or mannerisms, which are often interpreted according to generalisations or stereotypes on “how” gay or straight people should look or behave. In cases

where a male patients present with feminine looks, or speaks in a feminine voice, that patient will be presumed to be gay.

For the nurses, developing some perceptions about LGBTI patients seemed to provide a definition of what being LGBTI meant, therefore determining how they should respond towards the patient during clinical interaction. Recognising the differences that existed between their values and those of the patients, provided an opportunity for the nurses not only to know the other, but also to help gain a better insight into the 'self'. The experience of value conflict and tension associated with incongruent values between the nurses and LGBTI patients emerged as the main concern of participants.

7.5.1.1.2. SUB-PROCESS 1.2: ACKNOWLEDGING HAVING LIMITED KNOWLEDGE

Sub-process 1.2: Acknowledging having limited knowledge reveals that what nurses recognised as a barrier of facilitating LGBTI youth-inclusive care was having limited knowledge about LGBTI people and their health care needs. In some instances, what made the nurses uncomfortable to engage with LGBTI patients was the lack of training regarding LGBTI people and their health care needs. The nurses discussed limited knowledge on LGBTI people and their health care issues as a form of knowledge gap in the following ways: 1) being uncertain about what being LGBTI meant; 2) feeling helpless in providing care and support to LGBTI patients; 3) being ignorant about LGBTI issues; 4) assuming a heterosexist stance when interacting with LGBTI patients; 5) lacking knowledge about the behaviours and the lifestyle of LGBTI people; 6) lacking knowledge about the health care needs of LGBTI people; 7) lacking knowledge about the way in which the health care needs of LGBTI people should be addressed; 9) being uncomfortable to discuss LGBTI issues; 10) lacking adequate knowledge and skills in treating and caring for LGBTI patients; and 11) lacking adequate training about LGBTI people and their health care issues. The lack of knowledge about LGBTI health issues and their health care needs by the nurses became an issue of concern for the nurses,

which suggested that they were not providing adequate health care to LGBTI patients. This concludes the discussion of Phase 1: Recognising barriers of facilitating LGBTI youth-inclusive care, which informed the substantive theory of facilitating LGBTI youth-inclusive PHC.

7.5.1.2. PHASE 2: RECOGNISING THE NEED TO CHANGE VALUES AND ATTITUDES.

Phase 2: Recognising the need to change values and attitudes will be outlined as illustrated in Figure 10. Recognising the need to change values and attitudes reflects affective, cognitive and behavioural processes of how nurses redefined the way they perceived as well as behaved towards the LGBTI patients. Recognising the need to change values and attitudes occurred under conditions in which the nurses used their personal and personality traits to '*tackle and overcome their personal subjectivity*' towards LGBTI patients. The process reflects the nurses' willingness and ability to overcome the influences of their personal values and attitudes on nurse-patient interaction.

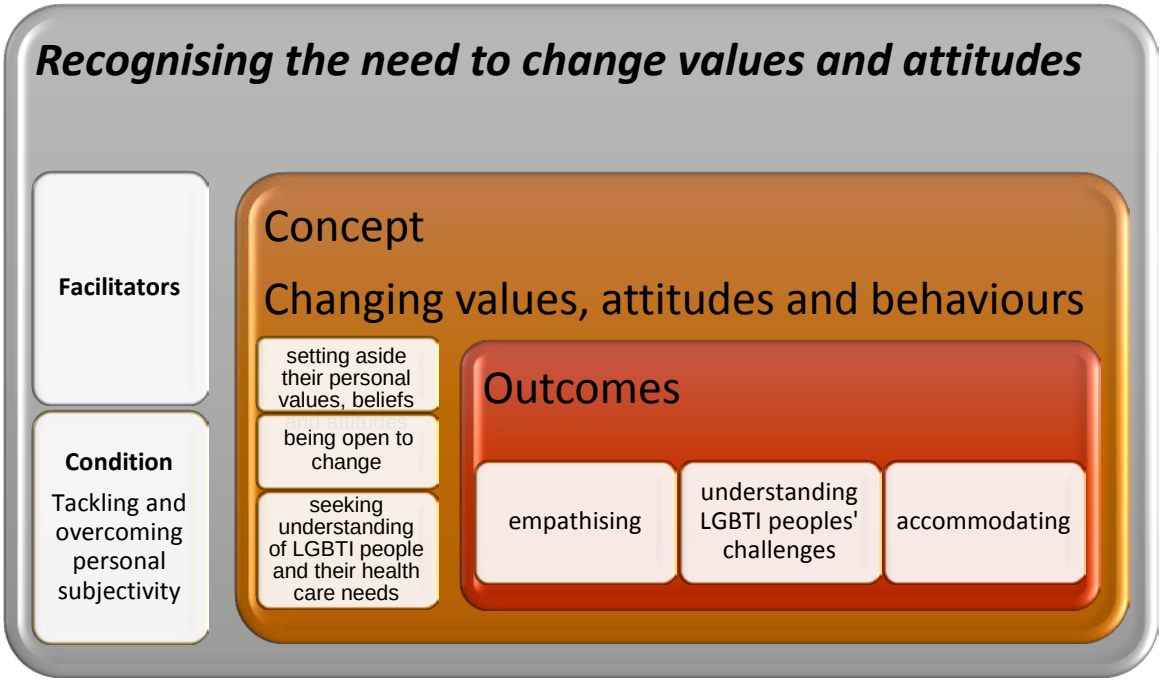


Figure 10: Phase 2: Recognising the need to change values and attitudes

This phase became a reflexive response, re-establishing the personal 'self' from the tension that they experienced due to value conflict and cultural shock. The nurses became aware of the 'self' within the context of themselves being both individuals and professionals, seeking various ways of resolving the tension experienced and its effects. They reflected further on their personal and professional values, beliefs and attitudes, and were over time able to pursue personal and professional transformation in order to establish a productive nurse-patient relationship in which they accommodated LGBTI patients on their own terms.

For the nurses, being aware of how personal traits like values and having limited knowledge, restricted them from facilitating LGBTI youth-inclusive care, aided them in expressing their willingness to change their attitudes towards LGBTI patients, and to be more accommodating of them and their health care needs. For the nurses, changing their values and attitudes towards LGBTI patients manifested in the following strategies and actions: 1) setting aside their personal values, beliefs and attitudes; 2) being open to change; and 3) seeking alternative ways of learning and increasing understanding of LGBTI people and their health care needs. Changing their values and attitudes towards LGBTI patients meant altering the meaning of their situation, which enabled them to gain some level of control and confidence in caring for LGBTI patients. Phase 2 will be followed by a discussion of sub-processes related to the phase.

7.5.1.2.1. SUB-PROCESS 2.1: SETTING ASIDE PERSONAL VALUES, BELIEFS AND ATTITUDES

Sub-process 2.1: setting aside personal values, beliefs and attitudes reflects that, for the nurses, by being aware of their own limitations in caring for LGBTI patients, they were able to set aside their personal values, beliefs and attitudes as a means of changing their attitudes and perceptions about LGBTI patients. Setting aside their own values and attitudes became a cognitive and affective

process guided by a combination of personal values, professional values and ethics. As a cognitive process, ‘setting aside personal values, beliefs and attitudes’ illuminated that the nurses understood the factors inherent in the conflict they experienced when they were faced with values in conflict with those of LGBTI patients. For the nurses, ‘setting aside own values, beliefs and attitudes’ became a process of suppressing and bracketing their own values, beliefs and attitudes and being open to change in order to meet their professional obligations towards LGBTI patients. Bracketing their own values also meant letting the patients know about the existing conflict of values and their feelings with regard to undermining the LGBTI community. However, bracketing was followed by reassuring the patients about not allowing personal feelings to affect their roles and moral obligations of caring for all patients in a humane manner.

‘Setting aside own values, beliefs and attitudes’ enabled the nurses to empathise with LGBTI patients. Empathising with LGBTI patients became an affective process that involved adjusting one’s behaviour, actions and emotions in order to make sense of what others are feeling and thinking. Nurses learnt that LGBTI people are ostracised in their families and society, including in the health care system. Thus, empathising allowed the nurses to reflect on how one would act, react and think if faced with the similar challenges as LGBTI patients. Empathising enhanced the nurses’ capability to critically think about their actions and reactions, engage in a new meaningful way of understanding the challenges and health care needs of LGBTI patients and responding to them in an appropriate manner.

It became apparent that for the nurses, being sensitive to LGBTI people and their health care needs was connected to understanding their challenges of discrimination in the society and the health care system, and therefore the need to meet their needs and to facilitate their care. In some instances, being aware and understanding LGBTI peoples’ challenges seemed to be strongly connected to experiencing professional and personal relationship with LGBTI

person either as a patient, an acquaintance or a relative, as they share with them their experiences of being judged and discriminated against. Through this interaction and experience, the nurses felt comfortable to accommodate a diversity of LGBTI patients.

7.5.1.2.2. SUB-PROCESS 2.2: BEING OPEN TO CHANGE

Sub-process 2.2: 'Being open to change', for nurses, involved transforming frames of reference through critical assessment and reflection of the assumptions they held about LGBTI people. For the nurses, '*being open to change'* constituted: 1) understanding of others' challenges; 2) changing attitudes; and 3) establishing new and changing old values. Being open to change has assisted the nurses to be more open to diversity and to be less judgmental about LGBTI patients. As the nurses became open to change, they became accommodative of the diversity of LGBTI patients, and began to perceive the patients' differences as distinctive personal traits of individuals that they have no control over, and ought not to be intimidated by. 'Accommodating' was seen as an affective process that involved giving up part of the 'self' in order to preserve the relationship with others. 'Accommodating' meant being sensitive to the needs and feelings of others including attending to those needs despite experiencing internal conflict.

The nurses shared how they had learned to deal with conflicting values by developing new attitudes and skills. They described how they became more accepting of others' differences and less judgmental of LGBTI patients. The nurses had to assess what should be achieved, which for them was meeting the needs of their patients, as opposed to what they had to give up, which in their case was their personal values, beliefs and attitudes during clinical interaction. As the nurses made this conceptual transition of reconciling differing values, they reported feeling more accountable for their own actions and began to perceive opportunities of caring for LGBTI patients in a humane manner. This increased sense of accountability and integrity helped the nurses to reach a compromising situation with regard to their values and avoided

judging and stigmatising the patients. As a result, this process has helped the nurses in eliminating or minimising their helplessness and the lack of confidence they had in caring for LGBTI patients.

7.5.1.2.3. SUB-PROCESS 2.3: SEEKING WAYS OF LEARNING AND INCREASING UNDERSTANDING OF LGBTI PEOPLE AND THEIR HEALTH CARE NEEDS

Sub-process 2.3: Seeking ways of learning and increasing understanding of LGBTI people and their health care needs commenced when the nurses acknowledged having limited knowledge about LGBTI people and their health care needs. Acknowledging having limited knowledge about LGBTI people and their health care needs is strongly linked to the nurses' eagerness to learn and increase their knowledge and understanding of LGBTI people and their health care needs. Acknowledging having limited knowledge about LGBTI health care involved nurses admitting that the lack of knowledge and formal education and training on LGBTI health care was a limitation towards efficiently accommodating the needs of LGBTI patients. Therefore, acknowledging the need to learn and increase understanding of LGBTI people and their health care needs expressed the nurses' self-determination and self-directed approach towards learning, an expression which became crucial in helping the nurses to change their attitude and perceptions towards LGBTI patients.

The sub-process: seeking ways of learning and increasing understanding of LGBTI people and their health care needs revealed that facilitating care for LGBTI patients involves the nurses gaining more knowledge and understanding of LGBTI people and their health care needs. The nurses discussed addressing the need to learn about LGBTI people and their health needs which demonstrated their eagerness to acquire deeper understanding of LGBTI issues. The nurses suggested various learning mechanisms that would enable them to acquire more knowledge about LGBTI issues. In addition, for some nurses, 'seeking knowledge about LGBTI issues' meant finding facts out of curiosity from the LGBTI community about the factors of being LGBTI, their lifestyle, sexual preferences, and sexual activities.

Nurses added a new strategy of acquiring new knowledge as ‘learning from each other’. They viewed learning from each other as a mutual and interactive process that takes places between people and results in connecting existing and new knowledge in order to obtain a better understanding of the phenomenon being addressed. Knowledge is generated in action and interaction, through sharing. Nurses suggested: learning from other health care workers who have experience in working with LGBTI people; a one-on-one interactive and collaborative process of learning from others; e-learning methods where information could be shared through available electronic media like emails; a database on LGBTI health issues; periodic counselling sessions; giving and receiving feedback; benchmarking with other institutions; and engaging in support groups. For the nurses, collaborating with others who are knowledgeable about LGBTI issues will assist those nurses working with LGBTI patients to bridge their knowledge gap. The nurses anticipated that these proposed innovative strategies will empower them to acquire the necessary knowledge that will aid them in facilitating LGBTI youth-inclusive care. Nurses shared how they had learned to deal with conflicting values by developing new attitudes and skills about LGBTI people and their health care needs. Fundamentally, the nurses shared how they have learned to become more accepting of others’ differences and less judgmental to LGBBTI patients. This concludes the discussion of Phase 2: Recognising the need to change values and attitudes, which informed the substantive theory of facilitating LGBTI youth-inclusive PHC presented in this study.

7.5.1.3. PHASE 3: APPLYING STRATEGIES TO PROMOTE INTERACTION WITH LGBTI PATIENTS

Whilst Phase 1 illuminates the subtle and covert ways that nurses used to make assumptions and judgments about LGBTI patients, Phase 2 and 3 reflect thoughtful and reflexive strategies used by the nurses to facilitate the care of LGBTI patients in the context of PHC. Phase 3: Applying strategies to promote interaction with LGBTI patients reveals conditions, actions and outcomes in which the nurses pursued to maintain professional objectivity when caring for

LGBTI patients. The conditions, actions and outcomes of Phase 3 are illustrated in Figure 11, and will be discussed in detail in this section.

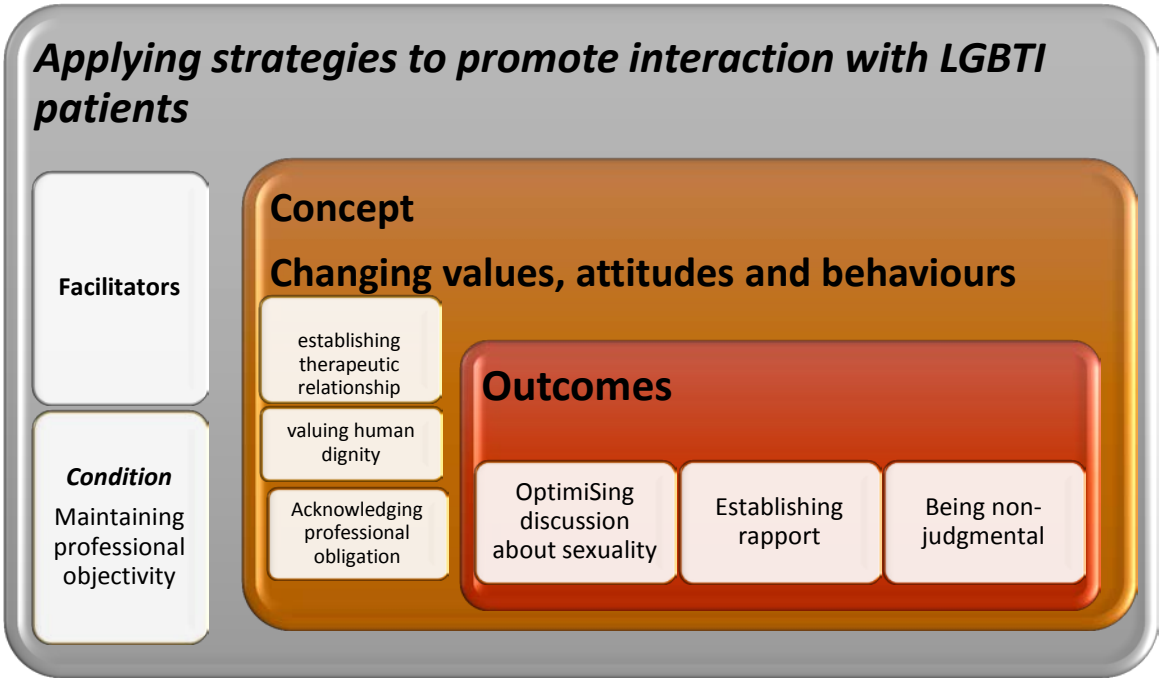


Figure 11: Phase 3: Applying strategies to promote interaction with LGBTI patients

Phase 3: Applying strategies to promote interaction with LGBTI patients involves actions of: 1) establishing therapeutic relationship; 2) valuing human dignity; and 3) acknowledging professional obligation, where these strategies will be discussed as sub-processes of Phase 3. Applying strategies to promote interaction with LGBTI patients demonstrated that for the nurses, reflecting on their professional 'self', and the values that guide their nursing profession and their moral obligation towards LGBTI people was what assisted them in developing strategies to facilitate LGBTI care. Nurses have, over time, learnt about the extent to which they made assumptions about LGBTI people based on their personal values, beliefs and attitudes, rather than being guided by professional values. They are of the opinion that professional values provide the rationale and an explanation for the ways in which they behaved and responded during clinical interaction with LGBTI patients. Nurses have learnt

that they might not have interacted with an individual patient *per se,* but rather the perceptions that they held about the patient was what influenced the way they interacted with them. Therefore, Phase 3: applying strategies to promote interaction with LGBTI patients explains how nurses reflected on their professional values and their moral obligations towards patients irrespective of their social circumstances.

The sub-process: seeking ways of learning and increasing understanding of LGBTI people and their health care needs explains that for the nurses, facilitating LGBTI youth-inclusive PHC involved nurses reflecting on professional values and moral obligations, and in this way, recognising the significance of not discriminating against LGBTI patients and creating an enabling interactive environment. The diverse and rich opportunities provided by professional values and moral obligations became a newly recognised source of meaning and contentment in facilitating LGBTI care, as nurses viewed nursing as a caring profession. Nurses acknowledged that the relationship between professional values and moral obligations became a mediating factor in the hindrance of facilitating LGBTI care as identified in Phase 1 of the substantive theory. Phase 3 shed light on how the nurses consciously developed approaches to manage tensions that existed when working with LGBTI patients. Phase 3 will be followed by a discussion of sub-processes related to the phase.

7.5.1.3.1. SUB-PROCESS 3.1: ESTABLISHING A THERAPEUTIC RELATIONSHIP

Sub-process 3.1: Establishing a therapeutic relationship with LGBTI patients demonstrates how the nurses' understanding of LGBTI patients and their health care needs, as well as how being guided by professional values, has influenced the way they perceived and interacted with LGBTI patients. Nurses adopted strategies of establishing a therapeutic relationship during clinical interaction with LGBTI patients which are described as: 1) establishing rapport; 2) increasing the patients' comfort level; 3) being available; 4) gaining patients'

trust; 5) engaging in open communication; 6) reaching out to the patients; 7) having good communication skills; and 8) treating people with respect.

Increasing LGBTI patients' comfort level and engaging in an open communication during clinical interaction, according to the nurses, is a gateway to gaining trust from the patients, enabling them to discuss sensitive health care issues with LGBTI patients. Such enabling environments optimise discussions about sexuality and sexual orientation; where LGBTI patients are even able to disclose their sexual orientation to the nurses without fear of being judged or discriminated against, and are able to return to the health care facility for further health care assistance. Building relationships with LGBTI patients by increasing their comfort level involved spending more time with them. Therefore, for the nurses, developing rapport was established by attempting to ascertain the patients' comfort levels, having good communication and listening skills, assuring patients of confidentiality and their availability and demonstrating empathetic understanding.

7.5.1.3.2. SUB-PROCESS 3.2: VALUING HUMAN DIGNITY

Sub-process 3.2: 'Valuing human dignity' was seen by the nurses as a conscious and intentional process of respecting human dignity in order to prevent doing any harm to LGBTI patients. For the nurses, valuing human dignity involved treating patients in a humane manner by "showing love"; "having a positive attitude"; "addressing patients with their titles rather than their names"; "treating patients comprehensively"; "effectively responding their health care needs" which will results in patients' satisfaction. Nurses demonstrate elements of confidence in caring for LGBTI patients as identified in their use of concepts like: "respect for others"; "respectful communication"; "treating everyone the same"; "being sensitive to patients' unique circumstances and health needs"; and "being non-judgmental", which demonstrated how much they valued human dignity during their clinical interaction with LGBTI patients. "Treating everyone the same" implied applying the principles of human rights of equality irrespective of their social background

and circumstances when caring for LGBTI patients. This process resulted in a caring professional conduct and an increase in the patients' sense of self-worth. Treating everyone the same meant: 1) putting everyone in the same queue as any other patients in the clinic; 2) not discriminating against anyone; 3) welcoming all patients; 4) making patients feel comfortable; and 5) not viewing patient's sexual orientation as significant when rendering care.

Reflecting on the professional values for the nurses raises awareness when it comes to the significance of these values in guiding decision-making and reducing the concerns and effects of prejudice, judgement, and discrimination in clinical interaction. Sub-processes such as 'establishing therapeutic relationship'; 'valuing human dignity'; and 'acknowledging professional obligation', reflect that professional values and moral obligations play an influential role in how nurses facilitate LGBTI care. The nurses discussed how using a valued-laden approach in clinical care which emphasises the significance of valuing human dignity would results in a more therapeutic nurse-patient relationship. For the nurses, discussing the significance of the role that professional values play in valuing human dignity, intensified respect for the 'self', the profession, as well as others, and enhances the ability to tolerate differences, and to interact with others in a respectful manner.

7.5.1.3.3. *SUB-PROCESS 3.3: ACKNOWLEDGING PROFESSIONAL OBLIGATION*

Sub-process 3.3: Acknowledging professional obligation became a sub-process that reflect how nurses reflect upon and uphold on the core values and ethical principles of the nursing profession, which are the frameworks that guide the technical and social aspects of nursing practice. Acknowledging professional obligation influenced beliefs, assumptions and behaviours of nurses and assisted them to base their decisions and actions on the values and principles of their profession, whilst caring for LGBTI patients. Acknowledging professional obligation was seen to be guided by professional values and served to direct and set boundaries on the actions and interactions.

Acknowledging professional obligation explains in some ways how nurses balanced and maintained their personal and professional 'self' whilst undertaking their professional nursing roles and obligations. Being guided by their professional values when providing clinical care to LGBTI patients has also helped the nurses to understand LGBTI patients' circumstances and to overcome the initial attitudes, beliefs and preconceived ideas that they had about them. The nurses' moral aspects were aided by often referring to their professional accountability. The nurses articulated that they strive to render quality care, by putting the needs of her patients first. This concludes the discussion of Phase 3 and all of the three phases of the substantive theory: facilitating LGBTI youth-inclusive PHC.

7.6. RELATIONSHIP STATEMENTS

According to Breakwell, Hammond and Fife-Schaw (1998:7), theories are basically sets of relational rules. They contain many concepts, and specify how concepts relate to one another. The relationship statements provide links amongst and between the concepts in the substantive theory. The relationship statements are discussed based on the theoretical definitions. Chinn and Kramer (1991:116) suggest that concepts ought to be given a structural form, so as to clarify their relationship by means of a symbolic representation. Therefore, the substantive theory of facilitating LGBTI youth-inclusive care brings together the generated categories and core category of reframing personal and professional values as the actions of facilitating LGBTI youth-inclusive PHC. Based on the definitions provided in the preceding section, the following relationships are proposed:

- facilitating care takes place in the context of PHC;
- facilitating LGBTI youth-inclusive care is an interactive process between the LGBTI patient, the nurse and the clinical environment;
- the outcomes of nursing care and the patients' perceptions about themselves and their health needs is influenced by the interactions which take place between nurses and LGBTI patients;

- the nurses' sense of identity and perceptions about themselves, their nursing care and the health care outcomes are influenced by the interactions they have with patients;
- the goal of facilitating LGBTI youth-inclusive care is to promote positive health care outcomes and optimise health care utilisation by LGBTI patients.

These statements suggest that facilitating LGBTI youth-inclusive care is a fluid, complex and dynamic occurrence involving thoughtfulness, adaptation and learning and open-mindedness over time and the nurses are best suited to facilitate this process.

7.7. SYNTHESISED THEORY

As discussed in earlier chapters, synthesising the theory of this study involved:

a) identifying a single focal concept which in this study is the core category that represents the process of a phenomenon or a framework, which were based on the theoretical framework of this study, as well as symbolic interactionism as illustrated in Chapter 5;
b) conducting a literature review to define relationships between concepts and properties, antecedents and determents of the concepts and indicate direction of relationships as discussed in Chapter 6 and 7; and
c) collecting a representative list of relational statements, organising and presenting them in a diagram and describing them in a theory (Walker & Avant 1995:167).

Chinn and Kramer (1995:101) assert that a theory should be deliberatively applied in practice to carefully assess and understand the effect of its usage on the quality of life, the quality of nursing care and/or the processes of health. It is anticipated that the theory that developed in this study will be utilised by nurses to enhance PHC care service delivery for LGBTI youth, in order to ensure that their health care needs are adequately met.

Synthesised theories may be expressed in several ways. When the relationships within and among statements are depicted in a graphic form, this

constitutes a model of the phenomenon. It is thus recommended that theory and theoretical model be used. The graphic form is a model and the linguistic form (storyline) is a theory. Theorists often move back and forth between expressing theories in written sentences and by means of visual devices, such as diagrammes (Walker & Avant 1995:155). Issues of causality and direction should be included in the diagramme (Walker & Avant 1995:158). In qualitative research, it is also important to indicate the antecedents of an event or process (Walker & Avant 1995:159). Antecedents refer to something existing or happening prior, especially as the cause or origin of something existing or happening thereafter. To determine a central feature of analysis, it became essential to put together theoretical concepts to create a unifying narrative of the basic processes of facilitating LGBTI youth-inclusive PHC, which mostly addresses the research questions: 'how do nurses and LGBTI youth experience their interaction in PHC in Tshwane District, Gauteng Province, SA?' And 'what are the basic social processes involved in facilitating LGBTI youth-inclusive PHC in Tshwane District, Gauteng Province, South Africa?'

7.8. EXPANDING THE THEORY

The following discussion expands the substantive theory. Glaser and Strauss (1967/2006:70) and Glaser (2005:np) assert that, when describing the theory, only variables that are related to the core category ought to be included. The core category revealed insight into the nurses' descriptions of their experiences with regards to what they perceive as both barriers and facilitators of LGBTI youth-inclusive care. The emergent theory of this study addresses the main concerns of participants' experiences, which depict that nurses were uncomfortable when they discovered the non-conforming sexual orientation of the patients during clinical interaction, because they hold incongruent beliefs to those of LGBTI patients, and they lacked the necessary knowledge to engage with them appropriately. The theory provides a means of understanding the way in which nurses understood and responded to the concerns related to LGBTI health care experiences and interactions. For most nurses, because they were socialised in a Christian heteronormative society, they found the

culture and lifestyle of LGBTI patients strange and unchristian. This heteronormative stance that the nurses hold, caused them to react in the following ways: 1) overt and covert cultural shock; 2) questioning what being LGBTI meant; 3) forming frame of reference by means of which to perceive LGBTI patients; 4) avoiding discussions related to sexuality. For this reason, facilitating LGBTI youth-inclusive care became a responsive process, in which nurses realised the importance of treating the patients in a humane manner, and to respect their human dignity without breaching professional values and principles.

The emergent theory of facilitating LGBTI youth-inclusive care identified the key basic social processes that could potentially provide a meaningful explanation as to why nurses developed positive attitudes that could facilitate care. The core category: 'reframing personal and professional values' represents the essence of what nurses do to facilitate care for LGBTI youth. For this reason, the emergent theory of this study identified the nurses, who function within the context of PHC as agents of facilitating LGBTI youth-inclusive care. The substantive theory may have scope, fit and applicability in other health care practices, and will assist nurses to employ strategies that could facilitate care and support to LGBTI patients by nurses.

7.9. RELEVANCE AND CONTRIBUTION OF THE THEORY TO THE KNOWLEDGE BASE

Relevance and contribution of the theory to the knowledge base will be discussed briefly in this section, and further details will be provided in Chapter 8.

The aim of this study was to gain an understanding of the experiences and perceptions of LGBTI youth and nurse participants working in PHC setting. It is anticipated that this understanding would add to the body of knowledge relating to the care of LGBTI population in a manner that reflects the current effort to gain understanding of the experiences of participants. It is also anticipated that

evidence generated from this study would inform clinical care, nursing education and training, nursing research, and the development of policies in a way that the health care needs of LGBTI patients would be adequately addressed.

7.10. RECOMMENDATIONS FOR THE APPLICATION OF THE THEORY

The substantive theory of this study contributes to the body of knowledge in the nursing context. Therefore, the purpose of the emergent theory of this study is to describe a process of how nurses are able to transform their values in order to accommodate the needs of LGBTI youth, thereby facilitating their care. The substantive theory provides an explanation as to how the participants experienced and resolved their main concerns. For the nurses, having acknowledged the negative impact that their values, beliefs and attitudes had on the care they provide to LGBTI patients, they changed, altered, modified, transformed and/or adapted their values, beliefs and attitudes in order to facilitate LGBTI youth-inclusive PHC. The theory will assist the nurses involved in working with LGBTI youth, to identify and reflect on their personal values, beliefs and attitudes, to perceive the impact on patient care, and to be guided by professional values and moral obligations which require that all patients be treated equally regardless of their background, race or sexual orientation. Professional values, along with moral obligations, guide the nurses to set aside their own values, attitudes and beliefs and treat the LGBTI patients in a non-judgmental and humane manner. These dimensions are dynamic and interactive revealing the interaction between the self, others and the environment.

The substantive theory of this study provides a perspective of facilitating care, which can be useful in all situations in nursing practice. This theory recognises the challenging aspects of interaction experienced between nurses and LGBTI patients. It provides the nurses with an opportunity to reflect on their values, beliefs and attitudes, and the way in which that negatively influences their perception and behaviour towards LGBTI patients and the potential to change

those value frameworks to promote positive nurse-patient interaction. The theory assists the nurses in managing the negative experiences that emanate from value conflict and tension during clinical care.

The substantive theory can be utilised in conjunction with other nursing theories to provide a unique perspective of the facilitation of LGBTI health care.

7.11. POTENTIAL AREAS FOR FURTHER STUDY

This study has provided a theoretical foundation from which further research can extend, test, and/or refine the substantive theory of facilitating LGBTI youth-inclusive PHC. The substantive theory of this study will make a specific theoretical contribution by providing a description of basic social processes involved in the facilitating of LGBTI youth-inclusive PHC. The theory can be operationalized and tested in future research using different methodologies for example, quantitative or mixed methods. The categories that emerged from this study offer opportunities for further research and comparison with other literature, concepts and higher level nursing models and theory. This theory could also be extended by exploring on the behaviour and perspective transformation in nurses caring for LGBTI patients and also exploring other structures and processes involved in facilitating LGBTI youth-inclusive PHC by health care providers.

7.12. CONCLUSION

This chapter introduced the substantive theory and discussed its purpose, assumptions and context. The structure and process of the theory were described and depicted as a visual representation. The substantive theory provides an explanation of how the participants experienced and resolved their main concerns. The substantive theory of facilitating LGBTI youth-inclusive care was presented in three phases, describing the conditions, actions and consequences of each phase. Recommendations for the application of the theory and potential for further studies has been discussed.

CHAPTER 8:

RECOMMENDATIONS AND CONCLUSIONS

8.1. INTRODUCTION

In Chapter 7, the substantive theory that describes the basic social process that nurses use to facilitate LGBTI youth-inclusive PHC was discussed. This chapter will review how the key findings of this study contribute to the knowledge base of nursing and discuss its implications for practice, education and future research. The chapter will commence by providing a reflection of how the study unfolded, also reflecting on the aim of this study to formulate the conclusions. The main aim of the study has been to develop substantive theory focused on the basic social processes involved in facilitating LGBTI youth-inclusive PHC in Tshwane District, Gauteng Province, South Africa. The study to sought to gain insight into participants' perspective on experiences, actions, interactions and meanings on how participants handled their situation during clinical interaction. Pursuing a method from constructivist grounded theory, and making reference to the theoretical framework of symbolic interactionism has assisted with the realisation of the aim of the study. The usefulness and relevance of the findings of the study with regard to the stated aim and objectives will be reflected. The chapter will conclude by acknowledging the limitations of the study and making recommendations for nursing practice, education and future research.

8.2. MOTIVATION OF THE STUDY

This study emanated from personal and professional experiences and a gap in local research literature. Many studies reveal that homosexual people experience challenges when accessing health care services, with the main concern being fear of discrimination or perceived homophobic attitude by health care providers (Igartua et al. 2009:602; Ochse 2011:4; McCabe et al. 2013:121; Rounds et al. 2013:99; Müller 2013:2; Rispel et al. 2011:47; Cele et al. 2015:5). Literature indicate that many policies and strategies have been

employed to ensure that the clinical environment is enabling (Flemmer et al. 2014:545) and provides culturally competent care by tailoring interventions that address the health disparities and the health care issues of LGBT clients (Brennan et al. 2012:96; Eliason et al. 2010:206). However, literature still indicates that LGBTI individuals are not receiving culturally competent care, which could continue to contribute to the health disparities experienced by this population (Brennan et al. 2012:96; Eliason et al. 2010:206)..

In developing African countries like SA, nurses exhibit homophobic and heterosexist attitude towards LGBTI patients (Mavhandu-Mudzusi & Sandy 2015:1059) in clinical care, a legacy that they have acquired through socialisation (Eliason et al. 2010:207208). However, there is still limited research that has been done to explore the experiences and perceptions of nurses concerning the care they provide to LGBTI patients. Nursing scholarship and the nursing profession have mostly been silent regarding LGBTI health and their health care concerns, and an appeal has been made to researchers to embark on emancipatory efforts in nursing education, research and professional advocacy to address the needs of LGBTI population (Eliason et al. 2010:206). Such a gap in research literature has prompted the researcher to not only to involve LGBTI participants in this study but to include the nurse participants as well. Involving nurse participants in this study has given a voice to nurses who experienced internal conflict when interacting with LGBTI patients in clinical care, and how they resolve those value-laden internal conflicts.

In SA, there has been a national response to promote the rights to health care of the youth including LGBTI youth. Discrimination on the basis of sexual orientation has been outlawed by the South African Bill of Rights. Section 27(1) (a) of the Constitution (Act 108 of 1996) states that all South African citizens have the right of access to health care (OUT LGBT Wellbeing 2007:2). Hence, SA has developed Adolescent and Youth Health Policy (2012) and National Implementation Guidelines for Adolescents and Youth Friendly Health Services

(2012-2016) guided by the National Youth Policy (2009-2014). The guidelines are aimed at preventing and responding to the health problems of the youth, including, among others, the LGBTI youth as a vulnerable group, and to address the barriers that prevent them from accessing health care services need to be developed (OUT LGBT Wellbeing 2007:2). As indicated in Chapter 2, in SA, research pertaining to LGBTI health care needs, practices and theories on how these needs should be addressed by health care providers has been overlooked (OUT LGBTI Wellbeing 2007:7). Although there is a significant amount of related research conducted internationally, its applicability within the developing countries like SA is still questionable, due the nature of the demographic, political and socio-cultural factors of the country, which differ from those of other developed and developing countries. Recent studies focusing on LGBTI health care concerns focus on the experiences of LGBTI people in health care and neglect to address the experiences and perceptions of health care providers with regard to interacting with LGBTI people in clinical care. Therefore, this study is unique in SA, as it considers both the experience and perspectives of LGBTI youth and nurses during mainstream clinical interaction with each other. The researcher is therefore of the opinion that the theory presented in this study provides a new conceptual interpretation of the data, which challenges, extends and refines current ideas, concepts and practices that could enable the facilitation of LGBTI-youth inclusive PHC.

8.3. CRYSTALLISATION OF KEY FINDINGS AND CONTRIBUTION TO NEW KNOWLEDGE

The substantive theory that emerged from this study describes the basic social process involved in facilitating LGBTI youth-inclusive PHC in Tshwane District, Gauteng Province, South Africa. The researcher asserts that the findings of the study permitted this aim to be achieved. From the findings of the study, a conceptual framework was developed which mostly addresses the research questions: how do nurses and LGBTI youth experience their interaction in PHC in Tshwane District, Gauteng Province, South Africa? And what are the basic social processes involved in facilitating LGBTI youth-inclusive PHC in Tshwane

District, Gauteng Province, South Africa? The conceptual framework outlines the process that nurses used to facilitate LGBTI youth-inclusive PHC and includes identification and description of core concepts and relationships and of the factors that influenced the core category of ‘reframing personal and professional values’. The basic process of facilitating LGBTI youth-inclusive PHC entails three phases, which did not necessarily occur sequentially, but are interdependent and interconnected, and therefore influenced one another. Each phase consists of sub-processes and the related concepts that explain the conditions, actions/interactions and consequences, of how the process unfolded as described in Chapter 7 of this study.

The substantive theory of this study addresses the main concerns of participants by showing that despite experiencing barriers that hindered nurses from facilitating LGBTI youth-inclusive health care, nurses were able to tackle and overcome their personal subjectivity. As nurses reflected on their personal and professional values, beliefs and attitudes and were able to pursue personal and professional transformation in order to establish a good therapeutic relationship. They were able to settle internal conflict experienced during interaction with the self and others by setting aside their own values, beliefs and attitudes, accepting their moral responsibilities and becoming more accommodating of the health needs of LGBTI patients. In summary, the basic social process of facilitating LGBTI youth-inclusive PHC emerged as a responsive process in which nurses realised the importance of treating their patients in a humane manner, and to respect their human dignity without breaching professional values and principles. The substantive theory became significant in explaining the positive intentions of the actions and behaviour of the nurses that needed to be changed. The actions involved discovering how the unpleasant behaviour can be replaced by an attitude and behaviour with more positive intentions.

The substantive theory of facilitating LGBTI youth-inclusive PHC suggests that nurses are required to make continuous and thoughtful reflection in order to

understand the factors inherent in the conflict that they experienced when faced with mismatching values to those of LGBTI patients. The nurses ought to also adapt to their personal and professional values in order to accommodate and address the health needs of diverse individuals, and to meet their professional obligations by suppressing, bracketing and/or compromising their own values and beliefs and being open to change. By being open to change, the nurses were able to become more open to diversity, to be less judgmental of LGBTI people.

The nature and extent of facilitating LGBTI youth-inclusive PHC is influenced by empathising with LGBTI patients in circumstances where nurses acknowledged the challenges encountered by LGBTI people in their families, communities and the health care system. In such circumstances, nurses shifted their own values and beliefs in order to make sense of what LGBTI patients were feeling and thinking. Empathising marked a shift from the personal to the professional 'self' as nurses demonstrated a strong sense of self and showed willingness to compromise their own values and beliefs in order to adopt and adapt to new attitudes of treating LGBTI patients in a humane manner. Some nurses discussed changing old values and establishing new ones as another conscious process of reflecting on shifting from the personal to professional self. Some nurses discussed being acquainted with LGBTI people as either a family member or a friend has impacted on their positive attitudes towards LGBTI people, and that helped them to be comfortable and sensitive in working with and accommodating LGBTI patients. Facilitating LBTI youth-inclusive PHC also happened in situations where nurses acknowledged that the lack of knowledge on sexuality and sexual orientation-related health care issues, contributing to their incompetency in effectively providing care to LGBTI patients. Facilitating LGBTI youth-inclusive PHC required of the nurses to acquire specific knowledge and skills about LGBTI people and their health care concerns, in order to facilitate LGBTI youth-inclusive health care.

The theory suggests that for the nurses, having realised and applied their professional 'self' has assisted them in changing their attitude and practice in caring for LGBTI patients. The ethical guidelines, professional values, and the code of conduct of the nursing profession provided guidance to their decision-making when interacting with LGBTI patients in clinical practice. Being guided by ethical guidelines and professional values signifies the personal and professional changes that occurred amongst the nurses as a response to the internal and external factors exerted by the need to overcome internal conflict that existed. Reflecting on their professional values was a significant driver for emotionally connecting the nurses with LGBTI patients and understanding what their health care needs are, as opposed to imposing their personal values when caring for patients. The nurses demonstrated their willingness to establish a therapeutic relationship during clinical interaction.

The nurses were of the opinion that they play a direct role in valuing the human dignity of the patients, had internalised their professional values, and therefore focused on the principles of equity and social justice by applying the principles of human rights, and of equality when treating patients. The majority of nurses acknowledged that professional obligation has assisted them to base their decisions and actions on the values and principles of their profession, whilst caring for LGBTI patients. Being guided by their professional values when providing clinical care has helped most nurses to understand LGBTI patients' circumstances and to overcome the initial attitudes, beliefs and preconceived ideas that they had about LGBTI people.

8.4. CONTRIBUTION TO THEORY, RESEARCH AND PRACTICE

This section will provide an understanding of the theory and positioning the theory of this study within the context of constructivist grounded theory study. The usefulness and relevance of the findings of the study with regard to practice and future research will be outlined.

Charmaz (2014:228) mentions that a theory attempts to answer a question or a concern, and offer accounts of what happened, how it happened and why it happened. However, there have been disagreements among theorists regarding how a theory should be constructed, what it should look like, and what it means (Glaser 1992:6;

Goulding 2002:3). Grounded theorists provide varied assumptions that theory means:

a) an empirical generalisation;
b) a core category;
c) a predisposition;
d) an explanation of a process;
e) a relationship between variables;
f) an explanation;
g) an abstract understanding; and/or
h) a description (Charmaz 2014:241).

Charmaz (2014:228) argues that theorists should always recognise their epistemological underpinning when constructing and interpreting a theory, since construction and interpretation of a theory depends on whether the researcher ascribes to an interpretive, positivist or constructivist stance. Therefore, different researchers may have similar ideas, but render them theoretically different (Charmaz 2014:238). This study assumed a constructivist stance, which perceives data and data analysis as constructed from shared experiences and relationships with participants, other data, and the researcher. Constructivist grounded theorists take a reflexive stance (Charmaz 2014:240), acknowledging that the resultant theory of a grounded theory study depends upon the researcher's view and interpretation, which is influenced by the researcher's experiences, perspectives, privileges, position, interactions and geographical locations (Charmaz 2014:238). Due to the continued influence of constructivist grounded theory, the substantive theory of this study comprised related concepts, constructed by the researcher, which when put together, constitute an integrated framework that explains or predicts a phenomenon under scrutiny (Strauss & Corbin 1998:15), viz. the process of facilitating

LGBTI youth-inclusive PHC. This study acknowledges the theoretical framework of symbolic interactionism, which guided the analysis, interpretation and construction of the theory (Strauss & Corbin 1998:123).

The theory of this study has offered some new knowledge claims, confirmed some existing knowledge claims, and challenged others as discussed in Chapter 6 of this study. This study offers new insight into understanding of the concept of 'reframing' as a cognitive, affective and behavioural process, which describes how nurses reflect on their own personal values, beliefs and attitudes and how that impacted on the nursing care of LGBTI patients. The process seek to conceptualise the process that nurses used to change, alter, modify, transform or adapt their values, beliefs and attitudes in order to deal with the effects of having realised that their values were in conflict to the values of LGBTI patients. This process of transforming and adapting their values, beliefs and attitudes was facilitated by reflecting and being guided by professional ethics and values, which has guided the nurses to treat LGBTI patients with respect and in a humane manner, thereby facilitating their health care utilisation.

8.5. USEFULNESS OF GROUNDED THEORY IN THIS STUDY

Charmaz (2014:337) echoes that it is the reader who has to make judgement with regard to the usefulness of a grounded theory study by judging the quality of the study and the way the constructed theory represents the data. Evaluating the quality and usefulness of this study is significant in determining the value of the basis from which conclusions can be drawn and recommendations can be made. The application of grounded theory methodology in this study, echoes with the key attributes of grounded theory. There is certain risk of bias in the interpretation of the findings of the study, which results when the researcher becomes too involved in the process (Backman & Kyngäs 1999:148), has been counteracted through reflexivity, which emphasises that the researcher ought to be able to identify the effect of self in these relationships. Through reflexivity and control over relationality, the

process of theory development becomes more transparent (Hall & Callery 2001:257) and therefore, a conclusion can be made that this study can be defined as a grounded theory study.

Charmaz (2014:337) offers that the quality of a product of grounded theory can be considered in terms of its criteria of credibility, originality, resonance and usefulness which was subsequently be discussed and applied in this study. Applying the methodological reference points of Urquhart et al. (2010:182-186) and of Charmaz (2014:337) in this study, has established that facilitating LGBTI youth-inclusive PHC has met the evaluation criteria for rigour.

8.5.1. CREDIBILITY

The depth and range of data collection should be sufficient to support the argument that the theory that emerges is logical and linked clearly to the data. For this study, to ensure credibility, data was collected until theoretical saturation occurred. The researcher also transcribed the audio-recorded interview verbatim so that the product of analysis can be compared with the primary data. The researcher adapted the interview guide, for the verification of the categories, concepts and emerging theory. The constant comparison of data and categories provided a further data source for analysis and justification of the emergent theory (Charmaz 2006:182). Since it is the aim of this study to make a unique contribution to the existing body of knowledge, comparison of the emergent categories to available literature was done to synthesise the findings, with relevant nursing and social scholarship literature and theories, and to reflect the researcher's interpretive perspectives (Chiovitti & Piran 2003:430), demonstrating how and where the findings fit or extend into those literature and theories (Charmaz 2006:169).

8.5.2. ORIGINALITY

Originality implies that the research ought to offer new insights, and fresh conceptual understandings (Watling & Lingard 2012:855). The researcher acknowledges that the findings of the research is not always the definitive truth, but is influenced by the researcher's interpretations and understandings. However, the researcher should still demonstrate that the findings of the research are 'constructed truths' and that they are firmly grounded in the data. Therefore, the researcher anticipates that the concepts developed in this study are original, and grounded in the data, and offer new insights into the processes involved in describing the basic social processes involved in facilitating LGBTI youth-inclusive PHC.

8.5.3. RESONANCE

Resonance implies that the grounded theory makes sense to the participants and captures the essence and fullness of their experiences (Watling & Lingard 2012:855; Birks et al. 2011:152). Throughout this study, detailed explanation of how methodological processes of grounded theory unfolded, how it has been applied and why, how data analysis process unfolded, how the categories and core category emerged from the data contributed by participants. Each category of this study provides detailed insights into the features that describe the substantive theory of facilitating LGBTI youth-inclusive PHC. The rich and complex explanation of the actions, processes, relationships and interactions within the substantive theory offered deeper insight into the meaning of the basic social process involved in facilitating LGBTI youth-inclusive PHC. The discretion of whether the substantive theory explains the basic social process involved in facilitating LGBTI youth-inclusive PHC and whether the truth, accuracy, reliability and authenticity of this process is openly represented within the researcher's explanation of the theory lies with the reader.

8.5.4. USEFULNESS

Usefulness implies interpretations that can be used in day-to-day situations by individuals who have interest in the phenomenon under study (Birks et al. 2011:152; Watling & Lingard 2012:855; Charmaz 2014:338). Chapter 3 of this study provided detailed information about the sample and setting characteristics of the study. The methodology of this study was guided by a constructivist grounded theory (Charmaz 2006) and was based on the lived experience of ten LGBTI youth residing in Tshwane District and seven nurses working in PHC facilities in Tshwane District, Gauteng Province, SA, who had experienced the phenomenon being studied. Chapter 4 and 5 provided a detailed explanation of how the categories and the core category emerged so that people who want to adopt and use the basic social process that emerged from this study, can decide whether it could be applicable to their context or not. The usefulness of a theory depends on the reader's ability to interpret its applicability in similar settings i.e., LGBTI youth primary health care.

8.6. THEORETICAL SENSITIVITY

Theoretical sensitivity constitutes a significant concept in grounded theory. It reflects the researcher's ability to use personal and professional experiences and methodological knowledge to view data in new ways and think abstractly about data as the theory is being developed (Glaser & Strauss 1967; Strauss & Corbin 1998). Theoretical sensitivity also include researcher's manipulation in order to explain data in a way that best reflects reality and should therefore be complemented by reflexivity, reflecting on how the researcher-participant interaction and the researcher's perspective affect the analysis and the results (Hall & Callery 2001). In this study, the researcher kept a reflective journal to reflect on her perspective throughout the research journey.

8.7. RECOMMENDATIONS

Recommendations stemming from the findings of this study relate to nursing practice, education and research.

The substantive theory that emerged from this study could assist in improving the health care and health-seeking behaviour of LGBTI youth. Extending the context of this theory beyond LGBTI patients to include the nursing care of all the vulnerable population who experience the same dynamics as LGBTI patients will offer significance contribution to expand this theory. This study has encouraged the nurses to develop their self-concept during interaction with minority and vulnerable populations, by reflecting on factors that hinders them from effectively addressing the needs of those patients. Having reflected and identified such factors will enable the nurses to adopt strategies that will help them overcome those barriers. In this study, nurses overcame a barrier to their nursing care of LGBTI patients by changing, altering, modifying, transforming or adapting their values, beliefs and attitudes in order to deal with the effects of having realised that their values were in conflict to the values of the LGBTI patients. This process has enabled them to be open to change, empathise with the patients and refer to the professional ethics and values, which influenced them to treat the LGBTI patients in a humane manner. It is therefore argued that theory of this study will bring new perspective to health care providers working with LGBTI patients so as to enable them to gain an understanding of the health needs and health care needs of LGBTI individuals. It is of importance that health care providers to familiarise themselves with the uniqueness of this basic social processes so as to ensure appropriate care, support and treatment of LGBTI individuals and groups. The findings of the study revealed that the importance of developing therapeutic relationships with LGBTI patients can reduce discrimination and promote their health care utilisation.

As the findings from this study demonstrated, that the lack of formal and informal training is what hindered nurses in providing effective nursing care to

LGBTI patients. The findings of the study suggested various mechanisms that will enable health care providers to acquire more knowledge about LGBTI issues and to facilitate their health care. Education strategies that focus on an evidence-based approach to LGBTI health care should be considered; therefore theories such as facilitating LGBTI youth-inclusive PHC can guide educators to develop educational programmes that could translate the theory into care. For this reason, tailored formal and informal nursing education programmes could be developed to assist nurses in developing skills in facilitating LGBTI youth-inclusive PHC and thus, improving LGBTI people's health care utilisation.

This study has provided a theoretical foundation from which further research can expand, be tested, and/or refine the substantive theory. The substantive theory of this study will make a specific theoretical contribution by providing a description of basic social processes involved in the facilitating of LGBTI youth-inclusive PHC that can be operationalised and tested in future research using different methodology, for example, quantitative or mixed methods. The categories that emerged from this study offer opportunities for further research and comparison with other literature, concepts and higher level nursing models and theory. The findings highlight the cognitive, affective and behavioural processes involved in facilitating LGBTI youth-inclusive PHC, which leaves room for further exploration in this area. This theory could also be extended by exploring on the behaviour and perspective transformation in nurses' caring for LGBTI patients, while exploring other structures and processes involved in facilitating LGBTI youth-inclusive PHC by health care providers. Studies could also explore the application of cultural competent care, within the context of facilitating LGBTI youth-inclusive PHC by health care providers. It is anticipated that this would provide further insight into the role that cultural competent care plays in facilitating LGBTI youth-inclusive PHC. It is further recommended that the use of triangulated methods in research, such as using observation and interviews, comparative studies, longitudinal studies may provide additional insight into the theory and might provide further

understanding of it from various perspectives. It is recommended that other versions of grounded theory be conducted, which should include theoretical sampling of nurses or other health care providers e.g., doctors, psychologists, social workers etc. working in different districts or different settings, in order to extend or test this theory.

8.8. LIMITATIONS OF THE STUDY

Like all other qualitative studies, there are a number of limitations that should be taken into consideration when evaluating this grounded theory study. As with any study, this study had certain limitations. Firstly, the results of this study cannot be generalised. The results of this qualitative study were based on interviews with a small, convenience sample from a specific area of the U.S. that has historically held progressive views towards sexual minorities. However, the goal of qualitative research is not to be able to generalise findings to the general population, but rather to record rich, detailed data from individuals in a specific socio-political and historical context. Every research study has limitations that influence the findings, the way the findings are interpreted and ultimately applied. Acknowledging the limitations of this study, provides an opportunity for other researchers to draw assumptions and arguments. For example, the main limitations related to all grounded theory studies conducted under the interpretive and constructivist paradigm is that the theory is not created but interpreted, constructed, and co-constructed by the participants and the researcher (Charmaz 2014:238). Therefore, the subjective nature of both data and theory building should be acknowledged. This study assumed a constructivist stance, which perceives data and data analysis as constructed and co-constructed from shared experiences and relationships with participants, other data, and the researcher, which is influenced by the researcher's experiences and perspectives. Therefore, different researchers may have similar ideas, but render a different perspective or add a greater sensitivity to the theoretical constructs. In this study, the data could have been used to form a different theoretical perspective and a theoretical framework by

other researchers who utilise a different philosophical underpinning from that of this study (Charmaz 2014:238).

The sampling methods used to recruit participants in this study, heavily relied on snowballing and the questions asked, as well as how they were asked by the researcher, and how they were interpreted by the participants may have yielded different results. The researcher decided on identifying and accessing the right participants in order to saturate theoretical categories, and decided when categories had been saturated, and therefore could have influenced the findings of this study. The sample comprised of ten self-identified LGBTI youth residing in Tshwane District and seven nurses working in PHC facilities in Tshwane District, Gauteng Province, SA, who had experienced the phenomenon being studied. However, LGBTI participants comprised of only self-identified lesbian, gay and bisexual youth, sample from the transgendered and intersexed population could not be obtained due to the following reason: 1) most LBGTI social network group that the researcher approached couldn't identify or refer any of the transgendered and intersexed population; 2) clinical facilities denied the researcher access to transgendered and intersexed patients' database due to fear of breaching patients' confidentiality; and 3) clinical facilities couldn't refer any of those patients to the researcher.

There was also a possibility of bias among the nurse participants. For instance, it could be that nurses who had less interest in LGBTI health care issues may not have been willing to participate in the study. On the other hand, nurses who already had interest or involved in LGBTI health care issues may have been willing to participate in this study. As a result, this could have impacted on the type of responses and/or the number of responses. This study was confined to Tshwane district, Gauteng Province, SA. Limiting the study to one specific district in a province comprising both urban and rural areas with different demographics could have impacted on the findings of this study. As a result of the regional limitation, the findings of the study could not be generalised to all other PHC settings in other provinces.

For the researcher, choosing the appropriate grounded theory method for this study was a challenging and tedious process, as there are different versions of grounded theory, which are influenced by the philosophical underpinning of the researcher. This study persuaded a constructivist grounded theory. As a novice grounded theory researcher, the researcher battled between concurrent data collection and analysis and memo-writing. As a result, presenting the research findings in a logical and linear manner became challenging. This study was interpretive and constructive in nature, therefore, data from the participants was interpreted and co-constructed by the researcher based on the researcher's personal and professional knowledge, experience, socialisation with LGBTI people, and the researcher's ability and skills as a novice grounded theory researcher. The findings of this study are limited within the boundaries that this study was also conducted as a process of learning about the grounded theory methods, which influenced the researcher's ability to interpret and give meaning to the theory that emerged from this study. As this study was done to obtain a doctoral degree within specified time constraints, as a novice grounded theory researcher, learning about the grounded theory method and applying the method and process to this study was a tedious process that required prolonged engagement with the literature to learn more about the method, as a result the study duration of the researcher was prolonged beyond the set duration.

Given the limitations of the study, the researcher cannot deny her influence on the overall findings of this study and cannot claim that the findings of this study can be generalised to all PHC settings. Rather, the usefulness of the substantive theory of this study will depend on the health care providers' ability to interpret its applicability in similar settings i.e., LGBTI youth primary health care.

8.9. DRAWING CONCLUSIONS

Given the arguments in these discussions, the substantive theory: facilitating LGBTI youth-inclusive PHC is a realistic and appropriate basis from which to surmise that the aim of this study has been achieved, and therefore to make recommendations for nursing practice, education and research. Quality nursing care is dependent on the decisions made by nurses during clinical encounters with patients; therefore, it is important to understand how nurses experience and respond to conflicting personal values with those of the LGBTI patients whilst at the same time having to fulfill their professional and moral obligations towards LGBTI patients. The substantive theory that has emerged from this study should stand to prove useful to the nurses involved in working with LGBTI patients and other minority and vulnerable population in the PHC settings. Over and above this, it should also be useful to health care providers who wish to deepen their understandings of LGBTI people, their health needs, and health care concerns, and how these needs and concerns ought to be addressed. This study makes explicit the process that will help the nurses to facilitate LGBTI youth-inclusive PHC, thereby promoting health care utilisation by LGBTI youth. The theory provides a foundation upon which future research can extend this knowledge, employing a variety of research methodologies, which would further contribute to advancing nursing science and the facilitation of LGBTI youth-inclusive health care services.

8.10. CONCLUSION

This study attempted to develop the basic social process involved in facilitating LGBTI youth-inclusive PHC in order to enhance the care provided by LGBTI patients and therefore promote their health care utilisation. Through the application of grounded theory method, a substantive grounded theory of facilitating LGBTI youth-inclusive PHC emerged to address the main concern of participants, namely, the facilitation of LGBTI youth-inclusive PHC. The substantive theory that emerged from this study set out conditions, context, actions, interactions and consequences of facilitating LGBTI youth-inclusive PHC and how the theory can be applied to enhance the nursing care of LGBTI

patients. Furthermore, the theory of this study provided recommendations for nursing practice, education, and future research.

9. REFERENCES

Adams, J, Dickson, P & Asiasiga, L 2013. Mental health issues for Lesbian, Gay, Bisexual and Transgender people: A qualitative study. *International Journal of Mental Health Promotion*. doi: 10.1080/14623730.2013.799821.

African Youth Charter. 2006.
[Available:
http://www.au.int/en/sites/default/files/AFRICAN_YOUTH_CHARTER.pdf]
Accessed: 12 November 2013.

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

Aksan, N, Kisac, B, Aydin, M & Demirbuken, S 2009. Symbolic interaction theory. *Procedia Social and Behavioral Sciences*. 1: 902-904.
doi: 10.1016/j.spspro. 2009.01.160.

Allen, O 2013. Lesbian, gay and bisexual patients: The issues for general practice. Quality in practice committee. ICGP. Gay and Lesbian Equality Network.

American Academy of Family Physicians 2016. Recommended curriculum guidelines for family medicine residents: Lesbian, gay, bisexual, transgender health. 19 pages.
[Available:
www.aafp.org/dam/AAFP/documents/medical...residency/.../Reprint257_Men.pdf] Accessed: 18 May 2017.

American Academy of Pediatrics 2013. Office-based care for lesbian, gay, bisexual, transgender, and questioning youth. *Pediatrics*. 132(1): 198-203.
doi: 10.1542/peds.2013-1282.

American Association of Colleges of Nursing 2008. The essentials of baccalaureate education for professional nursing practice. Washington DC. 61 pages.
[Available:
http://www.aacnnursing.org/Portals/42/Publications/BaccEssentials08.pdf]
Accessed: 02 April 2017.

American Psychiatric Association 1952. Diagnostic and statistical manual of mental disorders. Washington. DC: American Psychiatric Publication. 1st Edition.

American Psychiatric Association 1968. Diagnostic and Statistical Manual of Mental Disorders. Washington. DC: American Psychiatric Publication. 2nd Edition.

American Psychiatric Association 1994. Diagnostic and Statistical Manual of Mental Disorders. Washington DC: American Psychiatric Publication. 4th Edition.

Anderson, KN, Anderson, LE & Glanze, WD 1994. Mosby's Medical, Nursing and Allied Health Dictionary. 4th Edition. Mosby. St. Louise Baltimore.

Anderson, LM, Scrimshaw, SC, Fullilove, MT, Fielding, JE, Normand, J & the Task Force on Community Preventive Services 2003. Culturally competent health care systems. A systematic review. *American Journal of Preventative Medicine*. 24(3S): 6879. doi: 10.1016/S0749-3797(02)00657-8.

Annells, M 1997b. Grounded theory method, part II: Options for users of the method. *Nursing Inquiry*. 4: 176-180.

ARC International 2014. Sexual orientation, gender identity and expression and intersex related developments at the twenty-sixth session of the UN Human Rights Council.
[Available: http://arc-international.net/wp-content/uploads/2014/07/HRC26-report.pdf] Accessed: 18 March 2017.

Ash, M & Mackereth, C 2010. Mental and emotional health needs of LGBT (Lesbian, Gay, Bisexual and Transgender) populations of NHS South of Tyne and Wear: Gateshead, South Tyneside and Sunderland. NHS. Gateshead Primary Care Trust, South Tyneside Primary Care Trust and Sunderland Primary Care Trust. [Available:
http://www.equality-ne.co.uk/downloads/723_lgbt-mental-health-and-emotionalneeds-assessment.pdf] Accessed: 20 May 2013.

Atkinson, P, Coffey, A & Delamont, S 2003. Key themes in qualitative research, continuities and changes. Walnut Creek. California. AltaMira Press.

Babbie, E 2010. The practice of social research. Belmont. CA. Wadsworth.

Babbie, E 2011. Introduction to social research. Belmont, USA. Wadsworth.

Backman, K & Kyngäs, HA 1999. Challenges of the grounded theory approach to a novice researcher. *Nursing & Health Sciences*. 1(3): 147-153.

Baker, C, Norton, S, Young, P & Ward, S 1998. An exploration of methodological pluralism in nursing research. *Research in Nursing & Health*. 21: 545-555.

Banwari, G, Mistry, K, Soni, A, Parikh, N & Gandhi, H 2015. 'Medical students and interns' knowledge about and attitude towards homosexuality'. *Journal of Postgraduate Medicine*. 61(2): 95-100. doi: 10.4103/0022-3859.153103.

Bauer, GR & Jairam, JA 2008. Are lesbians really women who have sex with women (WSW)? Methodological concerns in measuring sexual orientation in health research. *Women and Health*. 48: 383-408.

Baumeister, RF 1998. The Self. In: D.T.F. Gilbert, ST & Lindzey, G. (Eds.). *The Handbook of social Psychology*. 1. New York. Oxford University Press. Inc.

Baumeister, RF, Campbell, JD, Krueger, JI & Vohs, KD 2003. Does high self-esteem cause better performance, interpersonal success, happiness, or healthier lifestyles? *Psychological Science in the Public Interest*. 4(1). 44 pages.

Bayer, R 1981. Homosexuality and American Psychiatry: The politics of diagnosis. Basic books. New York USA.

Berg, L & Danielson, E 2007. Patients' and nurses' experiences of the caring relationship in hospital: an aware striving for trust. *Scandinavian Journal of Caring Science*. 21: 500-506.

Berlan, ED, Corliss, HL, Field, AE, Goodman, E & Austin, SB 2010. Sexual orientation and bullying among adolescents in the growing up today study. *Journal of Adolescent Health.* 46(4): 366-371. doi: 10.1016/j.jadohealth.2009.10.015.

Birks, M & Mills, J 2011. Grounded theory: A practical guide. Los Angeles. CA: Sage.

Birks, M & Mills, J 2015. Grounded theory: A practical guide. London: Sage.

Birks, M, Mills, J, Francis, K & Chapman, Y 2009. A thousand words paints a picture: The use of storyline in grounded theory research. *Journal of Research in Nursing*. 14: 405-417.

Bjorkman, M & Malterud, K 2009. Lesbian women's experiences with health care: A qualitative study. *Scandinavian Journal of Primary Health Care*. 27: 238-243. doi: 10.3109/02813430903226548.

Blackall, G & Green, M 2012. "Difficult" patients or difficult relationships? *The American Journal of Bioethics*. 12(5): 8-9.

Blackwell, CW 2008. Nursing implications in the application of conversion therapies on gay, lesbian, bisexual, and transgender clients. *Issues in Mental Health Nursing*. 29: 651-665.

Bluff R 2005. Grounded theory: the methodology. In: Holloway, I. (Ed.). Qualitative Research in Health Care. Maidenhead: Open University Press.

Blumer, H 1969. Symbolic Interactionism: Perspective and method. Berkeley. CA. University of California Press.

Boeije, H 2002. A purposeful approach to the constant comparative method in the analysis of qualitative interviews. *Quality and Quantity*. 36: 391-409.

Bolmsjö, IA, Edberg, A-K & Sandman, L 2006. Everyday ethical problems in dementia care: A teleological model. *Nursing Ethics*. 13(4): 340-359. doi: 10.1191/0969733006ne890oa.

Bowen, G 2006. Grounded theory and sensitizing concepts. *International Journal of Qualitative Methods*. 5: 3. [Available: http://www.ualberta.ca/~iiqm/backissues/5_3/PDF/bowen.pdf]. Accessed: 14 February 2014.

Boychuk-Duchscher, JE & Morgan, D 2004 Grounded theory: Reflections on the emergence vs. forcing debate. *Methodological Issues in Nursing Research*. 48(6): 605-612.

Breckenridge, JP, Jones, D, Elliot, I & Nicol, M 2012. Choosing a methodological path: Reflections on constructivist turn. *A grounded theory review: An international journal*. 1(11). [Available: http://groundedtheoryreview.com/2012/06/01/choosing-a-methodologicalpath-reflections-on-the-constructivist-turn/] Accessed: 15 May 2015.

Brennan, AMU, Bransteiner, J, De Luone Sanitz, ML, Cotter, VT & Everette, J 2012. Lesbian, gay, bisexual, transgendered, or intersexed content for nursing curricula. *Journal of Professional Nursing*. 28(2): 96-104.

Brewster, KL & Tillman, KH 2012. Sexual orientation and substance use among adolescents and young adults. *American Journal of Public Health*. 102(6): 1168-1176. doi: 10.2105/ajph.2011.300261.

Bringer, JD, Johnston, LH & Brackenridge, CH 2006. Using computer assisted qualitative data analysis software to develop a grounded theory project. *Field Methods*. 18(3): 245-266.

Brookfield, S 2002. Reassessing subjectivity, criticality and inclusivity: Marcuse's challenge to adult education. *Adult Education Quarterly*. 52: 280. [Available: http://aeq.sagepub.com] Accessed: 15 May 2009.

Brown, RB & Murti AK 2004. The power of perspective: "Reframing" your framing skills for innovative instruction in leadership and influence. *Developments in Business Simulation and Experiential Learning*. 1: 113-115.

Brusin, JH 2012. How cultural competency can help reduce health disparities**.** *Radiologic Technology*. 84(2): 129-152.

Bryant, A & Charmaz, K 2007. Grounded theory in historical perspective: An epistemological account. In: Bryant, A & Charmaz, K (Eds.). The Sage handbook of grounded theory. 31-57. Los Angeles, CA: Sage.

Buchmueller, T & Carpenter, CS 2010. Disparities in health insurance coverage, access, and outcomes for individuals in same-sex versus different-sex relationships, 2000-2007. *American Journal of Public Health*. 100(3): 489-495.
doi: 10.2105/AJPH.2009.160804.

Burns, N & Grove, SK 2001. The practice of nursing research: Conduct, critique &utilization. 4th Edition. Philadelphia: WB Saunders.

Burns, N & Grove, SK 2005. The practice of nursing research: Conduct, critique, and utilization. 5th Edition. St. Louis. MO. Elsevier.

Burns, N & Grove, SK 2009. The practice of nursing research: Appraisal, synthesis and generation of evidence. Maryland Heights. Missouri: Saunders Elsevier.

Campinha-Bacote, J 1999. The Process of cultural competence in the delivery of health care services: A model of care. *Journal of Transcultural Nursing*. 13(3): 181184.

Canadian Nurses Association. (2008). *Code of ethics for registered nurses*. [Available: http://www.cna-aiic.ca/CNA/documents/pdf/publications/Code_of_Ethics_2008_e.pdf] Accessed: 12 August 2015.

Carabez, R, Pellegrini, M, Mankovitz, A, Eliason, M, Ciano, M & Scott, M 2015. "Never in all my years …": Nurses' education about LGBTI health. *Journal of Professional Nursing*. 31(4): 323-329.

Carrillo, JE, Carrillo VA, Perez, HR, Salas-Lopez, D, Natale-Pereira, A & Byron, AT 2011. Defining and targeting health care access barriers. *Journal of Health Care for the Poor and Underserved.* 22(2): 562-575. doi: 10.1353/hpu.2011.0037.

Cele, NH, Sibiya MN & Sokhela DG 2015. Experiences of homosexual patients' access to primary health care services in Umlazi, KwaZulu-Natal. *Curationis*. 38(2). Art. #1522. 9 pages.
[Available: http://www.curationis.org.za doi:10.4102/curationis.v38i2.1522]
Accessed: 16 May 2017.

Census 2011. Statistical release–P0301.4/Statistics South Africa.
[Available: https://www.statssa.gov.za/Census2011/default.asp]
Accessed: 26 Novemeber 2013.

Chally, PS & Loriz, L 1998. Ethics in trenches: Decision making in practice. A practical model for resolving the types of ethical dilemma you face daily. *American Journal of Nursing*. 98(61): 17-20. doi: 10.2307/3471749.

Charmaz, K 1990. 'Discovering' chronic illness: Using grounded theory. *Social Science and Medicine*. 30(11): 1161-1172.

Charmaz, K 1995c. Between positivism and postmodernism: Implications for methods. In: Denzin, NK (Ed.): Studies in symbolic interaction. 17: 43-72. Greenwich, CT: JAI Press.

Charmaz, K 2000. Constructivist and objectivist grounded theory. In: Denzin, NK & Lincoln,YS (Eds.). The Handbook of Qualitative Research. Thousand Oaks. CA: Sage.

Charmaz, K 2005. Grounded theory in the 21st century: A qualitative method for advancing social justice research. In: Denzin, NK & Lincoln, YS. (Eds.). Handbook of Qualitative Research. 3rd Edition. 507-535. Sage Publications. Thousand Oaks.

Charmaz, K 2006. Constructing grounded theory: A practical guide through qualitative analysis. London. England: Sage.

Charmaz, K 2007. Constructionism and grounded theory. In: Holstein, JS & Gubrium, J (Eds.). Handbook of constructionist research. New York. Guildford.

Charmaz, K 2008. Constructionism and the grounded theory. In: Holstein, JA & Gubrium, JF (Eds.). Handbook of Constructionist Research. 397-412. New York. The Guilford Press.

Charmaz, K 2014. Constructing grounded theory. 2nd Edition. Thousand Oaks. Sage.

Chenitz, WC & Swanson, JM 1986. From practice to grounded theory: qualitative research in nursing. MA: Addison-Wesley.

Chinn, PL & Kramer, MK 1991. Theory and nursing: A systematic approach. St. Louis: Mosby Yearbook.

Chiovitti, RF & Piran, N 2003. Rigour and grounded theory research. *Journal of Advanced Nursing*. 44(4): 427-435.

City of Tshwane 2016/21 IDP 2016. "The culmination of the first decade of gamechanging of Tshwane Vision 2055". [Available: http://beta2.statssa.gov.za/publications/P0302/District_Council_projection_by_sex_and_age (2002-2014).zip]. Accessed: 07 June 2017.

Clamp, C & Gough, S 1999. Resources for nursing research. 3rd Edition. Thousand Oaks. Sage.

Cochran, SD, Drescher, J, Kismödi, E, Giami, A, García-Moreno, C, Atalla, E, Marais, A, Vieirah, ME & Reedi, GM 2014. Proposed declassification of disease categories related to sexual orientation in the *International Statistical Classification of Diseases and Related Health Problems* (ICD-11). *Bull World Health Organization*. 92: 672-679. doi: 10.2471/BLT.14.135541.

Coker, TR, Austin, SB & Schuster, MA 2009. Health and health care of lesbians, gay, bisexual, and transgender youth: Reducing disparities through research, education, and practice. *Journal of Adolescent Health*. 45: 213-215.

Cole, M 2008. Qualitative research: a challenging paradigm for infection control. *British Journal of Infection Control*. 7(6): 25-30.

Collis, J & Hussey, R 2009. Business research: A practical guide for undergraduate & postgraduate students. 3rd Edition. London: Palgrave Macmillan.

Concise Oxford English Dictionary 2004. 11th Edition. Oxford University Press.

Constantine, MG & Ladany, N 2001. New visions for defining and assessing multicultural counseling competence. In: Ponterotto, JG (Ed.). Handbook of multicultural counselling. 2nd Edition. 482-496. Thousand Oaks. California: Sage Publications. Incorporated.

Constitution of the Republic of South Africa No. 108 of 1996. [Available: http://www.gov.za/documents/constitution/1996/a108-96.pdf] Accessed: 03 December 2013.

Cooley, CH 1902/1983. Human Nature and the Social Order. New Brunswick. New York: Scribner's. NJ: Transaction.

Corbin, J & Strauss, AL 1990. Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative Sociology*. 13(1): 3-21.

Coulter RW, Kenst KS, Bowen DJ 2014. Research funded by the National Institutes of Health on the health of lesbian, gay, bisexual, and transgender populations. *American Journal of Public Health*. 104: e105-e112.

Coyne, I & Cowley. S 2006. Using grounded theory to research parent participation. *Journal of Research in Nursing*. 11(6): 501-515.

Creswell, JW 1998. Qualitative inquiry and research design: Choosing among five approaches. 1st Edition. Sage. Thousand Oaks. California.

Creswell, JW 2007. *Qualitative inquiry and research design: Choosing among five approaches.* 2nd Edition. Sage. Thousand Oaks. California.

Crompton, T 2010. Common Cause: The case for working with our cultural values. Surrey: WWF UK.

Crooks, T 2001. The validity of formative assessments. Paper presented at the British Educational Research Association Annual Conference. Leeds. UK. [Available: http://www.leeds.ac.uk/educol/documents/00001862.htm] Accessed: 13 July 2016.

Cross, D, Brennan, AMW, Cotter, VT & Watts, RJ 2008. Cultural competence in the Master's curriculum-A course exemplar. *Journal of Professional Nursing*. 24(3): 150154. doi: 10.1016/j.profnurs.2008.01.007.

Crotty, M 1998. The Foundations of social research: Meaning and perspective in the research process. London. Sage.

Crotty, M 2003. The Foundations of social research: Meaning and perspective in the research process. London. Sage.

Cutcliffe, J 2005. Adapt or adopt? Developing and transgressing the methodological boundaries of grounded theory. *Journal of Advanced Nursing*. 51(4): 421-428.

de Chesnay, M & Anderson, BA 2008. Caring for the vulnerable: Perspectives in nursing theory, practice, and research. 2nd Edition. Jones and Bartlett Publishers. Sudbury. Massachusetts.

Deleuze, G & Guattari, F 1991. What is philosophy? New York: Columbia University Press.

Denzin, NK & Lincoln, YS 2005. The Sage handbook of qualitative research. 3rd Edition. USA.

Dilley, JA, Simmons, KW, Boysun, MJ, Pizacani, BA & Stark, MJ 2010. Demonstrating the importance and feasibility of including sexual orientation in public health surveys: Health disparities in the Pacific Northwest. *American Journal of Public Health*. 100(3): 460-467.

Dinkel, S, Patzel, B, McGuire, M, Rolfs, E & Purcell, K 2007. Measures of homophobia among nursing students and faculty: A Midwestern perspective. *International Journal of Nursing Education Scholarship*. 4(1): 1-12.

Dookie, S & Singh, S 2012. Primary health services at district level in South Africa: A critique of the primary health care approach. *BioMed Central Family Practice*. 13(67): 1-4.

Dorsen C 2014. Nurse practitioner's attitudes towards, and experiences working with, lesbian, gay and bisexual patients: a grounded theory. PhD Thesis. NYU College of Nursing at the College of Dentistry. New York University. UMI Number: 3581330. Unpublished.

Dorsen, C & Van Devanter, N 2016. Open arms, conflicted hearts: nurse-practitioner's attitudes towards working with lesbian, gay and bisexual patients. *Journal of Clinical Nursing*. 25: 3716–3727. doi: 10.1111/jocn.13464.

Douglas, CJ, Kalman, CM, & Kalman, TP 1985. Homophobia among physicians and nurses: An empirical study. *Hospital and Community Psychiatry.* 56(12): 1309-1311.

Adolescent and Youth Health Policy 2012.
[Available:
http://www.advocacyaid.com/images/stories/rrdownloads/Adolescent%20_Youth_He alth_Policy_120102.pdf] Accessed: 23 November 2013.

Drescher, J 2015. Out of DSM: Depathologizing homosexuality. *Behavioral Science*. 5: 565-575. doi: 10.3390/bs5040565.

Dufresne, P & McKenzie, A 2009. A culture of ethical leadership. *Principal Leadership*. 10(2): 36-39.
[Available: http://www.principals.org/KnowledgeCenter/Publications.aspx]
Accessed: 10 April 2017.

Duldt, BW & Giffin, K 1985. Theoretical perspectives for nursing. Boston: Little. Brown and Company.

Dunn, AM 2002. Culture Competence and the Primary Care Provider. *Journal of Pediatric Health Care*. 16: 105-111. doi: 10.1067/mph.2002.118245.

Durham, JD & Lashley, FR 2010. The person with HIV/AIDS: Nursing perspectives. 4th Edition. New York, NY: Springer Publisher.

Dysart-Gale, D 2010. Social justice and social determinants of health: Lesbian, Gay, Bisexual, Transgendered, Intersexed, Queer youth in Canada. *Journal of Child and Adolescent Psychiatric Nursing.* 23(1): 23-28.

Eady, AA, Dobinson, CC & Ross, LE 2011. Bisexual people's experiences with mental health services: A qualitative investigation. *Community Mental Health Journal*. *47*(4): 378–389.

Eaves, YD 2001. A synthesis technique for grounded theory data analysis. *Journal of Advanced Nursing.* 35: 654-63.

Ehlers, VJ, Zuyderduin, A & Oosthuizen, MJ 2001. The wellbeing of Gays, Lesbians and Bisexuals in Botswana. Issues and innovations in nursing practice. *Journal of Advanced Nursing*. 35(6): 848-856.

Eisenberg, N 2002. Empathy-related emotional responses, altruism, and their socialization. In: Davidson, RJ & Harrington, A (Eds.). Visions 52 of compassion: Western scientists and Tibetan Buddhists examine human nature. 131-164. London: Oxford University Press.

Eliason, MJ, Dibble, SL & DeJoseph, J 2010. Nursing's silence on Lesbian, Gay, Bisexual, and Transgender issues: The need for emancipatory efforts. *Advances in Nursing Science*. 3(33): 206-218.

Eliason, MJ, Dibble, SL & Robertson, PA 2011. Lesbian, Gay, Bisexual, and Transgender (LGBT) Physicians' Experiences in the Workplace. *Journal of Homosexuality*. 58(10): 1355-1371. doi: 10.1080/00918369.2011.614902.

Elliott, N & Jordan, J 2010. Practical strategies to avoid the pitfalls in grounded theory research. *Nurse Researcher*. *17*(4): 29-40.

Everett, BG 2013. Sexual orientation disparities in sexually transmitted infections: examining the intersection between sexual identity and sexual behavior. *Archive of Sexual Behaviour. 42*(2): 225-236.
doi: 10.1007/s10508-012-9902-1.

Fairman, JA, Rowe, JW, Hassmiller, S & Shalala, DE 2011. Broadening the Scope of Nursing Practice. *The New England Journal of Medicine*. 364(3): 193-196. doi: 10.1056/NEJMp1012121.

Fendt, J & Sachs, W 2006. Grounded theory method in management research: Users' perspectives. *Organizational Research Methods*. 11(3): 430-455.

Fish, J & Evans, DT 2016. Promoting cultural competency in the nursing care of LGBT patients. *Journal of Research in Nursing*. 21(3): 159-162.
doi: 10.1177/1744987116643232.

Fleming TM, Merry SN, Robinson EM, Denny SJ & Watson PD 2007. Self-reported suicide attempts and associated risk and protective factors among secondary school students in New Zealand. *Australian and New Zealand Journal of Psychiatry*. 41: 213221.

Flemmer N, Dekker, l & Doutrich, D 2014. Empathetic Partnership: An interdisciplinary framework for primary care practice. *The Journal of Nurse Practitioners*. 10(8): 545551. doi: 10.1016/j.nurpra.2014.04.009.

Fredriksen-Goldsen, KI, Kim, H-J, Barkan, SE, Muraco, A & Hoy-Ellis, CP 2013. Health disparities among lesbian, gay, and bisexual older adults: Results from a population-based study. *American Journal of Public Health.* 103: 1802-1809. doi: 10.2105/AJPH.2012.301110.

Furniss, D, Blandford, A & Curzon, P 2011. Confessions from a Grounded Theory PhD: Experiences and Lessons Learnt*. CHI.* May 7–12. Vancouver. BC. Canada.

Gates, GJ 2011. How many people are lesbian, gay, bisexual and transgender?
UCLA: The Williams Institute 2013.
[Available: http://williamsinstitute.law.ucla.edu/wp-content/uploads/Gates-How-ManyPeople-LGBT-Apr-2011.pdf] Accessed: 12 February 2016.

Gauteng, Tshwane District Profile-Health-e.
[Available: www.health-e.org.za/wp-content/uploads/2013/06/Tshwane-District-Profile.pdf&sa] Accessed: 14 March 2014.

Gearing, R 2004. 'Bracketing in research: A Typology'. Qualitative Health Research. 14(10): 1429-1452.

Glaser, BG & Strauss, AL 1967. The discovery of Grounded Theory: strategies for qualitative research. Aldine Transaction Publishers. USA.

Glaser, BG & Strauss, AL 1967/2006. The discovery of grounded theory: Strategies for qualitative research. Aldine Transaction Publishers. USA.

Glaser, BG 1978. Theoretical Sensitivity: Advances in the Methodology of Grounded Theory. Mill Valley. California: Sociology Press.

Glaser, BG 1992. Emergence vs. forcing: Basics of grounded theory analysis. Mill Valley. California: Sociology Press.

Glaser, BG 1998. Doing grounded theory: Issues and discussion. Mill Valley. California: Sociology Press.

Glaser, BG 2001. The grounded theory perspective: Conceptualization contrasted with description. Mill Valley. California: Sociology Press.

Glaser, BG 2002. Constructivist grounded theory? *Forum: Qualitative Social Research.* 3(3). [Available: http://www.qualitative-research.net/fqs/fqs-eng.htm] Accessed: 14 March 2017.

Glaser, BG 2005. The grounded theory perspective III: Theoretical coding. Mill Valley, California: Sociology Press.

Glaser, BG & Holton, J 2004. Remodeling grounded theory. *Forum: Qualitative Social Research*. 5(2).
[Available: http://www.qualitative-research.net/index.php/fqs/article/view/607/1315] Accessed 18 November 2016.

Glessner, HD, Vandenlangenberg, E, McCarthy Veach, P & LeRoy, BS 2012. Are genetic counselors and GLBT patients “on the same page”? An investigation of attitudes, practices and genetic counseling experiences. *Journal of Genetic Counseling.* 21: 326-336.

Goldberg, L, Harbin, A & Campbell, S 2011. Queering the birthing space: Phenomenological interpretations of the relationships between lesbian couples and perinatal nurses in the context of birthing care. *Sexualities*. 14(2): 173-192. [Available: http://sex.sagepub.com/content/14/2/173.abstract?rss=1] Accessed: 01 May 2016.

Goulding, C 2002. Grounded theory: A practical guide for management, business, and market researchers. London: Sage.

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

Grix, J 2004. The foundations of research. London: Palgrave. Macmillan.

Guba, EG & Lincoln, YS 1994. Competing paradigms in qualitative research. In:
Denzin, NK & Lincoln, YS (Eds.): Handbook of qualitative research. 105-117. Thousand Oaks. CA: Sage.

Grover, R & Glazier, JD 1986. A conceptual framework for theory building in library and information science. *Library and Information Science Research*. 8: 227-242.

Haas, AP, Eliason, M, Mays, VM, Mathy, RM, Cochran, SD, D'Augelli, AR, Silverman, MM, Fisher, PW, Hughes, T, Rosario, M, Russell, ST, Mpa, EM, Reed, J, Litts, DA, Haller, E, Sell, RL, Remafedi, G, Bradford, J, Beautrais, AL, Brown, GK, Diamond, GM, Friedman, MS, Garofalo, R, Turner, MS, Hollibaugh, A & Clayton, PJ 2011. Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: review and recommendations. *Journal of Homosexuality*. 58(1): 10-51. doi: 10.1080/00918369.2011.534038.

Hall, WA & Callery, P 2001. Enhancing rigor of grounded theory: Incorporating reflexivity and relationality. *Qualitative Health Research*. 11(2): 257-272.

Hallberg, LR-M 2006. The "Core Category" of grounded theory: Making constant comparisons. *International Journal of Qualitative Studies on Health and Well-being*. 1: 141-148.

Hancock, TU 2008. Doing justice: A typology of helping attitudes toward sexual groups. *Affilia: Journal of Women and Social Work*. 23(4): 349-362.
doi: 10.1177/0886109908323970.

Harry, B, Sturges, K & Klingner, J 2005. Mapping the process: An exemplar of the process and challenge of grounded theory analysis. *Educational Researcher*. 34(2): 3-13.

Hasman, A, Hope T & Østerdal. LP 2006. Health Care Needs: Three Interpretations. *Journal of Applied Philosophy*. 23: 145-156.

Hayman, B, Wilkes, L, Halcomb, EJ & Jackson, D 2013. Marginalised mothers: Lesbian women negotiating heteronormative health care services. *Contemporary Nurse* 44(1): 120–127.

Healthy People 2020. Lesbian, gay, bisexual, and transgender health. [Available: https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gaybisexual-and- transgender-health]. Accessed: 10 November 2014.

Hernandez, CA 1994. Collaborative alliance: A practice model whose time has come. *Canadian Journal of Diabetes Care*. 18(4): 6-7.

Hernandez, CA 2009. Theoretical coding in grounded theory methodology. *The Grounded Theory Review.* 8(3): 51-66.

Hershberger, SL 2001. Biological factors in the development of sexual orientation. In: D'Augelli, AR & Patterson, CJ (Eds.). *Lesbian, gay, and bisexual identities and youth: Psychological perspectives*. 27-51. New York: Oxford University Press.

Higgins, A, Sharek, D, McCann, E, Sheerin, F, Glacken, M, Breen, M & McCarron M 2011. The Problem with 'Behavioral Bisexuality': Assessing sexual orientation in survey research. Published by the Gay and Lesbian Equality Network (GLEN). Dublin. *Journal of Bisexuality.* 13: 148-165. doi: 10.1080/15299716.2013.782260.

Hinchliff, S, Gott, M & Galena, E 2005. 'I daresay I might find it embarrassing: General practitioner's perspectives on discussing sexual health issues with lesbian and gay patients. *Health and Social Care in the Community.* 13(4): 345-353.

Hoffman, ND, Freeman, K & Swann, S 2009. Health care preferences of Lesbian, Gay, Bisexual, Transgender and Questioning youth. *Journal of Adolescent Health*. 45: 229.

Holloway, I & Wheeler, S 2010. Qualitative research in nursing and health care. 3rd Edition. Oxford. Blackwell.

Hooker, E 1957. The adjustment of the male overt homosexual. *Journal of Projective Techniques.* 21(20).

Hudak, N 2015. Identity disclosure in lesbian, gay, and bisexual patient-provider communication. Master's dissertation. James Madison University. Unpublished.

Human Rights Watch 2017. World Report. Events of 2016. Human Rights Watch. [Available: https://www.hrw.org/report/2017/01/12/world-report-2017/events-2016] Accessed: 19 August 2017.

Igartua, K, Thombs, BD, Burgos, G & Montoro, R 2009. Concordance and discrepancy in sexual identity, attraction, and behaviour among adolescents. *Journal of Adolescent Health*. 45(6): 602-608.
doi: 10.1016/j.jadohealth.2009.03.019.

International Council of Nurses Code of Ethics 2006.
[Available:
http://www.icn.ch/images/stories/documents/about/icncode_english.pdf]
Accessed: 02 June 2015.

International statistical classification of diseases and related health problems (ICD 10). 10th revision 2016. 5th Edition.
[Available:
https://ec.europa.eu/cefdigital/wiki/display/EHSEMANTIC/ICD-10+The+International+Statistical+Classification+of+Diseases+and+Related+Health+ Problems+10th+Revision] Accessed: 10 May 2017.

Institute of Medicine 2011. The Health of Lesbian, Gay, Bisexual and Transgender People: Building a foundation for better understanding. Washington DC: National Academy Press.

John. MK 2006. What is motivation design?
[Available: http://www.mgrush.com/content/view/70/33] Accessed: 03 June 2017.

Johns, MM, Zimmerman, M & Bauermeister, JA 2013. Sexual attraction, sexual identity, and psychosocial wellbeing in a national sample of young women during emerging adulthood. *Journal of Youth and Adolescents. 42*(1): 82-95.
doi: 10.1007/s10964-012-9795-2.

Johnson, CV, Mimiaga, MJ & Bradford, J 2008. Health care issues among lesbian, gay, bisexual, transgender and intersex (LGBTI) populations in the United States: Introduction. *Journal of Homosexuality*. 54(3): 211-224.

Johnson, MJ & Nemeth, LS 2014. Addressing health disparities of lesbian and bisexual women: A grounded theory study. *Women's Health Issue*. 24(6): 635-640.
doi: 10.1016/j.whi.2014.08.003.

Johnstone M-J 2016. Bioethics. Nursing perspectives. 5th Edition. Elsevier. Australia.

Jormsri, P, Kunaviktikul, W, Ketefian, S & Chaowalit, A 2005. Moral competence in nursing practice. *Nursing Ethics*. 12: 582–594.

Kann, L, Olsen, EO, McManus, T, Kinchen, S, Chyen, D, Harris, WA & Wechsler, H 2011. Sexual identity, sex of sexual contacts, and health-risk behaviors among students in grades 9-12--youth risk behavior surveillance, selected sites. United States. 2001-2009. *Morbidity and Mortality Weekly Report*. Centres of Diseases Control and Prevention Surveillance Summaries. 60(7): 1-136.

Katovich, MA, Miller, DE & Stewart, RL 2003. The Iowa School. In: Reynolds, LT & Herman-Kinney, NJ (Eds.). Handbook of Symbolic Interactionism. 119–39. Walnut Creek. CA: AltaMira Press.

Kennedy, CE, Baral, SD, Fielding-Miller, R, Adams, D, Dludlu, P, Sithole, B *et al* 2013. "They are human beings, they are Swazi": Intersecting stigmas and the positive health, dignity and prevention needs of HIV-positive men who have sex with men in Swaziland. *International AIDS Society*. 6(3). doi: 10.7448/IAS.16.4.18749.

Kitts, RL 2010. Barriers to optimal care between physicians and lesbian, gay, bisexual, transgender, and questioning adolescent patients. *Journal of Homosexuality*. 57(6): 730-747. doi: 10.1080/00918369.2010.485872.

Klunklin, A & Greenwood, J 2006. Symbolic interactionism in grounded theory studies: Women surviving with HIV/AIDS in rural Northern Thailand. *Journal of the Association of Nurses in AIDS Care.* 17(5): 32-41.

Knight, RE, Shoveller JA, Carson AM & Contreras-Whitney, JG 2014. Examining clinicians' experiences providing sexual health services for LGBTQ youth: Considering social and structural determinants of health in clinical practice. *Health Education Research*. 29(4):662–670. doi: 10.1093/her/cyt116.

Knowles, MS 1990. The adult learner: A neglected species. 4th Edition. Houston: Gulf Publishing Company. Book Division.

Kotronoulas, G, Papadopoulou, C & Patiraki, E 2009. Nurses' knowledge, attitudes, and practices regarding provision of sexual health care in patients with cancer: critical review of the evidence. *Support Care Cancer.* 17: 479–501. doi: 10.1007/s00520-0080563-5.

Krajic, K, Strassmayr, C, Karl-Tummer, U, Noval-Zezula, S, Pelikan, JM 2005b. Improving ethnocultural competence of hospital staff by training: experiences from the European "Migrant-friendly Hospitals" project. *Diversity in Health and Social Care*. 2(3): 279–290.

Kroth, M & Cranton, P 2014. Stories in transformative learning. International issues in adult education. Sense Publishers. Rotterdam. The Netherlands.

Kuhn, T S. 1970. The Structure of Scientific Revolutions. 2nd Edition. University of Chicago Press. Section V. 43-51.

Kumagai, AK & Lypson, ML 2009. Beyond cultural competence: Critical consciousness, social justice, and multicultural education. *Academic Medicine*. 84(6): 782-787.

Kvale, S 1996. Inter Views: An introduction to qualitative research interviewing. Thousand Oaks. CA. Sage.

Kucukaydin, I & Cranton, P 2012. Critically questioning the discourse of transformative learning theory. *Adult Education Quarterly*. 63(1): 43-56. doi: 10.1177/0741713612439090.

Lakoff, G 2004. Don't think of an elephant. Know your value and frames the debate: The essential guide for progressives. Chelsea Green Publishing. Vermont. USA.

Lambrese, JV & Hunt, JI 2013. Mental health needs of sexual minority youth: A student developed novel curriculum for health care providers. *Journal of Gay & Lesbian Mental Health*. 17(2): 221-234.

LaRossa, R & Reitzes, DC 1993. Symbolic interactionism and family studies. In: Boss, PG, Doherty, WJ, LaRossa, R, Schumm, WR & Steinmetz, SK (Eds.). Sourcebook of Family Theories and Methods: A Contextual Approach. 135-163. Plenum. New York. doi: 10.1007/978-0-387-85764-0_6

Laska, MN, VanKim, NA, Erickson, DJ, Lust, K, Eisenberg, ME & Rosser, BRS 2014. Disparities in weight and weight behaviors by sexual orientation in college students. *American Journal of Public Health.* 105(1): 111-121. doi: 10.2105/AJPH.2014.302094.

Leininger, MM 1991. The theory of culture care diversity and universality. In: Leininger MM (Ed.). Culture care diversity and universality: Theory of nursing. New York. NY: National League for Nursing.

Leininger, M & McFarland, M 2002. Transcultural nursing: Concepts, theories, research and practice. 3rd Edition. New York: McGraw-Hill. Medical Pub. Division.

Levesque, PJ 2013. Nurse practitioners knowledge, attitudes, and self-efficacy for working with transgender patients. *Clinical Nursing Studies*. 1(4): 93-100. doi: 10.5430/cns.v1n4p93.

Levesque, JF, Harris, MF & Russell, G 2013. Patient-centred access to health care: Conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health*. 12: 18. doi: 10.1186/1475-9276-12-18.

Levine DA 2013. American Academy of Pediatrics Committee on Adolescence. Officebased care for lesbian, gay, bisexual, transgender, and questioning youth. Technical report. *Pediatrics*. 132: e297-e313.
Lewis, M & Brooks-Gunn, J 1979. Social cognition and the acquisition of self. New York: Plenum Press.

Lim, FA, Brown, D & Jones, H 2013. Lesbian, gay, bisexual, and transgender health: Fundamentals for nursing education. *The Journal of Nursing Education*. 52(4): 198203. doi: 10.3928/01484834-20130311-02.

Liaschenko, J 1999. Can justice coexist with the supremacy of personal values in nursing practice? *Western Journal of Nursing Research*. 21: 35–50.

LoBiondo-Wood, G & Haber, J 1998. Nursing research: Methods, critical appraisal, and utilization. 4th Edition. St. Louis. MO: Mosby.

Mabvurira, V, Motsi, PD, Masuka, T & Chigondo, EE 2012. The 'politics' of sexual identities in Zimbabwe: A social work perspective. *International Journal of Humanities and Social Sciences*. 2(13): 218–223.

Macapagal, K, Bhatia, R & Greene, GJ 2016. Differences in health care access, use, and experiences within a community sample of racially diverse lesbian, gay, bisexual, transgender, and questioning emerging adults. *LGBT Health*. 3(6). 434-442. doi: 10.1089/lgbt.2015.0124434-442.

MacDonald, M 2003. Seeing the cage: Stigma and its potential to inform the concept of the difficult patient. *Clinical Nurse Specialist*. 17: 305–310. Quiz 311–312.

Marshal, MP, Dermody, SS, Shultz, ML, Sucato, GS, Stepp, SD, Chung, T, Burton, CM, Markovic, N & Hipwell, AE 2013. Mental health and substance use disparities among urban adolescent lesbian and bisexual girls. *Journal of the American Psychiatric Nurses Association*. 19(5): 271–279.
doi: 10.1177/1078390313503552jap.sagepub.com.

Mavhandu-Mudzusi, AH & Sandy, PT 2015. Religion-related stigma and discrimination experienced by lesbian, gay, bisexual and transgender students at a South African rural-based university. *Culture, Health & Sexuality*. 17(8): 1049-1056. doi: 10.1080/13691058.2015.1015614.

Maza, C & Krehely, J 2010. How to improve mental health care for LGBTI youth: Recommendations for the Department of Health and Human Services. *Center for American Progress.* 1-11.

McCabe, J, Brewster, KL & Tillman, KH 2011. Patterns and correlates of same-sex sexual activity among U.S. teenagers and young adults. *Perspective of Sexual Reproductive Health. 43*(3): 142-150. doi: 10.1363/4314211.

McCann, TV & Clark, E 2003. Grounded theory in nursing research: part 2 - critique. *Nurse Researcher*. 11(2): 19-28.

McCann, TV & Clark, E 2003c. Grounded theory in nursing research: Part 3 application. *Nurse Researcher*. 11(2): 29-39.

McDonald, C 2009. Lesbian disclosure: Disrupting the taken for granted. *Canadian Journal of Nursing Research*. 41(1): 260–275.

McGhee, G, Marland, GR & Atkinson, J 2007. Grounded theory research: Literature reviewing and reflexivity. *Journal of Advanced Nursing.* 60(3): 334-342.

McNair, R, Szalacha, LA & Hughes, TL 2011. Health status, health service use and satisfaction according to sexual identity of young Australian women. *Women's Health Issues*. 21-1: 40-47.

Mead, G 1934. Mind, self, and society. Chicago. IL: The University of Chicago Press.

Mead, GH 1967. Mind, self and society. Phoenix Edition. Chicago and London: University of Chicago Press. (original 1934).

Meads, C & Moore, D 2013. Breast cancer in lesbians and bisexual women: systematic review of incidence, prevalence and risk studies. *BioMed Central*. 13: 1127. [Available: http://www.biomedcentral.com/1471-2458/13/1127] Accessed: 14 May 2017.

Mehmetoglu, M & Altinay, L 2006. Examination of grounded theory analysis with an application to hospitality research. *International Journal of Hospitality Management*. 25: 12-33.

Mew, HL 2013. Juggling a way of being: A grounded theory of how one group of nurses navigates tension among personal and professional values 'in the moment'. Master's dissertation. Dalhousie University. Halifax. Nova Scotia. Unpublished.

Mewborn, KN 2005. A grounded theory study of the multicultural experiences of school psychologists. PhD Thesis. University of Maryland, College Park. Unpublished.

Meyer, IH 2016. Does an improved social environment for sexual and gender minorities have implications for a minority stress research agenda? *Psychology of Sexualities Review*. 7(1): 81-90.

Mezirow, J 1971. Toward a theory of practice. *Adult Education.* 21: 135-147.

Mezirow, J 1978. Education for perspective transformation: Women's re-entry programs in community colleges. New York. NY: Teacher's College. Columbia University.

Mezirow, J 1991a. Transformative dimensions of adult learning. San Francisco: Jossey-Bass.

Mezirow, J 1996. Beyond Friere and Habermas: Confusion. A response to Bruce Pietrykowski. *Adult Education Quarterly*. 46: 237-239.

Mezirow, J 1997. Transformative learning: Theory to practice. In: Cranton. P (Ed.). New directions for adult and continuing education. Transformative learning in action: Insights from practice. 74: 5-12. San Francisco, CA: Jossey-Bass.

Mezirow, J 2000. Learning to think like an adult. Core concepts of transformation theory. In Mezirow, J & Associates. Learning as transformation. Critical perspectives on a theory in progress. 3-34. San Francisco: JosseyBass.

Mezirow, J 2003. Transformative learning as discourse. *Journal of Transformative Education*. 1(1): 58-63.

Mezirow, J 2009. Transformative learning theory. In Mezirow, J & Taylor, EW (Eds.). Transformative learning in practice. 18-32. San Francisco: JosseyBass.

Milliken, P & Schreiber, R 2001. Can you "do" grounded theory without symbolic interactionism? In: Schreiber, R & Stern, P (Eds.). Using grounded theory in nursing. 177-190. New York. NY: Springer.

Mills, J, Bonner, A & Francis, K 2006. The development of constructivist grounded theory. *International Journal of Qualitative Methods*. 5(1): Article 3.

Moghaddam, A 2006. Coding issues in grounded theory. *Issues in Educational Research*. 16(1): 52-66.

Moradi, B, Mohr, JJ, Worthington, RL & Fassinger, RE 2009. Counseling psychology research on sexual (orientation) minority issues: Conceptual and methodological challenges and opportunities. *Journal of Counseling Psychology*. 56(1): 5-22. doi:10.1037/a0014572.

Morrison, MA 2011. Psychological health correlates of perceived discrimination among Canadian gay men and lesbian women. *Canadian Journal of Community Mental Health.* 30: 81-98.

Morrison, S & Dinkel, S 2012. Heterosexism and health care: A concept analysis. *Nursing Forum*. 47(2): 123-130.
doi: 10.1111/j.1744-6198.2011.00243.x.

Mouton, J 1996. Understanding social research. Pretoria: Van Schaik.

Mosadeghrad, AM 2013. Health care service quality: Towards a broad definition. International *Journal of Health Care Quality Assurance*. 26(3): 203-219. doi: 10.1108/09526861311311409.

Müller, A 2013. Teaching lesbian, gay, bisexual and transgender health in a South African health sciences faculty: Addressing the gap. *BioMed Central Medical Education.* 13(174). doi: 10.1186/1472-6920-13174.

Mustanski, B, Van Wagenen, A, Birkett, M, Eyster, S & Corliss, HL 2014. Identifying sexual orientation health disparities in adolescents: Analysis of pooled data from the Youth Risk Behavior Survey 2005 and 2007. *American Journal of Public Health*. 104(2): 211–217. doi: 10.2105/AJPH.2013.301748.

Nakamura, N, Semple SJ, Strathdee SA & Patterson TL 2011. HIV risk profiles among HIV-positive, methamphetamine-using men who have sex with both men and women. *Archives of Sexual Behavior*. 40: 793-801.

Nathaniel, A 2006. Moral reckoning in nursing. *Western Journal of Nursing Research*. 28: 419-438. doi: 10.1177/0193945905284727.

National Association of Pediatric Nurse Practitioners 2011. Health risks and needs of lesbian, gay, bisexual, transgender, and questioning adolescents position statement. *Journal of Pediatric Health Care.* 25(6): 9A-10A.
doi: 10.1016/j.pedhc.2011.07.002.

National implementation guidelines for adolescents and youth friendly health services 2012-2016. Government Printers. Pretoria.

National Youth Policy 2009-2014.
[Available:
http://www.thepresidency.gov.za/MediaLib/Downloads/Home/Publications/YouthPubl ications/NationalYouthPolicyPDF/NYP.pdf] Accessed: 12 November 2013.

Naylor, MD & Kurtzman ET 2010. The role of nurse practitioners in reinventing primary care. *Health Affairs*. 29(5): 893-899.

Nell, M & Shapiro, J 2011. Out of the box: Queer Youth in South Africa today. Case study. [Available:
http://www.atlanticphilanthropies.org/sites/default/files/uploads/Out_of_the_box_que er_youth_in_South_Africa_Today_0.pdf] Accessed: 11 November 2013.

Neuman, WL 2011. Social research methods: Qualitative and quantitative approaches. USA: Allyn and Bacon.

Newcomb, ME, Birkett, M, Corliss, HL, & Mustanski, B 2014. Sexual orientation, gender, and racial differences in illicit drug use in a sample of US high school students. *American Journal of Public Health.* 104(2): 304-310. doi: 10.2105/ajph.2013.301702.

Newman-Valentine, D & Duma, S 2014. Injustice to transsexual women in a heteronormative health care system. *African Journal of Primary Health Care Family Medicine*. 26(1). Art. #574. 5 pages. doi: 10.4102/ phcfm.v6i1.574.
Nursing Act 33 of 2005. The South African Nursing Council 2006: Pretoria. [Available: http://www.sanc.co.za/pdf/Nursing%20Act%202005.PDF] Accessed: 24 June 2016.

O'Byrne, P & Watts, J 2014. Include, differentiate and manage: Gay male youth, stigma and health care utilization. *Nursing Inquiry*. 21(1): 20-29.

Ochse, A 2011. Real women and real lesbians: Discourses of heteronormativity amongst a group of lesbians. *South African Review of Sociology Association*. 42(1): 3-20. doi: 10.1080/21528586.2011.563532.

OUT LGBT Wellbeing 2007. Submission to the South African human rights commission public inquiry into the right to have access to health care services. Health care for Lesbian, Gay, Bisexual and Transgender People: Issues, implications and recommendations. Presented by OUT LGBT Well-being on the 31st May 2007.
Available
[http://www.sahrc.org.za/home/21/files/Health%20Report.pdf]
Accessed: 15 January 2013.

OUT LGBT Wellbeing 2016. Hate crimes against lesbian, gay, bisexual and transgender people in South Africa. Research initiative of the 'Love Not Hate' Campaign.

Page, MJL, Lindahl, KM & Malik, NM 2013. The role of religion and stress in sexual identity and mental health among LGB youth. *Journal of Research on Adolescence*. 23(4): 19 pages. doi: 10.1111/jora.12025.

Papastamatis, A & Panitsides, EA 2014. Transformative learning: Advocating a holistic approach. *Review of European Studies*. 6(4): 74-81.

Parahoo K. Nursing research: principles, process and issues. Basingstoke: Macmillan Press.

Pathela, P & Schillinger, JA 2010. Sexual behaviors and sexual violence: Adolescents with opposite-, same-, or both-sex partners. *Pediatrics.* 126(5): 879-886. doi: 10.1542/peds.2010-0396.

Pathela, P, Blank, S, Sell, RL & Schillinger, JA 2006. The importance of both sexual behavior and identity. *American Journal of Public Health*. 96(5): 765-765. doi: 10.2105/AJPH.2005.079186.

Phillips, KA, Mayer, ML & Aday, LA 2000. ''Barriers to care among racial/ethnic groups under managed care.'' *Health Affairs*. 19(4): 65-75.

Piko LM 2014. Optimising professional life: A grounded theory of doctors' careers. A thesis submitted for the degree of Doctor of Philosophy of the Australian National University. (Unpublished).
[Available: http://www.phcris.org.au/download.php?id=5716&spi=18] Accessed: 15 June 2017.

Plummer, M & Young, LE 2010. Grounded theory and feminist enquiry: Revitalizing links to the past. *Western Journal of Nursing Research*. 32(3): 305-321.

Polit, DF & Beck, CT 2008. Nursing Research: Generating and assessing evidence for nursing practice. 8th Edition. Lippincott. Williams and Wilkins. Philadelphia.

Polit, DF & Beck, CT 2010. Generalization in quantitative and qualitative research: myths and strategies. *International of Nursing Studies*. 47(11): 1451-1458.

Purtilo, R 2005. Ethical dimensions in the health professions. 4th Edition. Philadelphia. PA: Elsevier Saunders.

Poteat, T, German, D & Kerrigan, DK 2013. Managing uncertainty: A grounded theory of stigma in transgender health care encounters. *Social Science & Medicine*. 84: 2229.

Reback, CJ & Larkins, S 2010. Maintaining a heterosexual identity: Sexual meanings among a sample of heterosexually identified men who have sex with men. *Archive of Sexual Behavior*. 39: 766-773.
doi: 10.1007/s10508-008-9437-7.

Reed, PG & Runquist JJ 2007. Reformulation of a methodological concept in grounded theory. *Nursing Science Quarterly*. 20(2): 118-122.

Reitman DS, Austin B, Belkind U, *et al* 2013. Recommendations for promoting the health and well-being of lesbian, gay, bisexual and transgender adolescents: A position paper of the Society for Adolescent Health and Medicine. *Journal of Adolescent Health*. 52: 506-510.

Ridolfo, H, Miller, K & Maitland, A 2012. Measuring sexual identity using survey questionnaires: How valid are our measures? *Sexuality Research and Social Policy*. 9(2): 113-124. doi: 10.1007/s13178-011-0074-x.

Riskind, RG, Tornello, SL, Younger, BC & Patterson, CJ 2014. Sexual identity, partner gender, and sexual health among adolescent girls in the United States. *American Journal of Public Health.* 104(10): 1957-1963.
doi: 10.2105/AJPH.2014.302037.

Rispel, LC, Metcalf, CA, Cloete, A, Moorman, J. & Reddy, V 2011. 'You become afraid to tell them that you are gay: Health service utilization by men who have sex with men in South African cities'. *Journal of Public Health Policy*. 32(1): S137–S151. doi: 10.1057/jphp.2011.29.

Röndahl, G 2009. Lesbians and gay men's narratives about attitudes in nursing. *Scandinavian Journal of Caring Sciences*. 23: 146-152.
doi: 10.1111/j.1471-6712.2008.00603.x.

Röndahl, G 2011. Heteronormativity in health care education programs. *Nurse Education Today*. 31(4): 345-349. doi: 10.1016/j.nedt.2010.07.003.

Röndahl, G, Bruhner, E & Lindhe, J 2009. Heteronormative communication with lesbian families in antenatal care, childbirth and postnatal care. *Journal of Advanced Nursing*. 65(11): 2337-2344.
doi: 10.1111/j.1365-2648.2009.05092.x.

Rosario, M, Corliss, HL, Everett, BG, Reisner, SL, Austin, SB, Buchting, FO & Birkett, M 2014. Sexual orientation disparities in cancer-related risk behaviors of tobacco, alcohol, sexual behaviors, and diet and physical activity: Pooled Youth Risk Behavior Surveys. *American Journal of Public Health*. 104(2): 245-254. doi: 10.2105/AJPH.2013.301506.

Rosenstreich, G, Comfort, J & Martin, P 2011. Primary health care and equity: The case of lesbian, gay, bisexual, trans and intersex Australians. *Australian Journal of Primary Health*. 17(4): 302-308. doi: 10.1071/PY11036.

Rounds, KE, McGrath, BB & Walsh, E 2013. Perspectives on provider behaviors: A qualitative study of sexual and gender minorities regarding quality of care. *Contemporary Nurse*. 44 (1): 99-110. doi: 10.5172/ conu.2013.44.1.99.

Rubin, A & Babbie, E 2010. Essential research methods for social work. New York: Brooks/Cole Cengage Learning.

Russell, ST, Everett, BG, Rosario, M & Birkett, M 2014. Indicators of victimization and sexual orientation among adolescents: analyses from Youth Risk Behavior Surveys. *American Journal of Public Health*. 104(2): 255-261. doi: 10.2105/ajph.2013.301493.

Saewyc, EM 2011. Research on adolescent sexual orientation: Development, health disparities, stigma, and resilience: Sexual orientation decade in review. *Journal of Research on Adolescence*. 21(1): 256-272.
doi: 10.1111/j.1532-7795.201.00727.x.

Saewyc EM, Skay CL, Hynds P, Pettingell S, Bearinger LH, Resnick MD, Reis E 2007. Suicidal ideation and attempts among adolescents in North American school-based surveys: Are bisexual youth at increasing risk? *Journal of LGBT Health Research*. 3(2): 25-36.

Saldaña, J 2013. The coding manual for qualitative researchers. 2nd Edition. Sage. London.

Savin-Williams, RC 2005. The new gay teenager. Cambridge. MA: Harvard University Press.

Schreiber, RS 2001. The "how to" of grounded theory: Avoiding the pitfalls. In: Schreiber, RS & Stern, PN (Eds.). Using grounded theory in nursing. 55-84. New York: Springer Publishing Company.

Schreiber, RS & Stern, PN 2001. Using grounded theory in nursing. New York: Springer.

Schurink, WJ 2004d. Lecture Nine: Qualitative Evaluation Research. University of Johannesburg. 27-28 February. Waterkloof Glen. Pretoria.

Schwandt, TA 2001. Dictionary of Qualitative Inquiry. 2nd Edition. London: Sage Publications.

Scott, S 1997. The grieving soul in the transformation process. In: Cranton, P (Ed.). Transformative learning in action: Insights from practice. *New Directions for Adult and Continuing Education*. 74: 41-50.

Sedlovskaya, A, Purdie-Vaughns, V, Eibach, R, LaFrance, M, Romero-Canyas, R & Camp, N 2013. Internalizing the closet: Concealment heightens the cognitive distinction between public and private selves. *Journal of Personality and Social Psychology*. 104: 695-715. doi: 10.1037/a0031179.

Shattell, MM & Chinn, PL 2014. Nursing silent on LGBTQ health. Rebel nurses provide hope. *Archives of Psychiatric Nursing*. 28: 76-77.

Shulman, L 1991. Interactional Social Work Practice. FE Peacock Publishers. Itasca.

Simmons, M 2004. Facilitation of practice development: a concept analysis. *Practice Development in Health Care.* 3(1): 36-52.

Sinding, C, Barnoff, L & Grassau, P 2004. Homophobia and heterosexism in cancer care: The experiences of lesbians. *Canadian Journal of Nursing Research*. 36(4): 170188.

The South African Nursing Council 2013. Code of Ethics for Nursing Practitioners in South Africa. Excellence in Professionalism and Advocacy for Health care Users. SANC: Pretoria.

Sirota, T 2013. Attitudes among nurse educators towards homosexuality. *Journal of Nursing Education*. 52: 219-227.
doi: 10.3928/01484834-20130320-01.

Skovholt, TM & Ronnestad, MH 1992. The evolving professional self: Stages and themes in therapist and counselor development. Chichester, England: Wiley.

Smith, G, Bartlett, A & King, M 2004. Treatment of homosexuality in Britain since the 1950s-An oral history: The experience of patients. *British Medical Journal*. 382: 427-429.

Snyder, BK, Burack, GD & Petrova, A 2016. LGBTQ youth's perceptions of primary care. *Clinical Pediatrics*. 1-8.
doi: 10.1177/0009922816673306 cpj.sagepub.com.

Society for Adolescent Health and Medicine 2013. Recommendations for promoting the health and well-being of lesbian, gay, bisexual, and transgender adolescents: a position paper of the Society for Adolescent Health and Medicine. *Journal of Adolescent Health*. 52(4): 506-510. doi: 10.1016/j.jadohealth.2013.01.015.

South African Association of Campus Health Services. [Available: http://www.saachs.ac.za] Accessed: 14 January 2014.

South African Nursing Council 2017. Provincial distribution of nursing manpower versus the population of the Republic of South Africa as at 31 December 2016. [Available: http://www.sanc.co.za/stats.htm] Accessed: 25 January 2018.

Stanley, MJC & Matchett NJ 2014. Understanding how student nurses experience morally distressing situations: Caring for patients with different values and beliefs in the clinical environment. *Journal of Nursing Education and Practice*. 4(10): 133-134. doi: 10.5430/jnep.v4n10p133.

Stern 2007. On solid ground: Essential properties for growing grounded theory. In Bryant, A and Charmaz, K (Eds.): Handbook of grounded theory. London: Sage.

Stern, P & Porr, C 2011. Essentials of accessible grounded theory. Walnut Creek. CA: Left Coast Press.

Strauss, A 1993. Continual permutations of action. New York. NY: Aldine de Gruyter.

Strauss, A & Corbin, J 1990. Basics of qualitative research: Grounded theory procedure and techniques. Newbury Park. CA. Sage.

Strauss, A & Corbin, J 1998. Basics of qualitative research: Techniques and procedures for developing grounded theory. Thousand Oaks. CA: Sage.

Streubert, HJ & Carpenter, DR 1999. Qualitative research in nursing: advancing the humanistic imperative. 2nd Edition. Philadelphia: Lippincott & Wilkins.

Suar, D & Khuntia, R 2010. Influence of personal values and value congruence on unethical practices and work behavior. *Journal of Business Ethics.* 97: 443-460. doi: 10.1007/s10551-010-0517-y.

Swanson, K 1991. Empirical development of a middle range theory of caring. *Nursing Research*. 40(3): 161-166.

Taylor, E 2000a. Analyzing research on transformational learning theory. In Mezirow, J & Associates (Eds.). The Handbook of Transformative Learning: Theory, Research and Practise. 35-70. San Francisco, CA: Jossey-Bass.

Taylor, A 2011. The Fight for the Cure: The declassification of homosexuality as a mental illness. A paper written for Dr. Charles Hanson's Advanced Placement U.S. History class in the spring of 2011.29-42.
[Available: http://roundtable.menloschool.org/issue10/3_Taylor_MS_Roundtable10_Fall_2011.p df] Accessed: 30 May 2017.

The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. Geneva: World Health Organization. 1992.
[Available: http://www.who.int/classifications/icd/en/GRNBOOK.pdf] Accessed: 12 March 2017.

Thoreson, R & Cook, S 2011. Nowhere to turn: Blackmail and extortion of LGBTI people in Sub-Saharan Africa. *International Gay and Lesbian Human Rights Commission*. Brooklyn. USA.
[Available: https://www.outrightinternational.org/sites/default/files/484-1.pdf] Accessed: 03 February 2014.

Tisdell, EJ 2012. Themes and variations of transformational learning: Interdisciplinary perspectives on forms that transform. In: Taylor, EW & Cranton, P (Eds.). The handbook of transformative learning: Theory, research, and practice. 21-36. San Francisco, CA: Jossey-Bass.

Tjepkema, M 2008. Health care use among Lesbian, Gay and Bisexual Canadians. *Health Reports*. 19(1): 53-64.

Tongprateep, T & Nareuwat, N 2002. Religion: a basis for nursing practice. In: Tassanee, T, Noot, T, Nonglak, N *et al.* (Eds.). Buddhism for nursing. 17-3. Bangkok: Eak Pim Thai Press.

Travelbee, J 1963. What do we mean by rapport? *American Journal of Nursing*. 63: 70-72.

Travelbee, J 1966. Interpersonal aspects of nursing. Philadelphia, PA: F.A. Davis.

Tully, CT 1995. In Sickness and in health: Forty years of research on lesbians. In: Tully, CT (Ed.). Lesbian Social Services: Research Issues. 1-18. New York: Harrington Park. Press/Haworth Press. Inc.

Turner, BA 1981. Some practical aspects of qualitative data analysis: One way of organizing the cognitive processes associated with the generation of grounded theory: *Quantity and quality*. 15(3): 225-247.

United Nations Youth. Definition of Youth.
[Available: http://www.un.org/esa/socdev/documents/youth/fact-sheets/youth-definition.pdf] Accessed: 18 February 2014.

Urquhart, C 2013. Grounded theory for qualitative research: A practical guide. London: Sage Publications.

Veins, DC 1991. The moral reasoning of nurse practitioners [Dissertation]. San Diego, CA: University of San Diego. Unpublished.

Walker, L & Avant, K 1995. Strategy for theory construction in nursing. 3rd Edition. Norwalk. CT: Appleton & Lange.

Walker, LO & Avant, KS 2005: Strategies for theory construction in nursing. 4th Edition. CT: Appleton & Lange Norwalk.

Walker, LO & Avant, KC 2011. Strategies for theory construction in nursing. 5th Edition. Boston: Prentice Hall/Pearson.

Watling, CJ & Lingard, L 2012. Grounded theory in medical education research. AMEE Guide 70. *Medical Teacher*. 34: 850-861.

Wells, JE, McGee, MA & Beautrai, AL 2011. Multiple aspects of sexual orientation: Prevalence and sociodemographic correlates in a New Zealand National Survey. *Archives of Sexual Behaviour*. 40(1): 155-168.
doi: 10.1007/s10508-010-9636-x.

Weis, D & Schank, MJ 2002. Professional values: key to professional development. *Journal of Professional Nursing.* 18(5): 271-275. doi: 10.1053/jpnu.2002.129224.

Wilkinson, G 2008. Protecting client autonomy: A grounded theory of the processes nurses use to deal with challenges to personal values and beliefs. PhD Thesis. University of Newcastle. Australia. Unpublished.
[Available: http://hdl.handle.net/1959.13/29765] Accessed: 20 August 2016.

World Health Organization (WHO) 1971. Expert Committee on Health Statistics. 14th Report. Geneva. *WHO Technical Report Series*. 472: 21-22.

World Health Organizations (WHO) 1978. Primary Health Care. [Available: http://www.whqlibdoc.who.int/publications/1978/9241541288_eng.pdf] Accessed: 18 February 2014.

World Health Organizations (WHO) 2011. Youth and health risks. [Available: http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_25-en.pdf] Accessed: 23 June 2014.

Wright, RA 1987. Human values in health care: The practice of ethics. McGraw-Hill: New York.

Wuest, J, Ford-Gilboe, M, Merritt-Gray, M, Wilks, P, Campbell, JC, Lent, B & Smye, V 2010. Pathways of chronic pain in survivors of intimate partner violence. *Journal of Women's Health*. 19: 1665-1674. doi: 10.1089/jwh.2009.1856.

Whetten, D A. 1989. "What constitutes a theoretical contribution?" *Academy of Management Review*. 14(4): 490-495.

Varcoe, C, Doane, G, Pauly, B, Rodney, P, Storch, JL, Mahoney, K, McPherson, G, Brown, H & Starzomski 2004. Ethical practice in nursing: working the in-betweens. *Journal of Advanced Nursing*. 45(3): 316–325.

Xu, F, Sternberg, MR & Markowitz, LE 2010b. Men who have sex with men in the United States: demographic and behavioral characteristics and prevalence of HIV and HSV-2 infection: results from National Health and Nutrition Examination Survey 20012006. *Sexually Transmitted Diseases*. 37(6): 399-405.

Xu, F, Maya, SR & Markowitz, LE 2010a. Women who have sex with women in the United States: Prevalence, sexual behavior and prevalence of herpes simplex virus type 2 infection-Results from National Health and Nutrition Examination Survey 2001– 2006. *Sexually Transmitted Diseases*. 37: 407-413.

Yan, S 2014. Through an intersectionality lens: service provider views on the sexual health needs of racialized LGBTQ youth in Toronto. Master's thesis. Wilfrid Laurier University. Unpublished.

Yen, CF, Pan, SM, Hou, SY, Liu, HC, Wu, SJ, Yang, WC & Yang, HH 2007. Attitudes toward gay men and lesbians and related factors among nurses in Southern Taiwan. *Public Health*. 121(1): 73-79. doi: 10.1016/j.puhe.2006.08.013.

Yon-Leau C & Muñoz-Laboy M 2010 “I don’t like to say that I’m anything”: Sexuality, politics and cultural critique among sexual-minority Latino youth. *Sexuality Research on Social Policy*. 7: 105-117. doi: 10.1007/s13178-010-0009-y.

ADDENDUM A: PROBING QUESTIONS

ADDENDUM A

PROBING QUESTIONS FOR LGBTI YOUTH

NB This is not a questionnaire. The questions will only be used when necessary and not in a specific order. It might happen that none of the questions will be used during an interview. The researcher will only use the questions when the participant finds it difficult to tell about his or her experience.

- Have you disclosed your sexual orientation to a nurse in PHC clinic?
- What was the nurse's reaction towards you?
- How did you feel about disclosing your sexual orientation to the nurse?
- How did you feel about the nurse's response to the disclosure of your sexual orientation?
- Tell me about how your experience was when consulting the nurse with your health problem?
- What has it been like?
- How did you feel about the health service you have received from the nurse?
- Please describe the events and thoughts that influenced your feelings?
- Please describe what you consider positive experiences which you had encountered when seeking health care services at PHC clinics.
- What could the nurse have done to enhance the positive experiences that you have experienced?
- Please describe what you consider negative or unfavourable experience which you had encountered when seeking health care services at the PHC clinics.
- What could the nurse have done to mitigate the negative experiences that you have experienced?
- What concerns or problems will you feel at ease to discuss with the nurse in PHC clinics and why?
- What concerns or problems will you feel uneasy to discuss with the nurse in PHC clinics and why?
- What issues could prevent you from seeking health service at the PHC clinics?
- What do you think health care that accommodates the health care needs of LGBTI youth-inclusive should be like?

PROBING QUESTIONS FOR NURSES

NB This is not a questionnaire. The questions will only be used when necessary and not in a specific order. It might happen that none of the questions will be used during an interview. The researcher will only use the questions when the participant finds it difficult to describe his or her perspectives about LGBTI youth-inclusive PHC.

- Do you think that it is important to know the sexual orientation of the youth who consult you for health problems?
- Why do you think it is important to know the sexual orientation of the youth seeking health service at your clinic?
- What questions will you ask to determine the sexual orientation of youth seeking health service at your PHC clinic?
- Describe your beliefs and values with regard to LGBTI youth?
- How does your beliefs and values with regard to homosexuality affect the way you respond to the health care needs of LGBTI youth?
- In your opinion, what are the health care needs of LGBTI youth?
- What make their health care unique from their heterosexual counterparts?
- What has your experience been like when rendering health care to LGBTI youth?
- How did you feel about rendering health care to LGBTI youth?
- Please describe what you consider positive experiences when rendering health care to LGBTI youth.
- What could you do to enhance the positive experiences that arose during your encounter with LGBTI youth?
- What knowledge and skills could make nurses competent in delivering LGBTI youth-inclusive PHC?
- What support and resources are required to improve the competencies of nurses rendering health care to LGBTI youth?
- How would you determine whether your health care service is LGBTI youth-inclusive?

ADDENDUM B: LETTER REQUESTING PERMISSION FROM GAUTENG PROVINCE HEALTH SERVICES AUTHORITIES

ADDENDUM B: LETTER TO THE NATIONAL DEAPARTMENT OF HEALTH

2043 Ext 2
Tshukudu Street
Mamelodi East
P.O RETHABILE
0122
23 July 2014

The Director
Research Committee
Department of Health
Private Bag X838
Pretoria
0002

Dear Sir

PERMISSION TO CONDUCT RESEARCH AT PRIMARY HEALTH CARE FACILITIES IN THE TSHWANE DISTRICT

Permission is hereby requested to conduct research at the Mamelodi and Pretoria Central clinics. The study is for the purpose of fulfilling the requirements of the PhD degree in Nursing Science at the University of Pretoria.

I am a professional nurse holding a Masters Degree in Nursing Science and am currently studying to obtain the PhD degree in Nursing Science.

The title of the research is: Facilitating lesbian, gay, bisexual, transgendered and intersexed youth-inclusive primary health care in Tshwane District, Gauteng Province, South Africa: A Constructivist Grounded Theory Study. The aim of this study is to develop a substantive theory focused on facilitating LGBTI youth-inclusive PHC in Tshwane District, Gauteng Province, SA. The study is intended to take place between September 2014 and March 2015. A qualitative study design using a grounded theory approach will be used to collect data. Interviews will be held with 5 nurses and 10 lesbian, gay, bisexual, transgendered and intersexed youth at different Primary Health Care facilities in the Tshwane District. The venue for the interviews will be chosen by the

participants and thus might not be at the clinics.

The participants will be provided with information prior to the study about the nature of the study and will be requested to sign an informed consent form thus ensuring that they participate voluntarily. The rights of the participants will be ensured by not linking information to any participant's identity. The results will be shared with representatives of your institution.

I hope this request receives your favorable consideration.

Yours faithfully

Ms. Annah Sefolosha
E-mail: sefoloshaa@tut.ac.za
Tel: 012 382 6610
Cell: 082 411 1091

ADDENDUM C: LETTER REQUESTING PERMISSION FROM CITY OF TSHWANE HEALTH SERVICES AUTHORITIES

ADDENDUM C: LETTER TO CITY OF TSHWANE

2043 Ext 2
Tshukudu Street
Mamelodi East
P.O RETHABILE
0122
06 October 2014

The Director
Department of Health Services
City of Tshwane Metropolitan Municipality
2 Munitoria Building
302 Vermeulen Street
Pretoria
0002

Dear Sir

PERMISSION TO CONDUCT RESEARCH AT PRIMARY HEALTH CARE FACILITIES IN THE TSHWANE DISTRICT

Permission is hereby requested to conduct research at the Primary health care facilities of Tshwane District. The study is for the purpose of fulfilling the requirements of PhD in Nursing.

I am a professional nurse holding a Masters Degree in Nursing (Advanced Nursing Management) and currently studying towards PhD in Nursing at the University of Pretoria. I am currently employed as the Head of Department of the Directorate of Health and Wellness at Tshwane University of Technology managing primary health care programmes and services.

The title of the research is: Facilitating lesbian, gay, bisexual, transgendered and intersexed youth-inclusive primary health care in Tshwane District, Gauteng Province, South Africa: A Constructivist Grounded Theory Study. The aim of this study is to develop a substantive theory focused on facilitating LGBTI youth-inclusive PHC in Tshwane District, Gauteng Province, SA. The study is intended to take place between September 2014 and March 2015. A qualitative study using grounded theory approach

will be used to collect data. Interview will held with 5 nurses and 10 lesbian, gay, bisexual, trangendered and intersexed youth at different Primary Health Care facilities in the Tshwane District. The setting where the interview will be held will be selected by the participants.

The participants will be provided with information prior to the study about the nature of the study and will be requested to sign a consent thus ensuring that they participate voluntarily. The rights of the participants will be ensured by not linking information to any participant's identity. The results will be shared with the City of Tshwane, Department of Health; the Gauteng Department of Health, the participants of the study, through the publication of manuscripts in nursing research journals and presentations at nursing and health care conferences. The thesis will be available in the library of the Faculty of Health Sciences, University of Pretoria, as a reference for students.

I hope this request receives your utmost consideration.

Yours faithfully

Ms. Annah Sefolosha
E-mail: sefoloshaa@tut.ac.za
Tel: 012 382 6610
Cell: 082 411 1091

ADDENDUM D: LETTER TO THE RESEARCH ETHICS COMMITTEES OF THE UNIVERSITY OF PRETORIA

ADDENDUM D: LETTER TO THE RESEARCH ETHICS COMMITTTEEE OF THE UNIVERSITY OF PRETORIA

2043 Ext 2
Tshukudu Street
Mamelodi East
P.O RETHABILE
0122
23 July 2014

The Chairperson
Research Ethics Committee
University of Pretoria
Private Bag x323
Arcadia
0007

Dear Sir/Madam

PERMISSION TO CONDUCT RESEARCH FOR DOCTORAL STUDY IN NURSING

Permission is hereby requested to conduct research at the Students Health for the purpose of fulfilling the requirements of PhD in Nursing.

I am a professional nurse holding a Masters Degree in Nursing (Advanced Nursing Management) and currently studying towards PhD in Nursing at the University of Pretoria. I am currently employed as the Head of Department of the Directorate of Health and Wellness at Tshwane University of Technology managing primary health care programmes and services.

The title of the research is: Facilitating lesbian, gay, bisexual, transgendered and intersexed youth-inclusive primary health care in Tshwane District, Gauteng Province, South Africa: A Constructivist Grounded Theory Study. The aim of this study is to develop a substantive theory focused on facilitating LGBTI youth-inclusive PHC in Tshwane District, Gauteng Province, SA. The study is intended to take place between September 2014 and March 2015. A qualitative study design using a grounded theory approach will be used to collect data. Interviews will be held with 5 nurses and 10 lesbian, gay, bisexual, transgendered and intersexed youth at different Primary Health

Care facilities in the Tshwane District. The venue for the interviews will be chosen by the participants and thus might not be at the clinics.

The participants will be provided with information prior to the study about the nature of the study and will be requested to sign a consent thus ensuring that they participate voluntarily. The rights of the participants will be ensured by not linking information to any participant's identity. The results will be shared with the City of Tshwane, Department of Health; the Gauteng Department of Health, the participants of the study, through the publication of manuscripts in nursing research journals and presentations at nursing and health care conferences. The thesis will be available in the library of the Faculty of Health Sciences, University of Pretoria, as a reference for students.

I hope this request receives your utmost consideration.

Yours faithfully

Ms. Annah Sefolosha
E-mail: sefoloshaa@tut.ac.za
Tel: 012 382 6610
Cell: 082 411 1091

ADDENDUM E: LETTER TO THE RESEARCH ETHICS COMMITTEES OF THE TSHWANE UNIVERSITY OF TECHNOLOGY

ADDENDUM E : RESEARCH ETHICS COMMITTEE OF TSHWANE UNIVERSITY OF TECHNOLOGY

2043 Ext 2
Tshukudu Street
Mamelodi East
P.O RETHABILE
0122
23 July 2014

The Chairperson
Research Ethics Committee
Tshwane University of Technology
Private Bag X680
Pretoria
0001

Dear Sir/Madam

PERMISSION TO CONDUCT RESEARCH AT THE STUDENTS HEALTH AND WELLNESS CENTRE OF YOUR UNIVERSITY

Permission is hereby requested to conduct research at the Students Health and Wellness Centre of your University. The study is for the purpose of fulfilling the requirements of PhD in Nursing.

I am a professional nurse holding a Masters Degree in Nursing (Advanced Nursing Management) and currently studying towards PhD in Nursing at the University of Pretoria. I am currently employed as the Head of Department of the Directorate of Health and Wellness at Tshwane University of Technology managing primary health care programmes and services.

The title of the research is: Facilitating lesbian, gay, bisexual, transgendered and intersexed youth-inclusive primary health care in Tshwane District, Gauteng Province, South Africa: A Constructivist Grounded Theory Study. The aim of this study is to develop a substantive theory focused on facilitating LGBTI youth-inclusive PHC in Tshwane District, Gauteng Province, SA. The study is intended to take place between September 2014 and March 2015. A qualitative study using grounded theory approach

will be used to collect data. Interview will held with 5-10 nurses and 10-15 lesbian, gay and bisexual youth at different Primary Health Care facilities in the Tshwane District. The setting where the interview will be held will be selected by the participants.

The participants will be provided with information prior to the study about the nature of the study and will be requested to sign a consent thus ensuring that they participate voluntarily. The rights of the participants will be ensured by not linking information to any participant's identity. The results will be shared with the City of Tshwane, Department of Health; the Gauteng Department of Health, the participants of the study, through the publication of manuscripts in nursing research journals and presentations at nursing and health care conferences. The thesis will be available in the library of the Faculty of Health Sciences, University of Pretoria, as a reference for students.

I hope this request receives your utmost consideration.

Yours faithfully

Ms. Annah Sefolosha
E-mail: sefoloshaa@tut.ac.za
Tel: 012 382 6610
Cell: 082 411 1091

ADDENDUM F: LETTER REQUESTING PERMISSION FROM THE DIRECTORS/MANAGERS OF THE UNIVERSITY-BASED PHC

ADDENDUM F: LETTER TO THE DIRECTOR: STUDENT HEALTH AND WELLNESS, TUT

2043 Ext 2
Tshukudu Street
Mamelodi East
P.O RETHABILE
0122
06 October 2014

The Director
Student Health and Wellness
Tshwane University of Technology
Private Bag x680
Arcadia
0007

Dear Sir/Madam

PERMISSION TO CONDUCT RESEARCH AT THE STUDENTS HEALTH AND WELLNESS CENTRE OF YOUR UNIVERSITY

Permission is hereby requested to conduct research at the Students Health and Wellness Centre of your University. The study is for the purpose of fulfilling the requirements of PhD in Nursing.

I am a professional nurse holding a Masters Degree in Nursing (Advanced Nursing Management) and currently studying towards PhD in Nursing at the University of Pretoria. I am currently employed as the Head of Department of the Directorate of Health and Wellness at Tshwane University of Technology managing primary health care programmes and services.

The title of the research is: Facilitating lesbian, gay, bisexual, transgendered and intersexed youth-inclusive primary health care in Tshwane District, Gauteng Province, South Africa: A Constructivist Grounded Theory Study. The aim of this study is to develop a substantive theory focused on facilitating LGBTI youth-inclusive PHC in Tshwane District, Gauteng Province, SA. The study is intended to take place between September 2014 and March 2015. A qualitative study design using a grounded theory approach will be used to collect data. Interviews will be held with 5 nurses and 10

lesbian, gay, bisexual, transgendered and intersexed youth at your institution. The venue for the interviews will be chosen by the participants and thus might not be at the clinics.

The participants will be provided with information prior to the study about the nature of the study and will be requested to sign a consent thus ensuring that they participate voluntarily. The rights of the participants will be ensured by not linking information to any participant's identity. The results will be shared with the City of Tshwane, Department of Health; the Gauteng Department of Health, the participants of the study, through the publication of manuscripts in nursing research journals and presentations at nursing and health care conferences. The thesis will be available in the library of the Faculty of Health Sciences, University of Pretoria, as a reference for students.

I hope this request receives your utmost consideration.

Yours faithfully

Ms. Annah Sefolosha
E-mail: sefoloshaa@tut.ac.za
Tel: 012 382 6610
Cell: 082 411 1091

ADDENDUM G: LETTER REQUESTING PERMISSION FROM THE DIRECTORS/MANAGERS OF THE UNIVERSITY-BASED PHC

ADDENDUM G: LETTER TO THE DIRECTOR: STUDENT HEALTH AND WELLNESS, UNIVERSITY OF PRETORIA

2043 Ext 2
Tshukudu Street
Mamelodi East
P.O RETHABILE
0122
24 July 2014

The Manager
Student Health and Wellness
University of Pretoria
Private Bag x323
Arcadia
0007

Dear Sir/Madam

PERMISSION TO CONDUCT RESEARCH AT THE STUDENTS HEALTH AND WELLNESS CENTRE OF YOUR UNIVERSITY

Permission is hereby requested to conduct research at the Students Health and Wellness Centre of your University. The study is for the purpose of fulfilling the requirements of PhD in Nursing.

I am a professional nurse holding a Masters Degree in Nursing (Advanced Nursing Management) and currently studying towards PhD in Nursing at the University of Pretoria. I am currently employed as the Head of Department of the Directorate of Health and Wellness at Tshwane University of Technology managing primary health care programmes and services.

The title of the research is: Facilitating lesbian, gay, bisexual, transgendered and intersexed youth-inclusive primary health care in Tshwane District, Gauteng Province, South Africa: A Constructivist Grounded Theory Study. The aim of this study is to develop a substantive theory focused on facilitating LGBTI youth-inclusive PHC in Tshwane District, Gauteng Province, SA. The study is intended to take place between

September 2014 and March 2015. A qualitative study design using a grounded theory approach will be used to collect data. Interviews will be held with 5 nurses and 10 lesbian, gay, bisexual, transgendered and intersexed youth at your institution. The venue for the interviews will be chosen by the participants and thus might not be at the clinics.

The participants will be provided with information prior to the study about the nature of the study and will be requested to sign a consent thus ensuring that they participate voluntarily. The rights of the participants will be ensured by not linking information to any participant's identity. The results will be shared with the City of Tshwane, Department of Health; the Gauteng Department of Health, the participants of the study, through the publication of manuscripts in nursing research journals and presentations at nursing and health care conferences. The thesis will be available in the library of the Faculty of Health Sciences, University of Pretoria, as a reference for students.

I hope this request receives your utmost consideration.

Yours faithfully

Ms. Annah Sefolosha
E-mail: sefoloshaa@tut.ac.za
Tel: 012 382 6610
Cell: 082 411 1091

ADDENDUM H: INFORMED CONSENT FROM THE LGBTI YOUTH PARTICIPANTS

ADDENDUM H: PARTICIPANT INFORMATION LEAFLET – LESBIAN, GAY, BISEXUAL, TRANSGENDERED AND INTERSEXED YOUTH

Title of the Study: "Facilitating lesbian, gay, bisexual, transgendered and intersexed youth-inclusive primary health care in Tshwane District, Gauteng Province, South Africa: A Constructivist Grounded Theory Study"

Dear Participant,

1. INTRODUCTION

You are invited to participate in a research study. This brochure will assist with giving you the relevant information to help you decide whether to participate in this particular study. It is important to understand what the study entails before you can make a decision to participate. Should this brochure fail to provide all the information you need to know, feel free to ask the researcher.

2. THE NATURE AND PURPOSE OF THIS STUDY

The aim of this study is to develop a substantive theory focused on the basic social processes involved in facilitating lesbian, gay, bisexual, transgendered and intersexed youth-inclusive Primary Health Care in Tshwane District, Gauteng Province, South Africa. You have been invited to take part in this study because you:

- Are between the ages of 18 and 24 years;
- Reside in the Tshwane District;
- Identify yourself as either gay, lesbian, bisexual, transgendered or intersexed youth; and
- Have experience of using public sector and/or university-based Primary Health Care clinics in Tshwane District.

You as a member of the target population are a very important source of information and are thus approached to take part in this study.

3. EXPLANATION OF PROCEDURES TO BE FOLLOWED

You will be expected to participate in an interview which will take place at a setting where you feel comfortable and at your own time. The interview will last approximately 45 minutes. Your participation is voluntary. The interview will be audio-taped and the tapes will be kept in a safe place to ensure confidentiality. Should you feel that some of the questions are sensitive, you need not respond to them.

The study is focused on how you experience care at the primary health care clinic. The researcher is specifically interested in your opinion whether the service at the clinic is lesbian, gay, bisexual, transgendered and intersexed youth-friendly. She also wants to know how the services can be improved to encourage lesbian, gay, bisexual, transgendered and intersexed people to use the services.

4. RISK AND DISCOMFORT INVOLVED

There are no risks associated with participating in the study. However, should you feel distressed during or after the interview, the researcher will organize a counsellor for you for debriefing in order to deal with any emotional crisis that might arise from the interview process or you may also be referred to the counsellor of your own choice should they so wish.

5. POSSIBLE BENEFITS OF THIS STUDY

By participating in the study, you will receive no direct benefits. The envisaged benefits of your participation will be towards the improvement of the functioning of primary health care clinics.

6. WHAT ARE YOUR RIGHTS AS A PARTICIPANT?

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the interview without giving any reason. Your withdrawal will not affect you in any way.

7. HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This study has received written approval from the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria and the Gauteng Department of Health Research Committee. Copies of the approval letters are available if you wish to have one.

8. INFORMATION AND CONTACT PERSON

The contact person for the study is Mrs Annah Sefolosha. If you have any questions about the study please contact her at cell 082 4111091. Alternatively you may contact her supervisor Prof Neltjie van Wyk at cell 082 776 1649.

Should you have any questions regarding the ethical aspects of the study, you can contact the following:

- Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria, Dr R Sommers, during office hours at Tel (012) 354 1677 or 086 651 6047, E-mail: deepeka.behari@up.ac.za.
- Chairperson of the TUT Senate Committee for Research Ethics, Dr WA Hoffmann, during office hours at Tel (012) 382-6265/46, E-mail: hoffmannwa@tut.ac.za. Alternatively, you can report any serious unethical behaviour at the University's Toll Free Hotline 0800 21 23 41.

9 COMPENSATION

Your participation is voluntary. No compensation will be given for your participation.

10 CONFIDENTIALITY

All information that you give will be kept strictly confidential. Once we have analysed the information no one will be able to identify you. Research reports and articles in scientific journals will not include any information that may identify you.

CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that the person asking my consent to take part in this study has told me about the nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (Information Leaflet and Informed Consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports. I am participating willingly. I have had time to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not affect me in any way.

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

Participant's name .....(Please print)

Participant's signature: .....Date.....

Investigator's name .....(Please print)

Investigator's signature ..... Date.....

Witness's Name .....(Please print)

Witness's signature ..... Date.....

VERBAL INFORMED CONSENT

I, the undersigned, have read and have fully explained the participant information leaflet, which explains the nature, process, risks, discomforts and benefits of the study to the person whom I have asked to participate in the study.

The person indicates that he or she understands that the results of the study, including personal details regarding the interview will be anonymously processed into a research report. The participant indicates that he or she has had time to ask questions and has no objection to participate in the interview. He or she understands that there is no penalty should he or she wish to discontinue with the study and the withdrawal will not affect him or her in any way. I hereby certify that the client has agreed to participate in this study.

Participant's Name .....(Please print)

Person seeking consent .....(Please print)

Signature.....Date.....

Witness's name[24] .....(Please print)

Signature .....Date.....

ADDENDUM I: INFORMED CONSENT FROM THE NURSE PARTICIPANTS

ADDENDUM I: PARTICIPANT INFORMATION LEAFLET – NURSES WORKING IN PRIMARY HEALTH CARE CLINICS

Title of the Study: "Facilitating lesbian, gay, bisexual, transgendered and intersexed youth-inclusive primary health care in Tshwane District, Gauteng Province, South Africa: A Constructivist Grounded Theory Study"

Dear Participant,

1. INTRODUCTION

You are invited to participate in a research study. This brochure will assist with giving you the relevant information to help you decide whether to participate in this particular study or not. It is important to understand what the study entails before you can make a decision to participate. Should this brochure fail to provide all the information you need to know, feel free to ask the researcher.

2. THE NATURE AND PURPOSE OF THIS STUDY

The aim of this study is to develop a substantive theory focused on the basic social processes involved in facilitating lesbian, gay, bisexual, transgendered and intersexed (LGBTI) youth-inclusive Primary Health Care (PHC) in Tshwane District, Gauteng Province, SA. You have been invited to take part in this study because you:

- Are a nurse working in the public sector or university-based PHC clinic;
- Have provided care to LGBTI patients; and
- Have more than two years' experience in the PHC.

You as a member of the staff of primary health care clinics are a very important source of information and are thus approached to take part in this study.

3. EXPLANATION OF PROCEDURES TO BE FOLLOWED

You will be expected to participate in an interview which will take place at a setting where you feel comfortable and at your own time. The interview will last approximately 45 minutes. Your participation is voluntary. The interview will be audio-taped and the tapes will be kept in a safe place to ensure confidentiality. Should you feel that some of the questions are sensitive, you need not respond to them.

The study is focused on your perceptions of the services that LGBTI youth require at primary health care clinics. The researcher is specifically interested in your opinion whether the service at the clinic is LGBTI youth-friendly. She also wants to know how the services can be improved to encourage LGBTI people to use the services.

4. RISK AND DISCOMFORT INVOLVED

There are no risks in participating in the study.

5. POSSIBLE BENEFITS OF THIS STUDY

By participating in the study, you will receive no direct benefits. The envisaged benefits of your participation will be towards the improvement of the functioning of primary health care clinics.

6. WHAT ARE YOUR RIGHTS AS A PARTICIPANT?

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the interview without giving any reason.

7. HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This study has received written approval from the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria and

the Gauteng Department of Health Research Committee. Copies of the approval letters are available if you wish to have one.

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The contact person for the study is Mrs Annah Sefolosha. If you have any questions about the study please contact her at cell 082 4111091. Alternatively you may contact her supervisor Prof Neltjie van Wyk at cell 082 776 1649.

9 COMPENSATION

Your participation is voluntary. No compensation will be given for your participation.

10 CONFIDENTIALITY

All information that you give will be kept strictly confidential. Once we have analysed the information no one will be able to identify you. Research reports and articles in scientific journals will not include any information that may identify you or your clinic. The information received during the project will only be used for research purposes and will not be used or released for any employment-related performance evaluation, promotion and/or disciplinary purposes

CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that the person asking my consent to take part in this study has told me about the nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (Information Leaflet and Informed Consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports. I am participating willingly. I have had time to ask questions and have no objection to participate in the study. I understand

that there is no penalty should I wish to discontinue with the study and my withdrawal will not affect me in any way.

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

Participant's name .....(Please print)

Participant's signature: .....Date.....

Investigator's name .....(Please print)

Investigator's signature ..... Date.....

Witness's Name .....(Please print)

Witness's signature ..... Date.....

ADDENDUM J: MEMOS

MEMO

DATA COLLECTION AND ANALYSIS PROCESS

08/11/2015
During initial coding which is the first level of coding process, I attempted to explore "what was actually happening in the data? Thus, allowing data to speak for themselves. Transcripts were printed and codes were hand-written in red pen along the margins of the transcript and then typed into a separate document along with their quotations. Codes were initially identified from line by line coding to develop initial codes. Each code was substantiated by two or more quotations from the interviews. In some instance quotations would fit into more than one code where codes overlap each other. The next step was to group together codes which had similar meaning into focused codes. Connections were made between focused codes with similar meaning to form sub-categories from which categories will be developed. This process included constant comparison of data to establish relationships between codes. Ultimately establishing causes, conditions, contexts, and consequences and allowing a conceptual framework to emerge which will provide a theory to explain the social processes surrounding the phenomenon. At some point of initial coding, some codes had to be disregarded because there were no connections to other codes.

02/02/2016

How codes were developed and how categories emerged.
Through constant comparative method, data collection and analysis of interviews transcripts were done concurrently. Initial coding was first done on all transcripts through line-by-line coding, looking for concepts with similar meaning. The initial codes were then compared and contrasted with one another to form focus codes. Similarly, focus codes were also compared and contrasted with one another to form categories until saturation occurred. The findings of the LGBTI participants were presented first, followed by those of the nurse participants. The findings of nurse participants' data were compared with those of LGBTI participants to look for similarities and differences so as to finally allow the core category that formed the substantive theory to emerge. Consequently, having gained a deeper insight into the nature of each code, the properties of each code and the dimension of the incidents were sorted, condensed, and were further conceptualized by theoretical coding from which the core category which formed the theory emerged. The findings of the data analysis process reflect my interpretation about the viewpoints of LGBTI and nurse participants' interactions.

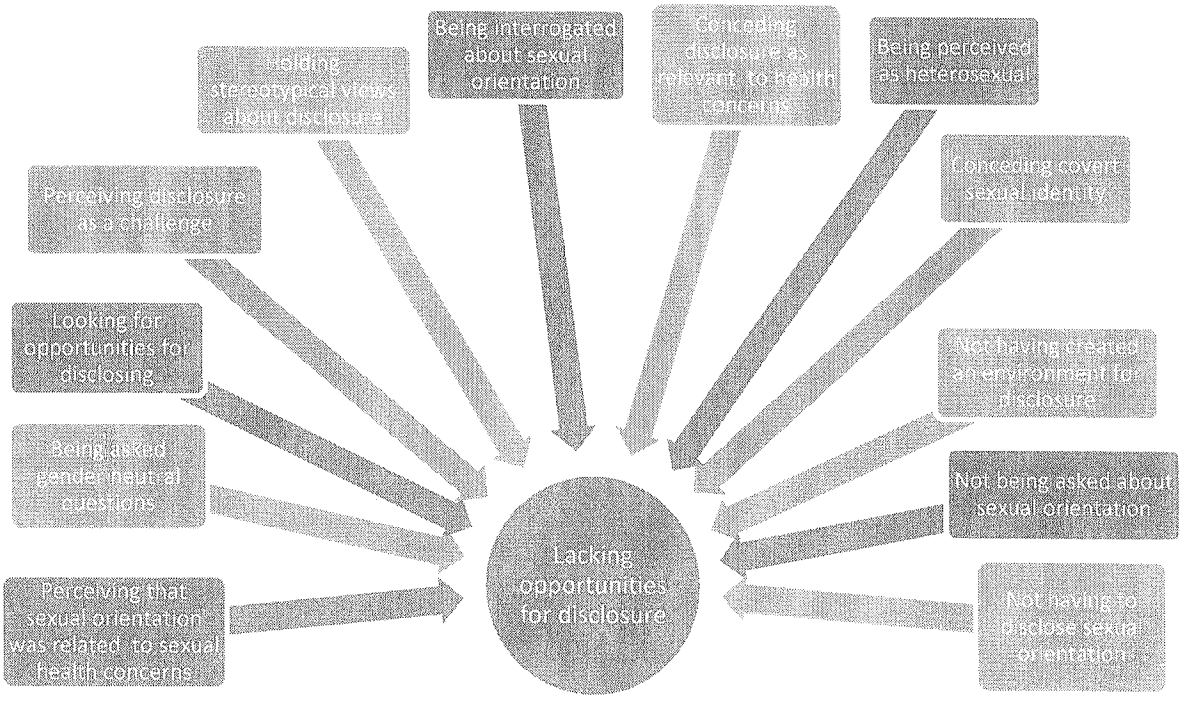
LGBTI MEMO

16/09/2015 edited 03/11/2015

Focus code 1: Deciding to disclose the self to others
The question arose in the researcher's mind: **How would the nurse know that the patient is LGBTI.** Hence, the interview questions that were asked attempted to explore the process by which the LGBTI participants would disclose their sexual orientation to the nurses by asking them to relate their experiences. The nurse participants' interview question attempted to explore the process by which they would identify their patients as LGBTI by also asking them to relate the experience as they interacted. For the LGBTI participants their experience during interaction with the nurses at the PHC clinics began when they were faced with **deciding to disclose their sexual orientation** or not. The code describes specifically

factors that motivated the LGBTI participants to **decide to disclose their sexual orientation to the nurses.**

Disclosure refers to a process of **revealing personal information to others** that they wouldn't have known if you didn't tell them and it forms an integral part of social interaction. For the LGBTI youth, the process of **deciding to disclose their sexual orientation to the nurses** involved communicating about their identity and sexuality which could be a direct or indirect process that emerged in different forms and was influenced by diverse intrinsic and extrinsic factors. **Deciding to disclose the self to others** is a process which involved **deciding who to talk to, when, where, how and what to talk about**. Once the decision has been made, the parties affected interacted with each other by exchanging verbal and non-verbal information and ideas with the aim of reaching a common understanding of the phenomenon being discussed and therefore resolving issues that needed attention. Data demonstrated that when LGBTI participants related their experiences of and feelings about disclosing their sexual orientation to the nurses, mostly referred to their sexuality in terms of their "inner self", since they perceived their sexuality as part of who they were and that process either facilitated or inhibited the process of **deciding to disclose**. The study had identified a number of ways in which the process of **deciding to disclose** might have occurred during the LGBTI interaction with the nurses which included **verbal, behavioural, consciously or unconsciously** expressed cues. Issues of choice and challenges related to disclosure were presented.



18/09/2015

Initial Code 1.1: Identifying the self as covert homosexuals

Some LGBTI participants decided not to disclose their sexual orientation to the nurses because they **identified themselves as covert homosexuals**. As they were interviewed, it became apparent that they perceived being gay as something personal, which **comprises of the inner "self"** that could not be shared with anyone. When questioned if they have ever disclosed their sexual orientation to the nurses, Participant 1 responded that he didn't because he didn't find it necessary to disclose his sexual orientation. He perceived being gay as the "inner self", because he didn't have visible features that identified him as a gay

man which he referred to as "feminine look"; as he identified himself as a "masculine" gay man. Participant 1 asserted that he doesn't find it necessary to disclose his sexual orientation, and that opportunities are not yet created at the clinics where people could feel comfortable to disclose their sexual orientation. He furthermore mentioned that for someone who didn't have access to a private clinic it is a problem since, it is difficult to disclose certain things at a public clinic.

Initial Code 1.2: Not being asked about their sexual orientation

Interestingly, some participants did not disclose their sexual orientation because of **not being asked about their sexual orientation** by the nurses. When questioned if they had ever disclosed their sexual orientation to the nurses, participant 2 responded that he had not disclosed his sexual orientation to any nurse. When asked why, participant 2 gave the reason that the nurses never asked about it. Participant 2 indicated the significance of disclosing as he acknowledged that for him not disclosing his sexual orientation to the nurses could have detrimental health care outcomes. This showed how the participant perceived **the relevancy of sexual orientation to their health concerns**. He viewed his non-disclosure as some form of **self-betrayal** which consequently could cause him to receive the wrong diagnosis from the nurse. At the same time, he didn't disclose his sexual orientation because he feared **rejection from** the nurses, since he anticipated the **nurses to be homophobic.** This conclusion was informed by the fact he perceived **the nurses as lacking information on LGBTI issues**, since he had been observing that the nurses didn't refer to LGBTI issues when they gave health education and some nurses were shouting at the patients. This observation clearly illustrated that he feared the possibility that the nurses will react in the same way towards him when he disclosed to them. With Participant 5, when asked if the nurse had asked him about his sexual orientation, he responded that the nurse didn't ask. However, he was of the opinion that it was obvious for one to disclose his sexual orientation when consulting. Participant 2 shared the same sentiment by acknowledging the importance of disclosure. However, Participant 2 had never disclosed his sexual orientation to any nurse, because he had never been asked by any nurse about it.

20/09/2015

Initial Code 1.3: Being perceived as heterosexuals

Whilst exploring factors that lead the LGBTI youth to **decide to disclose their sexual orientation**, it was interesting to note that sometimes the participants didn't disclose their sexual orientation because of **being perceived as heterosexuals by the nurses**. They viewed the nurses as heterosexists. Heterosexism is when people hold the perception that heterosexuality is superior or normal sexual orientation and could be regarded as another **form of discrimination**. Here, **being perceived as heterosexuals by the nurses** is manifested in various forms. It was also interesting to note that, the majority of participants believed that they were **being perceived as heterosexuals** by the nurses based on the **assumption that they didn't have visible features that identified them as homosexuals, they looked "straight"**. They were of the opinion that the nurses assumed that everyone who comes to the clinic is heterosexual and that nurses have limited knowledge on LGBTI issues. Participants declared that, based on the questions that the nurses asked them during consultation, they have concluded that the nurses assumed that everyone visiting the clinics is heterosexual. Participant 3 eloquently discussed that because he looked "straight", he had only disclosed when he was given a chance to do so, but mostly he had experienced that the nurses had assumed already that everyone coming to the clinic is heterosexual thus **denied him of the opportunity to disclose.** He usually accepted the assumption that he was heterosexual and thus didn't disclose. Participant 3 also articulated that because one couldn't tell from a distance that he was gay since he looked "straight" and not feminine, the nurse would ask him questions about his girlfriend, and neglected to acknowledge that a partner could be of the same sex as well. Therefore, that made it really difficult for him to disclose his sexual orientation to them.

Theoretical Memo

12/10/2016

While the nurses are working with LGBTI patients, they discovered that issues brought up by LGBTI patients challenge their own values, beliefs or experiences. So, whilst working with LGBTI patients, nurses interrogated their own values and beliefs against their professional values and attitudes in an attempt to remain open to and respectful to LGBTI patients. At some point they experienced ambivalence and hypocrites as they had to uphold something that was against their values and beliefs. Nevertheless, they acknowledge that they are guided by their professional values and obligations and therefore had to strike the balance between personal and professional values as they relate to LGBTI care. They therefore applied the same principles of care and professionalism that they apply to heterosexual patients irrespective of how they feel about LGBTI. However, at some stage, they have to determine the unique needs of the patients and customize the health care to meet those needs.

Most nurses expressed their limitation to work well with LGBTI patients as not knowing what kind of support they require and their lack of training in LGBTI issues and their health care concerns. However, at the same time they expressed the significance of capacity building in sexuality and sexual orientation to deal effectively with LGBTI patients. The mentioned that that they could work closely with LGBTI patients, and learn from them what kind of support they require. They also articulated that they need to consult with other health care providers who are expertise in LGBTI health care, attend workshops and seminars to learn more about how to be sensitive to LGBTI patients and their health care concerns.

They gave clear signals of a therapeutic relationship which included raising the importance of increasing the patients' comfort level by applying the basic rules of listening to their stories, acknowledging their challenges and to create a safe environment. Asking questions in a sensitive manner and 'breaking the ice' by asking questions expressing humour before asking sensitive questions indicates that the nurse is open to explore areas that might be uncomfortable for LGBTI patients to talk about.

They expressed the importance of being non-judgemental to promote a therapeutic relationship. The nurses saw the importance of developing empathy and finding a way of understanding LGBTI people's experience and challenges. Empathy meant putting oneself in another person shoes and checking how would one feel and respond if one was in a similar situation as LGBTI patients. Some nurses tried to put their patients at ease by talking about their personal experiences with LGBTI people and being alliance to LGBTI people, some referred to their parental role (mother understanding the needs of a child). LGBTI participants and nurse participants talk about how in a safe and friendly environment LGBTI patients are able establish trust and to talk openly about their sexual orientation and their challenges totality of their lives.

11/09/2015

Coding Memo

All nurse participants in the study related that as a PHC nurses, they have come across many LGBTI youth. Some nurse participants mentioned that they had observed the youth **conducting themselves as LGBTI**. This statement showed that according to the nurse participants, they **perceived being LGBTI as a behaviour or an act**. Thus, based on the manner in which the youth conducted themselves made the nurse participants to classify them as LGBTI. This perception emanates from the fact that in some cases, when LGBTI youth presented themselves to the clinic, **they related to them the reasons that brought them to become LGBTI**. This made them **believe that being LGBTI is a condition that is brought about by certain circumstances and is eventually exhibited in the person's behaviour or actions**.

Nurse participant 1 related an encounter whereby the patient explained to her his reason for being gay. The patient related that he became attracted to people of the same sex as a result of poverty. He related that because his partner who is also a male is working, he was able to provide for him financially since he was a student and not working. His other reason was that a couple of the same sex understands each other and each other's needs.

Some nurse participants **imposed their own religious beliefs and values on their patients**. Nurse participant 1 referred to the fact that God said that a man will marry a woman and not a man will marry another man. The patient responded that the country's democracy allows people of the same sex to marry each other. Since Nurse Participant 1 was curious about gay relationship, she wanted to know if the patient was satisfied with being in a gay relationship.

Most nurse participants related how they found out that their patients were LGBTI was because of the medical condition that they presented with at the clinic. When nurse participant 1 started asking the patient about what brought him to the clinic, the patient responded that he had anal sores. When she asked the patient what type of anal sores he had, the patient didn't hesitate to undress and let her examine him. Nurse participant 1 examined the patient and discovered that he had wart-like sores on his anus. When she tried to ask the patient about his condition, the patient explained that he's been engaging in anal sex with his male partner, she eventually called the doctor to help and the patient was then treated and referred to the hospital for further treatment. The patient **disclosed his sexual orientation due to perceived relevancy of his sexual orientation to his health concern**. Nurse participant 1 **established a rapport** with the patient by asking the patient to come back to her so that she can see if there is any improvement in his condition. She related that **the patient was calm and comfortable throughout** and that they **had built a good nurse-patient relationship**. According to nurse participant 1, she had a good relationship with her patient because the **patient didn't hesitate to tell her about his medical problem and the fact that he is in a homosexual relationship, and she further asked to patient to feel free to come and visit her at home or see her when he comes to the clinic and talk to her with whatever he is concerned** about. What nurse participant 1 considered a **good interpersonal relationship was when the patient was free to talk to her about his medical condition and disclosing his sexual orientation to her. The patient felt**

welcomed and relaxed during his interaction with her and that facilitated him to engage in an open and free communication.

For most participants, when asked about how their beliefs and values influenced the way they cared for their LGBTI patients, most felt very sorry and sad for the LGBTI people. Nurse participant 1 initially was of the opinion that being LGBTI was a choice that they made, she said they were just doing it on their own. She thought that LGBTI people were insane. From her response, one can deduce that nurse participant 1 is of the opinion that **being LGBTI is a choice, a situation that someone choses to be in**. This confirmed a statement that she mentioned earlier that the **youth are conducting themselves to be LGBTI**. She once more imposed her own beliefs and values when she mentioned that a girl is not supposed to be in a relationship with another girl and the same with boys. She is of the opinion that **choosing to be LGBTI is not right** and **believed that to be LGBTI is an act of Satanism**. She believed that Satanism has invaded the communities and that is the reason why the youth are turning themselves and behaving like LGBTI by doing gay and lesbian things. She felt sorry for them and put herself into their boots and imagined what if her child also developed to be LGBTI. Again based on her beliefs and values, she believed that being LGBTI is inherited from the forefathers since she is of the opinion that children cannot just "develop into these things" meaning being LGBTI. According to her beliefs being LGBTI is ancient but our forefathers were not openly talking about it. Data revealed that nurse participant 1 had different perceptions about LGBTI. **Firstly, she believed that it was a choice that people let themselves into to deal with certain situation that is manifested in their actions and behaviour of being LGBTI. Secondly, she believed that being LGBTI is an act of Satanism, it seems Satan is busy turning the young ones into LGBTI. Thirdly, she believed that being LGBTI is genetically inherited from the forefathers which is manifested during the early childhood development whereby a boy child starts behaving like a girl by wearing girls' clothes and play with dolls. Fourthly, she related the clinical findings of her patient to his sexual orientation.** She asserted that the condition that the patient presents himself with at the clinic could provide a clue that the patient is gay. In her case, the patient came in with an anal STI which suggested that he might be having anal sex which is a common sexual practice in gay couples and that prompted her to ask the patient about his sexual activities and sexual orientation, **asking the patient if he is sexually active, about number of partners he has and whether the partner is a male or female** and that is when the patient will be stimulated to talk openly about his homosexuality. **Lastly, she could also recognise that her patient was gay based on the external traits that the patient exhibited. She mentioned that he could pick up cues that her patient was gay from the manner that he was dressed and his straightened hair. He described him as a beautiful boy. Again, she mentioned that he could notice that the patient was gay from his voice when he was talking. She described the patient's voice as "high pitched" and said that based on her experience, she could tell that the people with such high pitched voices are gay.** However, she felt very sorry and sad because the LGBTI people also don't like the situation that they find themselves in, because they would also like to behave like any other people if they had that choice and have partners of the opposite sex. Hence she wondered what she will do if her own child was in that situation.

ADDENDUM K: TRANSCRIPT

LGBTI Participant

Date 10/11/2015 P5

Tape 18

R: Good Day Bongani

P: Good day

R: How are you?

P: I'm good and you?

R: I'm okay.....er ....I'm Mrs Annah Sefolosha, I'm a PhD Nursing student at the University of Pretoria, I'm doing research for my PhD....er..my study is aimed at facilitating LGBTI youth friendly services in Tshwane ....and (sigh) let me first ask you about your experiences, when you visited one of the health services in Tshwane, what has the experience been like, just relate to me from the time when you got to reception until you saw the nurse, what was the interaction between yourself and the nurses,

P: Mmm

R:... what was the attitude that took place, what was the behaviour between you and the nurse?

P: Well, I went to the clinic first of all to test for HIV and... the nurse, well the nurse wasn't really friendly because first of all the kind of questions she was asking me were not the kind of questions that I think that she would ask any other person and... I feel like she automatically assumed that I was sleeping around and I was just there to test whether because you...er...er do your tests on a monthly basis, I do mine on a monthly basis only to find out you know to be on the safe side, so the kind of questions that she was asking, yes as a nurse you're supposed to ask personal questions to get to understand the sexual orientation and the sexual activities of that person but I feel like she was more of... em...more...more... more, she was basically a bit judgemental , you know because I feel like the overall of judgement of her about me was that I sleep around and I found that a bit you know distorting because where I come from in...in...in Johannesburg, in Tembisa the nurses there are...are different from here, maybe it's because maybe I'm outspoken, I speak a lot so it was easier for them to understand where I come from, this side I feel like it's a bit difficult, the boundaries are bit difficult to break because it's a very ....it's a very conservative city and... it is different from where I come from, so here, it's a lot slow and the process takes longer and the nurses are... you know as .....people, you know, would obviously classify nurses as ignorant and they don't really take care of, you do their job properly and they don't take care of their patients

R: Mmm

P: I feel like they do it's just that they are impatient and for me, my...my... my experience has been that when I go to the clinic, to do whatever that I do, whether is to test for HIV or test for any other disease er that exist...I...I just get there and do what I want and do what I need to do ....without having to interact with them, they have to interact with me because it's

their job, they have to be friendly to me and I have to feel at ease especially when you do a test like HIV. I mean that is very personal and it is a scary experience for a person to go through, so when you go there er you not only need need need need motivation but you need warmth and the person sitting next to you has to be kind and nice ...em because of the... the ....the... the stigma around HIV, so I feel like Pretoria is... is very slow but yah.

R: So from what you are saying, are you saying that you didn't get that....warmth?

P: I didn't get the support and the warmth yes, em because you, normally when you go and test for HIV, even though you know you're on the safe side because you do monthly tests, you or three months, after three months or six months, you... you... you want support because I mean anything can go wrong, HIV is not only contro...contracted from...from sleeping with the person basically there are other ways you can get it, so you're never sure...

R: Mmmm

P: ... You are never really sure that you are negative or positive because... because of er the daily activities that we go through on a daily basis, so I... I didn't get the... the support that I needed, I needed a pillar, I needed someone to be you know very, you know very soft with me

R: Okay er, you said that you er...based on the questions that she asked you... you felt that she was being judgemental and can you recall the types of questions that she asked you?

P: Well I remember the first, the first remark that she made when I got there was like, you guys sleep around a lot ....and okay I didn't... I... I mean I mean I doubt they are very educated I think and...there's certain things that when a person says feel like okay I don't know if that is ethical, you know

R: Mmmm

P: Maybe it is because a lot of gay people come there and they are HIV and they disclose their sta..status because it...it was...it was, it shouldn't be a general overview from her side, point of view so I feel like she boxed me and... you know I was just a number, you know of people who came through so I...er, okay, so the type of questions that was the ... first when I got there she made that comment and I was gonna like so okay, it's gonna be, she wasn't even smiling she wasn't even hard, she made the process even harder because you know, even on the nerves that you have as a person and you know dealing with a very difficult person as well knowing that okay, this is their job, they have to do it to the best of their ability but they not doing it to the best of their ability and when I was there she wanted lunch in the middle of our session and I was like so I'm not that important and so it wasn't that nice

R: But mmmh did you disclose your sexual orientation, did she ask

P: She didn't ...I feel like it is an obvious thing... you have to disclose and tell them about your sexual orientation this is the situation....

R: Mmmm

P: .... But with me I didn't, I felt like it was obvious....

R: Mmmm

P: … you know and … and yah so I didn't really disclosed my sexual orientation, I thought that she, it was obvious for her to

R: Mmm, you assumed that it was obvious

P: Yah,

R: But obviously from what you have said, it seems that she assumed and even from the remarks…

P: Mmmh….

R: You assumed that you were gay

P: gays around, yes

R: Okay, based on those behaviour and attitude, how did you feel about it?

P: It was… it was such a… it was a… because if for almost an hour and d that hour felt like a day because obviously I had no….. I didn't ….. and you know here I come test you know and… not only that but , I remember there was a time when I went to the same clinic and I wanted information….

R: Okay, let's …we'll get to that incident later, just park it for now, let's talk about this one for now

P: Yes

R: Mmmm

P: … so I felt like an hour was a day, and… obviously because when … when you're having a session with someone er, it's not only professional session especially when … when you are dealing with health, it's not only a professional thing, you have to be very, you have to understand, you have to be er empathise with the person from their point of view because as a nurse you have to know that you have to differentiate between the person who is nervous…

R: Mmmm

P:… especially when they are doing tests

R: HIV test?

P: Because now when a person is doing a HIV test, it's… it's a matter of life choices, having to change…

R: Mmmm

P: …. You know and all those things so my day was just, but I, I don't know, I just said to myself, you know what just do what you have to do and get out of here and find out what you need to find out even though it was a long, long, long time but yah, it wasn't nice yah

R: Yah, you mentioned the fact that yah it felt like a long day…

P: Yah

R:… can you explain that further so that we get the meaning of what exactly do you mean by saying your day was very long even if it was for that short period of time

P: Okay, so obviously when you get to a clinic you stand in the queue for people who came to test for HIV and the stigma, when you go to that queue everybody knows that queue people often think that you have done something you know…

R: Mmm

P: ..from the get go, when I got there, the eyes, you know….

R: Mmm

P: Look at you differently, people look at you in a sense like you don't belong

R: Mmm

P: And then you get into the session, you get into the room with the nurse and then joo (sigh), okay you sit down and then you talk and obviously for me that conversation cos it was not for me, I feel like it was not a productive conversation and I didn't get anything from it because I feel like when you go and test for HIV, there are certain things that you have to tell them dos and don'ts about you… next time do this …. Because sometimes you know you… you do things and then you want to correct your mistakes …

R: Yah

P: … you want to find out whether you have done wrong or not

R: Mmmm

P: It's… it's not their responsibility to tell you what to do, but they do have a part to play because they went to school for it they are supposed to tell you that these are the steps to being you know a different person, you know being careful with your life, do this, don't do this next time don't do this you know when you encounter a sexual person, when encounter a person with different sexual orientation….

R: Mmm….Mmmm

P: That, I didn't, I didn't get any information and with that nurse I felt like she wanted to finish with m, get it over and done.

R: Mmm

P: Get it.

R: Mmm

P: Get it go and whe… when I got that kind of impression, I also wanted to get it done…

R: To get it done…..

P: To get it done and over, overall when I left .... When I was at the gate, I was like okay what did I learn from the whole session, nothing so there is a chance that I'm gonna make the same mistake, I didn't get any comment from er... er..a more professional kind of view.

R: Okay, so what is the meaning that you eventually attached to the whole experience?

P: Mmm (sigh)..., the meaning? Er...er...I couldn't ....I couldn't my... my experience I feel is my experience and I separate clinics and people because people don't have the same behaviour pattern

R: Mmmm

P: And for me I'm like overall I go to the next clinic to test for HIV what is the treatment that I'm gonna get because I went to clinic one and got that kind of treatment....

R: Mmmm

P:....I'm gonna think of going to clinic two.....

R: Mmmm

P: ... if I go to clinic two and I get the same treatment that means clinic three is gonna be the same

R: Yah

P: ... so for me I feel like, okay is it a... is it a tendency or is it just that clinic or....

R: Mmmm

P: .... Or the nurse because you cannot compete with the same, so for me it's it's a bitter sweet experience, I would put it like that, yah

R: Mmm, okay

P: I would attach it to that

R: So now you mentioned that there was this other incident, can you relate to that other incident you had an encounter with the nurse at the clinic?

P: I .... I.... I went there to get information about you know certain er... the department of health had actually em... imple...implemented something, a programme and I wanted to get information on it, obviously from the nurses and this is the information that is obviously going to help you know, I was not getting, like getting it for me, I wanted to disseminate that information to ... but the difficultness of the... the... the .... The that nurse, I mean, you know I mean not, what I was doing there was not only for me but for people....

R: Mmmm

P:... and also for her because, I was er, I was, you know we... they have a lot of work, I was actually lowering it for her because when you have to explain one thing over and over to patients as opposed to me having to dessimate that information, so the difficultness of that nurse, I didn't understand because.....

R: Mmmm

P:... it's a public service and of which you were to being helping people...

R: Mmm

P: ... and the aspect whether is information wise and... practical wise, you need to be helping people or so, I ... I did not understand the difficultness of that nurse and it was just a very weird encounter.

R: Okay, can you er ... you mentioned that the .... Behaviour was difficult, so can you explain exactly what happened for you to conclude that she was being difficult?

P: So, I get in the office and I look for the ...er... I don't know, the ... the bigger one, the bigger nurse?

R: Oh, the matron or the sister in charge?

P: Yes, cos, I got an impression that nurse didn't want to... to give information especially amongst ... I don't know whether it's intending... people were intending what

R: Mmm

P: So I was like okay since nobody is willing to give me information, let me rather ask for a person who is in charge

R: Mmm

P: ...Who's ... who's .... When they ask for information and first thing that she said was I should go to er.. the, I should get a letter and the information that I needed at that point was not em ... to put the clinic, because obviously the image of that clinic is important, as a nurse as the person in charge, you have to protect her, so not only was I helping them, but I feel like because we... this has been the clinic for .... Maybe they had an encounter before....

R: Mmmm

P:... which was not nice, not pleasant, but that is not you know a definition of when a person come to ask for information, you need to send them for to get a letter....

R: Mmmm

P: I'm in Jo'burg and you're in Pretoria and that person said, you need to go to the head office to .... So I was like so, is this a way of saying I don't want to give you information...

R: Mmmm

P: ... because I can't go to Jo'burg

R: Mmm

P: You are in Pretoria and you are sending me to Jo'burg when I have a deadline you know

R: Okay,

P: That can be tomorrow, and I need that information today but you are sending me to Jo'burg, it's not gonna work, Jo'burg is far…

R: Mmm

P: …. Forty five minutes' drive, so you know I thought like it was rather her way of saying no, to me which I didn't understand but I was like okay, you know if you are not willing to talk to me then it is okay, I would just leave, she didn't even refer me to anyone when… when you are in charge, you are very busy, you would say to me, listen go to ask that one, may she or he might be able to help you, but she didn't yah.

R: So, can you relate to er… reaction or her actions being due to the fact that you are being… you are gay or she just treated you as ordinary person?

P: No, because the thing is, when… when you in the society also, when… when as a person obviously there's certain things they would expect from you …. The… the way you speak, you know the way you act as … so when I got there, I… I … I'm gonna agree, I'm a confident person, I'm not get to a place where I …. Whatever I wanted to ask I ask and sometimes I may come across very big and that may be scary, but for her it was well she was in ….. manner obviously and the stigma around gay people is still raw, it's still ripe…

R: Mmmm

P: …especially amongst the African people

R: Yes…

P: …. So I felt like okay, this is… and then she wasn't even ….. for me as a gay person, I … I do not expect special treatment

R: Yah

P:… but I expect you to treat me like an adult person, you know

R: Yes.

P: So if you derail from that whole …. You know the other way, I can say that as a person you can see when a person is treating you differently

R: Mmmm….mmmmh

P: You can, from… from whether you are looking at that person from … so that person just wanted to dismiss me

R: Mmmm

P: You know, just dismissing you

R: Mmmh…….(silence)…. Okay

P: I want the same treatment that the next person is getting, so if I'm not gonna be getting the same treatment I'm gonna see and I'm gonna feel you know the tension that is there, it's not gonna be a nice one

R: And then how did this whole experience make you feel?

P: Wheeh, well, I.. I've learnt, I'm not gonna lie and say I'm a thick person and .... Yes you grow up and you tend to do this kind of things and you go, but to what point are we gonna have er... a free life to a point, at what point rather .....

R: Mmmm....

P:.... Are we gonna go to the clinic, and be treated the same as ordinary Tom, you know.....

R: Mmmm.....

P: ... why do we need to prove ourselves over and over again, why do we need to have the same conversations over and over again, for them as straight people who are not accepting, for them to treat us the way we are not supposed to be treated....

R: Mmmm

P:.... To what point are .... are we willing to take it, so I feel like I feel very disrespected because we are the citizens of this country, and I have the same right as you have, and you gonna deter my rights as you are superior to me, I have a problem with that, I'm not gonna be sad, I'm gonna be sad at the fact that ..... this stigma is still .....

R: Mmmm

P: ... you know, I feel in years to come it's gonna change, but ten years is too far, it's too far, especially in a country that is infiltrated with the western life

R: Yah.

P: It is very digitalized, ten years is too far, we need to change, to act now and to be equal, we need to teach each other, today because I mean we are human, you are my brother, my sister, my uncle, we all the same people, if we judge each other, who do we as people as gay people, as lesbian people as transgender people, who do we look up to, who do we look at, who ..... we can't always be a group ....

R: Mmmm

P:... you know I can' t always be with a gay friend and ... I need to also cross boundaries and have straight people and understand their lives and they need to understand my life, so if I'm gonna be clustered with other gay, how are we gonna be able to teach you, you know our ways of living....

R: Mmmm

P: ....the way we live....you know

R: Mmmm

P:...so, I felt very disrespected, I... but I was like you know what...there is a lot that I'm still going to encounter in my life and I just have to deal with it and dealing with it doesn't mean I'm gonna have to take it all the time,

R: Mmmm

P: .... Obviously I have to stand up for myself.

R: Okay

P: Yah

R: And then let's go back to earlier when you mentioned the fact that you when you go to Tembisa the experience is very different

P: Correct

R: What makes it different in your opinion?

P: Wheew, Tembisa, well in Tembisa they are not really, where... where I come from there are not really a lot of people, but I feel like the....the ....the...the idea of....of gay people in Tembisa has not manifested in their brain because when, for example when I went to the clinic, I remember I had a... I had a pox and I went to the clinic to... to, you know to get medicine there, the people there are amazing, they are beautiful and you know, it was very different and I felt, I felt very calm....

R: Mmmm

P:... and the experience was professional, it was very professional.

R: Okay, let's rather talk about the interaction that actually transpired for you to make that conclusion that the experience was amazing, for you to attach that meaning to say wow, this experience is very amazing, what really happened, how did you interact, what was their behaviour, what was their attitude?

P: I remember when I got in at the reception because I was not gonna... because of the pox it's... it's not gonna ..... it's contagious

R: Mmmm

P:... so, I went to the reception and there was an old lady and she was very nice, she's been there for a very very long time....

R: Mmmm

P:... she was very very nice to me, and she scheduled an appointment right there for me with the doctor and imagine it's a queue, it's a very long queue, and because what I heard was more of a severe, severe, ...

R: Mmmm

P: She... er , 10 minutes down the line I went into the doctor, it was a female doctor, I don't know maybe because she was female...

R: Mmmm

P: and you know the… we had a conversation before we went to the disease talk

R: So, i…i during that consultation did the doctor ask you about your sexual orientation?

P: No she didn't, I… I think she, she ….she….she….she knew because …she, you know how you know that people know?

R: Yah

P: In… in Pretoria, they call you "chomi"

R: Mmm

P: When somebody says "chomi" well you just know that I don't have to disclose my sexual orientation because this person know

R: Okay

P: And in Tembisa, they call you ….

R: Okay….

P: Yes, so for her that word, she started by calling me that

R: Okay

P: So obviously the person is nice to you, you see the smile, the…the…. the ….the attention they give you and with me it was…. I think even the session took longer than it was supposed to be

R: Mmm

P: It was, it was very nice

R: Mmm

P:

R: So the meaning that you attach to the whole experience?

P: (Coughs) Mmm, I would say professional…..

R: Mmmm

P: …and responsible and ……. Doing what you are qualified to do at that point because being… being a professional, like a health one, the same as the other one, they have good communication, communication is key, is n't?

R: Mmmm…

P: …. Where there's communication between you and the patient and the patient goes with trust and then nothing can go wrong

R: Yes, yes....so based on the two experiences what do you think makes the... the two experiences so different in terms of Tembisa and Pretoria what could be the factors in your opinion

P: You know in my opinion, before I came to Pretoria, Pretoria was.... Was gay friendly more than any other city in the country and you know, I'm not gonna give that fact away because of what I experienced there is not a general overview of the whole city...

R: Mmm

P: But, I could say that the....the....the... the experience I had here in Pretoria, the people here in Pretoria have a long way to go, not a long way to go, they have, somewhat long way to go ....

R: Mmmm

P: For ....for the understand of what gay is, understand what bisexual is, you know and it does not only take us educating them but it also to educate themselves only if they are willing to learn and....and there's a difference between this....this .....I feel like maybe this side they are more exposed, I don't know, I feel like, these two places are special, but obviously the people have to decide more than anything they have to understand that, you know on this... on this earth there's certain things that no one can explain.

R: Yah

P: Because we

R: Yah

P: ....but we have to make sure the process and understand the process that happens, they cannot understand, nobody is here by mistake, nobody is here by mistake just the wrong signs of it, everything that happens on the planet earth was supposed to happen, so Pretoria and Tembisa are...are very different, you know, but I did, I needed to because it's...it's I needed to know also that I...I can tell other people that listen, when you go to Pretoria, don't be stubborn because we don't have the same experience, meaning we do not see the same things every day.

R: Mmm

P: We do not encounter the same thing every day, some people; there are people who don't even know what gay is.

R: Yes.

P: 2015, there are people who don't know, people still need you to explain to them what you are, you are like that. Yes it might, you might feel like, it's 2015 it's beyond repair but you just have to be patient and you feel like explaining it, explain it because, not everyone is educated, everyone as...as....as knowledgeable about this kind of things who they think they are yah

R: Yah, okay, based on your negative experience at this clinic, what do you think should happen just to mitigate this kind of behaviours

P: I think that awareness is very important, we need to be aware, you know once in a while

R: When you say awareness are you talking about the nurses?

P: Yes, specifically I am, yes, they need to, because they need to be taught about this kind of things and I'm not only talking about, you know the entire gays, also we need to learn about other people as well, you know they need taught that listen in...in ....you have an experience with a gay person, you know, I'm not saying that a person should go there and explain himself to say you see, I was born like this, leave me to understand, you know, you do not only have a personal relationship with a gay person to understand a gay, you only need to open your mind, the open minded person you just have to be open minded and understand that the world ticks, so based on my experience I feel like awareness is very important, workshops....

R: Mmmm

P: Those are very important to get the difference, so in my experience learning...learning whether it is outside learning or ...or inside but they need to have er...er...a session where you have a gay person who's gonna say listen, this is how we tick

R: Mmm

P: Yah, and this is how we receive information, this is how we receive attitude

R: Yah

P: Because, I'm not gonna get there and have attitude over something if...if I'm here as a person and I'm smiling at you because you know at the end of the day you my...my attitude towards you is all that matters especially if we are seeing each other for the first time, if I'm not nice to you obviously you not gonna be nice to me

R: Yah

P: But if I am nice to you, I think it's...it's fair for you to return the favour, so if I was nice and I was nice to that nurse, I expected her to be nice to me too, even if I do have problems at home, or on my way to the clinic somebody tried to tell me I'm gay or what, I'm not gonna....beca....because we see the same ideas in the street on... er...you know on a daily basis, this what we do, we are discriminated. I do not need an educated person like another person to discriminate against him, there is education that goes by....

R: Yah

R: Okay, tell me for us to say er, a health service is LGBTI friendly, what should it look like?

P: Mmmm, that's a very good question

R: Mmm

P: For, firstly for a service to b, firstly for a service to be gay friendly

R: friendly

R: When we talk about the service, we talk about the environment and personnel which includes the nurses

P: I think that, they couldn't be gay friendly, that's how it is, when you get there, when you are treated like one more person, like er… like any other person wanting information whatever, that's how I will know that, that service is friendly not only gay friendly but everyone else….

R: Mmm

P:…. So if I get there I don't feel like an outcast because I'm gay, I will know that this service is gay friendly not because I'm gay but it is actually friendly in general, yah

R: And then in terms of the nurses?

P: The nurses….nurses, the nurses, I think nurses need to be…er, before we go there, nurses need to also understand that more upper hand

R: Yah

P: Because they are more educated

R: Mmm

P: You know in a society they are more educated and they need to disseminate information to people you know, so for them I feel like they just need to again….try to level, you know try to initiate conversation, initiate trust, trust is important, you should trust because if I trust, there are certain things that I'm gonna disclose if we were sitting down in a session, so if… if you have trust then we can't go wrong on or something is going wrong when I'm at home, I would definitely not hesitate to come to you ask you a question because I know the …. Experience

R: Yah, eish….sigh, okay is there anything that you think I should know that I didn't ask a question about but you feel it is important for me to know about?

P: Mmmm

R: Oh, I feel you are on the right track, you answered, I think you… asked the relevant questions, to which I answered, I'm not sure if I answered correctly, the questions were spot on, you tackled everything ….pretty much a good session yah

R: And is there anything that you would like to find out from me

P: (Silent)…. Yah, let me see, what… what…. What are you doing er around the campus, campus to ensure that the campuses are gay friendly, what …

R: As I said, this is a stepping stone

P: Mmm

R: Yah at the moment we have

P: Yah, because I mean, you know obviously this is a university and everyone hear is supposed to be different from the people in the streets you know, here it has to be looked at when… when you see a gay person or lesbian person or a transgendered person for that matter need to, to look at them at a point of educated person because when we still get questions you know very awkward er, so like do you really date guys, I mean, so for… for the campuses because campuses are different and this one is in town, it's very nice here but other campuses it's… it's different and you have to… you have to fend for yourself most of the time, you have to fight for the place but I feel like it's… it's ….slowly but surely because I mean we not gonna, I mean we not gonna blame, at the end of the day we need to know that it is more of an African culture which is that we live by, they lived by from back in the days still dictate to us even up to today we need to understand that it will also take time, so we… we as gay people, lesbians and you know, transgender and bisexual …. We just a process that, that will finally

R: Yah

P: and if we finally understand, it's, we will get there eventually …. We need to do this, we need to have this conversation, the next generations that is coming will have this conversation

R: No, it's true

P: Yes

R: Okay, thanks for your contribution and I hope you have a nice day

P: Anytime

R: But I just want to as I go on and analyse the data there will be some information that I would like to clarify or verify, so I'm not sure if you are willing to or again participate

P: I'm willing to participate; anytime I'm available I need to help wherever I can because at the end of the day you are doing this for a bigger, bigger picture

R: Yes

P: and I would like to thank you so much, you are such a lovely person

Tape 22

10/11/2015

Nurse Participant 1

R: Good Morning, I am Sister Annah Sefolosha I'm a PhD student at University of Pretoria, I'm doing a study based on facilitating LGBTI youth friendly primary health care, I've invited you to participate because I see you meet the criteria of participants.

P: Thank you, I am Mary, I am a professional nurse working in the clinic, thank you very much, for being invited in your studies, thank you.

R: Okay, I know somewhere in your life as a nurse you have come across LGBTI, LGBTI simply means lesbian or gays or bisexual or transgendered or intersexed youth that you have treated within primary health care setting. So what I would like to find from you is, what has the experience been like, please tell me from the time when the patient came into your consulting room until you treat the patients. What is the interaction between you, the youth, what has it been like, what influenced your thought, what influenced your feelings, what was the outcome of the interaction? Just take me through that whole experience.

P: (Clearing throat) Er, er first thing what I can explain to you is that er, as we, we work in the community we saw many of the lesbians and many of, of our youth, many of our youth have er, conduc.... conducted themselves to, to become lesbians, to become er, the gays and er mixed intersex , so we used to meet them in our consultation, coming into our consultation with some problems, and then those patients when they confront us, you find that when that patient, he or she will tell you about er what brought him or her to be a gay and then there was one who I er, have seen and I've asked that patient why are you students are you you're especially new generation now, you're turning to be er, the gays and the lesbians and then, he said to me, "No, sister it is because, because of er, er the problems in the family, you know we are coming from the er, different families who don't have nothing, so I said to myself let me, if maybe I can meet a friend of my sex and then maybe I 'll be er, I'll be well or okay financially because at least one of my partner, like er, one of er, the partner who is a gay, you see he's working and I'm not working, I'm under my parents and then I...I'm attending school, I don't have money, and then I found that it was, the relationship was very good because that gay er taking care of, I was not born and I used to continue with my schooling and then I ended up er, leaving the, the school and then he said to me that I must join him and then he, he found employment for me so at least we are working together it, it is, it is very nice to be together". As the, the.... the gay was explaining to me that it is very interesting, now I don't have any problem. "Sometimes if, if.... If you are of different sexes it is a problem sometimes, some will tell you story, some will tell you this story, so er, er.... Er we are not gay, we are gays we are all gays at least we understood to each other and we love to each other, you know there's no difference, there is love, the relationship is good". So and then I, as a professional I said but do you er, do you er,mxh... feel satisfied er about er being gays, because according to er, according to the bible er, God said a man is going to marry er, a woman and then not a man marry a man and then otherwise er, gay told me that "We are no more concentrating on the.... on the bible now, now we are according to democracy now, now is democracy, democracy has already opened doors for us that every er, gay, a gay can marry.... A man can marry a man, it's the law which was passed and...

and that law passed in .... in parliament, so that is why er we are having the gays, we've got the lesbians and then we've got" er, the other mmm ....

R: Bisexual?

P: Bisexual relationships so I said okay, if it's like that then there is nothing that you.... But er said, but are you satisfied about er the life that you... you live together with the er, with this relationship and then otherwise I said that, that er gay told me that "No, we are alright, we are happy, we think this relationship is, the relationship that we are having, it's a very good relationship when we have problems, with the er.... The relationships the, the older regime where you marry a woman and and... and er you marry as er unlike when you marry you are a man and then you marry a woman and then you find that that woman is not ... you are a man and you work alone, so when it's like this and then we think er it's good for us to turn into this relationships and again, we don't have problems with this er problems of the er.... er the diseases that are are, are now a problem like HIV and AIDS, so when we are gays, we can even encourage to each other to go to do the circumcision, and then er I think the the stats of er HIV it's very, very, very down, it's the....the.... the number is very limited especially when coming to the gays and the lesbians because a least we are not to have many relationships, so we are having, I'm having my partner as a gay, so I don't think that is very er, important for us as the gays, and the lesbians.

R: Okay, now my next question is, that student came to the room, and then he was opening up about his sexual orientation, what led to him to telling you, how did you find out about his sexual orientation?

P: Can you repeat?

R: How did you know that person who came into your room was gay person, what brought that about?

P: Mmmm

R: Because I know every time a person just comes as an ordinary person, so in this particular case, you happened to know that you were dealing with a gay person, what brought that up?

P: Okay, er a patient who came to me, so that I can know that that gay, that person is a gay, is because of the condition that he came to my room for consultation, I asked that patient er what is the problem with you, and then the patient er gave the history that "Sister, I am here today because I have a problem", I said "What problem do you have". He said "I've got a problem with my er, I've got the sores on, on the rectum, I said "The sores on the rectum? What type of sores do you have on the rectum? "And then he said "Sister, maybe if I can undress and show you how are my sores and I said er, " Do you think it's a problem?", he said "Yes, sister, let me undress and show you, if it is not a problem to you". Then I said "Okay, just undress and get into the er, curtains into the room there, there is a private room where we examine, then I pulled the curtains and said undress and the patient undressed, undressed and then, I put on my gloves, I said the patient must lie, lie, lie on the abdomen, so that I can observe the area where he is complaining about the sores on the rectum, when I opened the rectum I found that this patient has got er some er warts-like, so it was sort of a cauliflower, that came out of the rectum and er, er protru... protrudes through the rectum,

like a cauliflower or something like that, and then I asked this er, patient " What is wrong with you, wha... what is happening here?" And then, he said to me, "Sister I've got er, a partner that I'm sleeping with, and he is a, a gay, I'm a gay..... sister, that is why I was explaining to you that er, I've got a partner, the one I'm sleeping with, so when he sleeps with me, he likes to sleep at the back." So I said oh my patient, let me help you, and I said he must wake up and then he woke up, and then I called one of the doctor who was working with me and then I said "Come and see what I see here, maybe you can help me with your opinion, what to do." And then I called one of the, the....the doctors who was working on the ground with us and then he came and I showed him, the problem the patient is having and then the doctor said "No, we must refer this patient for er, for er warts that have developed on the rectum, so as I told the doctor, these are cauliflower-like, that is STI, sexually transmitted diseases, so I, I advised the patient that "We are going to transfer" and refer her, him to hospital so that they can cauterize those er, STI sores that developed on the rectum and then I've also advised the, the..... the.... the patient that he must er, go to the er, HIV counselling, so that he can do the testing, but before I... I told him, I told him that, I have requested him to go to her that er, does he want to go and test because sometimes some of these STI condition can relate them to... to.. to... to have the HIV like especially this mmm the warts and the warts type of disease can led him to have, have er HIV condition, HIV and AIDS condition and the he said "No, sister I don't have any problem, I'll go and do the test." I even er wrote a letter to give his partner, so that the partner must also go to the clinic to attend the clinic so that they can check his partner that they must also do the HIV testing and treat the STI conditions also so that they can be prevented from other diseases and then that patient didn't refuse. I even started treated him for that STI condition he came with, I gave him the STI treatment, referred him to hospital, gave him referral letter to hospital, so that they can cauterize all those warts that developed on the rectum and to also go for HIV and AIDS counselling, from counselling then he must go for testing, and from there I said he must come back to me and, so that I can see whether there is any improvement on the condition, but otherwise the patient was very calm and then, we had a very good relation together with that patient because he didn't, he didn't even hesitate to tell me the problem, then we even made the friendship, relation with the patient that when he comes. I think we, we'll make some talks and we'll make some relationship, I even gave him some my addresses that "whenever you have anything or what if you want to talk to me, you can come and visit me even at the clinic, never be afraid, whatever that you want, come to the clinic and talk to me, you know my consultation, I gave him my consultation to come and see me and then ... he must never hesitate, he must just ask er the clerks at the reception that I want to see sister Mary and then they'll tell, they'll show him er, my consultation as long as I know what our relation is, so it was a very good er relation, together with er, the gay patients'

R: Okay, now based on your beliefs and the values with regard to LGBTI, what was going through your mind during that time of consultation, what was your feelings, what was in your thought as you were busy consulting because you know your values, you know your beliefs, so as you were going through the process of consulting, what was actually going through your mind, what was your thought, what was your feeling, how did you feel about it?

P: (Clears throat) You know, you know er, my feelings about er, er this gay and er lesbian you know I feel, I felt very, very, very sorry, I felt very sad because when I look at this children, I told myself before that this people are just doing it for, for.... For they just do it on their own, only to find out er that this thing that they are doing, it is not because of they....

they.... they did like to be the way they are, it is because of something, something that is in them, it is not because they .... they did like to be the way they are, so I told myself that because according to my values, according to our values, we are not as a er.... er a girl, you are not supposed to stay with a girl and if you're a boy you are not supposed to be staying with a boy but the way it is, I , before I, I said these people are mad you know, this is not right, it's not er, er....mmm....the things of er, of God, these are sa.... these is Satanism according to me, I told myself that this is Satanism, Satanism which is in i....i... in ....i.... inside our er in our er.... er.... in our community, into our people, our people now Satanism is into, is is.... is.... is inter, is entering into their hearts, so that is why these people are, are now behaving er starting to do this things of gay things and lesbian things, so I told myself, I said no, man, no, this.... these people there's something that is happening with them, so it's very, very, very sad because if I said to myself, what about if it was me, and then I've got a child who is a ....a... . a gay and he start developing to this, so I said, I think this thing sometimes it's from the fathers. I think this is from our forefathers, children cannot just start and develop this thing, so it's just that our parents they... \they did, they don't tell us, you find that some of our forefathers were doing these things ....

R: Mmmm

P: .....it's hereditary, so that is why I say no, man these children they don't do, they don't just do it on themselves, you know they, they, this thing it come from somewhere the child start developing thing and then starts to behave like a boy, and do you know funny things, it's like the boys communicate with boys, start to... to click with boys and he start to change, if he is a girl, he start wearing er boys clothes, you know doesn't, it it's a girl, she doesn't look like a girl, she starts behave like boys and then to play, in fact you will see it from childhood, you'll s...you'll know this child but from childhood this one, this.... this girl was not playing with er dollies....

R: Mmmm

P: He was playing with the cars, she'll take the bricks, you know until you see when she starts to be er adolescent stage and then it's then that you start to notice that no, man this thing, this child started from childhood not now, it's just that we were not observant, we, we are very .... And we are negligent, we don't er , er check our children, so this thing it felt that, these children it's very, very, very sad to see them struggling like this because even themselves they like to be, they like to behave like other people to have different sex partners.....

R: Mmmm

P: ..... but because this thing is in them there's nothing that they can do, they have to behave like that, so if it's like that as human beings, we have to accept them into our community, we have to accept them, and treat them, treat them as human beings because they are all humans, they are not er ....., so it's just to respect them, they'll respect us and give them all the love and a welcome them into our community

R: So based on what you have mentioned, do you really think that they have unique needs, based on the background you have given me, or I they just like any ordinary person or do they have unique needs, you mentioned the fact that they came with anal sores, anal STI whereby they present with er warts because they are having anal intercourse and then you

mentioned the fact that there could be something with their heredity to make them behave the way they are behaving now, so in your opinion, do you think they might be having unique needs that need to be catered for, or should they be treated like any other ordinary person that comes to the clinic?

P: I think these.... Because they are human beings, they are human beings given treatment in totality, they must be treated like everybody, they are supposed to be treated er, as unique people of which they need special treatment because they are gays, they can't be er.... er differentiated from other people, they are human beings, they are, they need to be treated in totality and equally, so I don't think their needs are unique, they.... they need something that is unique, they must be treated in totality like everybody and get the full treatment like each...every normal human being.

R: Okay

P: Yes

R: And then again you mentioned that er, it was easy for the patient to tell you about the problem that he had.....

P: Yes

R: In your opinion, what could have made him that comfortable for him to just disclose the fact that he has anal int... STI?

P: I think, this er, what made this er patient to be open to me because first thing when the patient entered into my room, that warmly acceptance that he, he received from me, you know first thing we greeted to each other and then I asked him where he is staying and the age, I even praised him for you for being so beautiful, you know the way the hair was so beautiful, the dressing, you know I said even, you know you're so beautiful. I like the way you are and you are so clean and then I even told him that I'm so and so I'm Sister Mary and then you are welcome into my consultation, you know Ilike people who are open, you know I've got so many children and I'm, you know I'm, I told him my social life and then so, this patient what made him to be so open, not to fear is because I welcomed him, to my consulting room, I said he must never be afraid, I'm a human being like himself, I'm his mother...

R: Mmmm

P: ..... he must be free for whatever he want to tell me, I'm here to come and help him, he must never be afraid that I'm going to say this and that, no, no, no I said I talk to him very friendly and then he start to open, that is why I think he just judged me and said "no, this one is a woman, a mother, I'm going to tell him, I'm not going to lie, I'm going to tell her the problem that I'm having, I want help. Thank you.

R: Alright, okay, you... you just mentioned gore (that) you.... you talked about his dressing, the way he was well dressed, the hair was neatly done, could you relate that to his sexual orientation by the time you observed that, or you only realized that were dealing with a gay person only when he told you or could you make an, an assumption from the way he appeared?

P: Yes, the way he... he appeared to me I alrea, I...I've already seen that this is a gay, why because of the way he dressed, the way he was dressing and the way he was talking even the, their voice .... And then the voice according to experience, it will tell you that ee, this one is not a woman it is a male but with er, voice er... er voice, it was highly pitched, yes, and then the way he was stretching the hair, you know, the way he, you can see the feature of a male but it was a very beautiful boy, so that's I....I....I when I started to see him this is a gay.

R: But then, when you get those gays that don't even show when they come to your room, they don't even show that they are gay, because they are so masculine, you see just an ordinary heterosexual guy that you see as heterosexual guy, so in your opinion, is it really important to know the sexual orientation of every person that comes to your consulting room. Do you think sexual orientation plays a role in the patient's health problem, hence is it important to know the sexual orientation of the person?

P: Mmm.... I can say, sexual orientation of a patient is.... Is not so important, wha... what is the problem that the patient is having, so the thing is er, according to er, when we open the file, the first thing when we open the file, I see the sex of the patient, is a male or a female, so but to know that this patient is a heterosexual or not I don't think it is important. What you... you, you're going to get the... the..... the type of the sexual relation when the patient is talking to you, with others you can see that this one it's a...it's a gay, a female but it's a gay, but when coming to er.... sexual er mxh let me say homo, homosexual, homosexuality, you can't just see it but the person him or herself will tell you that I'm like this, so I don't think that it is very important to write that thing into the patient's er...er history, to write "this is a heterosexual patient or what, what, what and write the story about it, no I don't think, it...it...it's important, as long as the patient has told you er, problem that he or she came with and then that is what you are going to concentrate on the condition of the patient, yes, he or she is telling you.

R: Okay, errr, but we know for a fact that we have some that will not find it simple to just talk about their sexual orientation and as the, as you have indicated before that only when they present with those signs indicating that they are having homosexual relationships, so in your opinion, there's what kind of questions would you really ask to find out if the person is having, if a male person is having a male or a female partner? Because I think from what you said, like the fact that the person is presenting with a....anal, anal infection is an indicator that this can be an individual with unique health problems. How would you probe to find out if a person has er... er a heterosexual relationship or homosexual relation?

P: Okay, so from er to find out whether the person has got er... sexual er sexual relation, so it will depend on the condition the patient is coming with especially if the patient is coming with er.... er sexual er.... especially the STI conditions, if it's er.... er a male coming with er sexual er problems, one of the question you are going to ask the patient whether, is the patient er sexually active and the you are going to ask the patient if he or she having any partner, that he is having and then you are going to ask how many partners does the patient have and then that patient will tell you that " I've got so many partners or I've got er a partner" whether it's a female or whether it's a male, sometimes a male patient will say "No, sister, I don't have a girlfriend, I've got a .... a boyfriend, so if the patient is telling you that I've got a... a boyfriend and she.... he is a...a...a... male and he is having a boyfriend, so that will tell you in your mind oh, by the way this person is saying he doesn't have a

girlfriend, he is got a boyfriend because usually when this patient comes with the STIs, those are the questions you are supposed to ask from the patient so that you know er what type of er STI is the patient suffering from because some are having STIs whereby you find that the patient has got er STI er and then others are having sexual STI disease from the back, so from er those conditions it is where you are going to detect, this person how can she or he develop such, so from those questions that I've asked about, I've talked about that er partner, partners that the patient is sleeping with, who.... How many partners is the patient sleeping with and then at least those questions are the ones that will guide you that this patient is having,

R; .... You believe this people are turning themselves into being gay and lesbians?

P: Mmmm (nodding)

R: ..... so you mentioned your values before, that it is something that you don't believe in but during that consultation, you managed to help the patient until he was happy when left....

P: Yes

R: So what could have helped you being something inside you or something external, what could have helped you to manage that patient as you did?

P: Okay, what er helped me to... to manage that patient is because er I think er ...er, the nursing oath is the one which is binding us because I have to treat that patient whether which colour, whether which sex, whether er what culture, I had to treat that patient, so I think er I told myself that er, let me take all the things, all the things that people are talking about, all the values and the everything, let me just keep them aside and treat this child as a human being who's in need of help, so let me treat the patient in totality and get everything and put them aside and treat the patient in totality, yes.

R: So, based on the whole experience what is it that you have learnt?

P: Mmm...

R: You with your different belief with the patient, I think form that whole experience, as you interacted with the person, because you know in everything you learn something new, as you go about with your patient, so during that interaction with the gay person, and you being a nurse, being a mother, being a religious person, what is it that you have learnt from the whole experience/

P: Mxh, what I have learnt is that, I have learnt that er, mxh they say if you're a human being, when you are a human being, and then you told yourself that you are a Christian, being Christianity doesn't mean that you need to er judge the people or you have to discriminate the... the people or what, yours is just to, you must learn that a human being is a human being, even if he can come how, how, how difficult it can be, and how the person can be, whether a gay or a las...lesbian, or if the patient can be a sangoma, or if a person can come being a very, very poor patient, even if he can come you know ragged or what, getting into your consultation, first thing think about one thing gore (that) this is a human being and he's a man of God, so we have to treat these people, the same, you must treat them the same and you must treat them in totality , so that's what I've learnt. I've learnt that er these people are men of God, they are not er the ancestors er children but they are the

God's creators, so God created us, so that we can help each other, so we are there because of them, so what we must do is to help them to get what they want, that's all.

R: Okay er, ...er, as nurses, because we know we have, as I said we have different opinions, different values and other things as nurses, so do you think we need to have special knowledge and skills to render LGBTI care, or it's just the treat as the mainstream health care or do we need to know more about them, we need to... to.... to have some competencies that we have to acquire in order to service them effectively?

P: I think it's very important to have the knowledge about these er type of people so that when they.... They....they come in to the service, the service must be, we must have er, service free especially for the lesbians and the gay and the er bisexuals, so I think they need a special care, it's the same as er, youth health services, they must be accommodated, they must feel when they get into the service especially with our services they must be er, there must be er, at least er, a.... which shows that the service is a youth and youth health and friendly services, so... so that er the youth must never feel accepted, must feel free and be accepted when they get into the services they must never be afraid and say, I'm not going into that service because when you get in those sisters are just rushing " Here are they, they are coming... that gay and what, what, this....this, you know this one, he is sleeping with.....no. They want to be accepted er warmly accepted. They must be warmly accepted when they get into the service, they must feel free, and they must feel that we are the part of the community, well accepted in the service, we get everything that they want, even if they meet the....the...the sister in the corridor, she or he greets you and then ask you where do you want, what can I help you and then you get the direction where you want to go. So I think, people they need to be treated specially, they need a special er, care, they need er warmly care, they need to be accepted so that they can feel themselves that they're welcome so that as I say we need er a special, we need a special knowledge about them. So, we as nurses, we must have a very good attitude, we must have a very good attitude according to...mmm... we must have a good attitude towards this er, ... so that when they see us, they must never be afraid, they must feel that they are welcome in the clinic. So all the services must be free for...for... for these people, mmhm (nodding).

R: Okay, at the moment can you say our services are LGBTI inclusive and free to accommodate them?

P: Mxh, er ....er at the moment, with according to my, according to me, er the services, the services are not er they, they are not having er, they are not er free services for these youth because as you go you find that the youth is talking about the services "Hey you know I went to the clinic, when I arrived at the clinic, they said hey, here are they, they are coming, they want this, they want condoms, the want this, they sleep with men, they do this and that and that. So, I think er, we nurses we need to change our attitudes towards gay people, I think it's very , very important for the nurses to have a very good knowledge and they need a thorough training about the attitudes, about the, about the attitudes, about the, the (cellphone ringing), about the, the values because, so Ithink it's very important for us nurses to have er, er attitu, to have good attitude towards these er, youth know that these people are (cellphone ringing) they are people, they are our children, we must accept them, (cellphone ringing) inaudible (attending to cellphone), okay.

R: So what support do we require to have those things that you said at least we should have, just to make them comfortable, what resources, what support being it from management, from colleagues, what is it that we need to have to promote those attitude and promote their health.

P: (Sound), I think it is very important at least management must check and check the…the….the…..the nurses whether they get quality training about er, youth friendly services and then again I think the (cellphone ringing) (attending to cellphone) I think er, so er I talked about the training and I think even the structure of the clinics must be well developed and then, the structure must be, must show that these services are well, are welcome, are welcoming the youth. There must be all those billboards that are showing that the service, starting from the outside the er, structure of the clinic must show that this service is well accepting the youth. We must have all those posters that show that youth are accepted, you know, the structure also must show, the youth must have their own, you know there must be, there must be a … a room where the youth are being treated, the nurses must be allocated according to the skills that they have been trained with and then, the… the must be also er, facilities must be like maybe there is a….a…..an office where the youth maybe afternoon they come, there is office where there are TVs, you know where we put the condoms , you know everything that needs the youth, maybe the books, you know, where they are, we can interact with them. So I think we need a very good structure that shows even if when the youth enters into that service er, youth can think and see that we are being accepted in this clinic, so I think this clinic will accept us.

R: So,

P: (Fidgeting) (excused herself) Took a break of 5 minutes.

(Participant returned and the interview continued)

R: Based on your experience, what advice can you give to others?

P: The advice that I can give to others to the other for example, the other colleagues is that it is very important when we admit the patients, we must admit our patients with love, and then we sssss, not have attitudes, all these attitudes that we are having as nurses and treat them as human beings and with us, leave this thing of judging, when the patient comes we must never judge and say this is so and so, the so and so, we must take everybody as human being and er when we see them we must address them as Mr and Mrs or er if it's a student, it's a student and then we must never, never er call these people by names. So let's give them that love and treat them comprehensively and then give them whatever they came er whatever the problem they came in with, let's solve those problems and forget er this thing of judging. So, it's very important, so I'm advising you people, some of our colleagues "let's treat er our patients er with love, so let us not judge, call these people with names, so I think it's very important, let's treat these patients as human beings, they are all human beings of God. So, I think that will help other and then we can get a…. a good nation and a proper nation, okay.

R: I have asked you a lot of questions, anything else that I should know that I didn't ask, maybe in your opinion, you feel this is important for this project and I didn't ask?

P: I think er, you have asked the very most important things that are needed especially you've asked about the values, you've asked me about the...the.... the ....you've asked me about the attitude, you've asked me about, the condi the....the....the.... the..... the diseases, you've asked me about relationship of these patients, these patients, you have asked me about the, about er how do I er relate with this type of patients, you know I think, you asked me everything.

R: Okay.

P: So, I think it's very important and I want to say thank you very much because I've learnt so much from the questions that you asked me I think even myself, I'm going to grow and even changing the, treating the patient with a good attitude, because I've been learning most of the skills about these youth. So, thank you very much.

R: Okay, a...and I would like tyo also thank you for making yourself available for this project and Ihope er this is going to make a contribution towards the project as LGBTI health care and I just wanted to let you know that sometimes when I do analysis I find that something, something crop up, I'll come back to you and do further interviews with you. Is it fine with you?

P: Thank you very much, you're welcome.

R: Okay, thank you

ADDENDUM L: REFLEXIVE JOURNAL

REFLECTIVE JOURNAL

13/11/2015

Purpose of the reflective journal

The purpose of this journal is to reflect on my research journey. Cooley's 1902 theory the "looking glass self" suggests that people tend to form an image of self mainly from reflecting on and responding to how others perceive them. In essence, people actions and interactions are influenced by the reflections of themselves through others. Likewise the journal assist me to interact with myself, to have dialogue with myself as I embark on this study and to reflect on myself as researcher and how I influence the research process. The purpose is also to generate ideas and to critique myself and explore what was happening throughout the research process.

02/04/2016

This study began out of interest of working as a mentor for a group of LGBTI students. During my interaction with them I realised that LGBTI youth experiences some challenges especially when they have to access health care. This experience prompted me to become curious and developed deep interest about a study to find out more about how nurses and LGBTI patient interact with each other at the clinics and how can nurses facilitate better care for LGBTI patients and that is when I asked myself what is it that I wanted to achieve from this study. The answer became: What is going on during nurses and LGBTI patients clinical interaction? My intention was to enquire about the phenomena, understanding it, and also considering how the study can make contribution to the knowledge in the field of nursing especially diversity groups like LGBTI. Therefore, the provisional research question started as: What are the experiences of LGBTI youth and nurses as they interact with each other at the clinic? However, I struggled to think of a research method that could assist me to answer the research question and found it very challenging I then changed the research question to: How could nurses facilitate LGBTI youth-inclusive care? which later changed to a more concrete research question: What are the basic social processes involved in facilitating LGBTI youth-inclusive PHC in Tshwane District, Gauteng Province, SA? I became interested in discovering meaning from both LGBTI and nurse participants through an in-depth qualitative enquiry, which grounded theory seemed to fit the RQ. However, the method seemed to be unfamiliar to me as a novice researcher. I became concerned about whether my RQ is an answerable RQ or not. I therefore had to study the grounded theory method in-depth by reading, attending workshops and consulting experts learnt about grounded theory method. I studied literature related to the method. Charmaz (2006:20) suggests that grounded theory method attempts to answer a broad question 'What are the basic social processes? Grounded theory is a method that focuses on human interaction.

22/04/2016

As a novice grounded theory researcher, I found the method very tedious and complex. I had to read through book and articles related to grounded theory method.

I have learnt the following about the method:

- It was discovered in the 1960s by sociologist Glaser and Strauss who studied the process of dying. They wanted to know how does it happen and what's going on when it happens.
- It was later reviewed by Strauss and Corbin, and Charmaz who came up with a new version of grounded theory which Glaser disputed.
- Constructivist grounded theory believes that the researcher uses her interpretive frame of reference, prior knowledge, background, experiences to construct meaning to what the participants are saying.
- It is an inductive method
- The theory is discovered from the data
- It explains data through theoretical framework.
- Studies human group life through field work and participant observation
- Guided by the sociological framework of symbolic interactionism which depicts that people attach meaning during interaction with each other and that people act on the basis of the meaning they attach to situations
- Its ontological assumption is that meaning is constructed as people interact with each other
- Aimed at discovering social processes through exploring the complexity of human experiences
- Entails constant comparative data analysis whereby data collection and analysis takes place concurrently.
- Data analysis entails line by line coding followed by identification of codes which are then clustered systematically into categories.
- The recurrent categories are conceptualized to form the core category and then theory development.

25/05/2016

Data collection and analysis

It was interesting to note that sometimes during the interview; the participants' answers indicated different understandings of the questions. In some instances, they will generalise the responses for example, they will refer to their interaction with staff at the clinic and not with the nurses *per se*, the general public and would refer to their experience of how they've observed other LGBTI being treated at the clinic. The researcher couldn't be sure whether this was deliberate to avoid responding to the questions directly or the questions were truly misunderstood. Irrespective of that, sensitivity to, and responding to the needs of the participants remained significant throughout the interview. Whilst guarding against any emotions that the interviews might trigger or any perceived threat that the interviews might bring forth, the researcher had to repeat or rephrase and clarify those questions to ensure

that the participants eventually comprehend. It was also noted that for those participants who didn't disclose their sexual orientation or were not in one way or the other identified by the nurses as LGBTI, it became problematic to follow the interview schedule in such interviews as their experiences were not related specifically to them being identified as LGBTI patient which was the focus of the study. Therefore, in such instances, the researcher had to only explore their opinions on problem solving strategies. During the interview, I took field notes and noted issues that were significant and required further probing from the participant being interviewed or in a different interview. Furthermore, I developed a journal about my experience during the research journey and also took notes of the ideas as they emerged. During transcription of audiotapes, I have noted that transcribing interviews was time consuming and therefore a challenge. An interview that took ±60 minutes would take 8 hours to transcribe, thus 10 interviews took ±80 working hours which could be translated into ten days. It was also interesting to note that participants related their experiences of several encounters with different nurses in one interview, sometimes which posed a challenge with regard to interpreting the meaning of a continuous process from the beginning to the end of the experience.

09/06/2016

Through constant comparative method, data collection and analysis of interviews transcripts were done concurrently. Initial coding was first done on all transcripts through line-by-line coding, looking for concepts with similar meaning. The initial codes were then compared and contrasted with one another to form focus codes. Similarly, focus codes were also compared and contrasted with one another to form categories until saturation occurred. The findings of the LGBTI participants were presented first, followed by those of the nurse participants. The findings of nurse participants' data were compared with those of LGBTI participants to look for similarities and differences so as to finally allow the core category that formed the substantive theory to emerge. Consequently, having gained a deeper insight into the nature of each code, the properties of each code and the dimension of the incidents were sorted, condensed, and were further conceptualized by theoretical coding from which the core category which formed the theory emerged. Memos were written throughout to keep track of how codes and categories emerged. The findings of the data analysis process reflects the researcher's interpretation about the viewpoints of LGBTI and nurse participants' interactions and are presented without any reference to the existing literature or theories.

As constant comparison data analysis was undertaken, I constantly reminded myself of the objectives of the study so that the goal of the analysis process remained focused on achieving the objectives of the study. The objectives of the study were to

- **Explore and describe the experiences of LGBTI youth** regarding health care they received in PHC clinics.
- **Explore and describe the basic social processes** involved in facilitating LGBTI youth-inclusive PHC.

To achieve the objective of the study, the study was guided by the following two main research questions:

- How do **nurses and LGBTI youth experience their interaction** in PHC in Tshwane District, Gauteng Province, SA? And
- What are **the basic social processes involved in facilitating LGBTI youth-inclusive PHC** in Tshwane District, Gauteng Province, SA?

The research questions were more concerned with **understanding the process involved in human social interaction**. Therefore, the analysis focused on unfolding the basic social process that underlies the phenomenon of interest i.e. "How does the basic social process of (X) happen in the context of (Y environment)? In this study, the **basic social process referred to LGBTI-youth inclusive PHC** and was the core category around which the study intended to evolve. Over and above, I reminded myself of the theory that guided the study which is **symbolic interactionism. Symbolic interactionism** illustrates that the **self is developed out of interaction with the world** and focuses on how individuals interpret meanings and act in specific contexts which in this study implies the **meanings of LGBTI and nurses actions and interaction within the context of PHC.**

ADDENDUM M: CODES FROM ATLAS TI7

Codes-quotations list
Code-Filter: All

HU: Nurses Codes
File: [C:\Users\Sefolosha\Desktop\Nurses Codes.hpr7]
Edited by: Super
Date/Time: 2015-12-22 20:08:57

Code: Acquiring knowledge about LGBTI {8-0}

P 2: Nurse 2.pdf - 2:26 [I think it's very important to..] (8:434-8:569) (Super)
Codes: [Acquiring knowledge about LGBTI]
No memos

I think it's very important to have the knowledge about these er type of people so that when they.... They....they come in to the service

P 2: Nurse 2.pdf - 2:41 [we need a special knowledge ab..] (8:2047-8:2085) (Super)
Codes: [Acquiring knowledge about LGBTI]
No memos

we need a special knowledge about them.

P 2: Nurse 2.pdf - 2:42 [So, I think er, we nurses we n..] (8:3017-8:3622) (Super)
Codes: [Acquiring knowledge about LGBTI] [Overcoming own values and attitudes]
No memos

So, I think er, we nurses we need to change our attitudes towards gay people, I think it's very , very important for the nurses to have a very good knowledge and they need a thorough training about the attitudes, about the, about the attitudes, about the, the (cellphone ringing), about the, the values because, so Ithink it's very important for us nurses to have er, er attitu, to have good attitude towards these er, youth know that these people are (cellphone ringing) they are people, they are our children, we must accept them, (cellphone ringing) inaudible (attending to cellphone), okay

P 2: Nurse 2.pdf - 2:43 [I think it is very important a..] (9:16-9:306) (Super)
Codes: [Acquiring knowledge about LGBTI]
No memos

I think it is very important at least management must check and check the...the....the.....the nurses whether they get quality training about er, youth friendly services and then again I think the (cellphone ringing) (attending to cellphone) I think er, so er I talked about the training a

P 2: Nurse 2.pdf - 2:46 [So, I think it's very importan..] (10:18-10:351) (Super)
Codes: [Acquiring knowledge about LGBTI]
No memos

So, I think it's very important and I want to say thank you very much because I've learnt so much from the questions that you asked me I think even myself, I'm going to grow and even changing the, treating the patient with a good attitude, because I've been learning most of the skills about these youth. So, thank you very much

P 5: Nurse 6.pdf - 5:22 [I think the nurses training sh..] (5:719-5:867) (Super)
Codes: [Acquiring knowledge about LGBTI]
No memos

I think the nurses training should include a—the LGBTIs ____ they know more about LGBTIs how to—their conditions and how to treat those conditions

P 5: Nurse 6.pdf - 5:24 [maybe we can—they can be like ..] (5:1035-5:1230) (Super)
Codes: [Acquiring knowledge about LGBTI]
No memos

maybe we can—they can be like a—in service training could be formal or informal about LGBTI so that er it keep—it keeps the nurses er abreast about the knowledge and on how to treat the LGBTIs.

P 5: Nurse 6.pdf - 5:28 [Understanding their behaviour ..] (6:7-6:165) (Super)
Codes: [Acquiring knowledge about LGBTI]
No memos

Understanding their behaviour and what they need from us and er—yah...it's the—be the behaviour and what they need from us and the—the support from the nurses.

Code: Adopting a non-judgemental attitude {12-0}

P 2: Nurse 2.pdf - 2:25 [what I have learnt is that, I ..] (7:2138-7:3315) (Super)
Codes: [Adopting a non-judgemental attitude]
No memos

what I have learnt is that, I have learnt that er, mxh they say if you're a human being, when you are a human being, and then you told yourself that you are a Christian, being Christianity doesn't mean that you need to er judge the people or you have to discriminate the... the people or what, yours is just to, you must learn that a human being is a human being, even if he can come how, how, how difficult it can be, and how the person can be, whether a gay or a las...lesbian, or if the patient can be a sangoma, or if a person can come being a very, very poor patient, even if he can come you know ragged or what, getting into your consultation, first thing think about one thing gore (that) this is a human being and he's a man of God, so we have to treat these people, the same, you must treat them the same and you must treat them in totality , so that's what I've learnt. I've learnt that er these people are men of God, they are not er the ancestors er children but they are the God's creators, so God created us, so that we can help each other, so we are there because of them, so what we must do is to help them to get what they want, that's all.

P 2: Nurse 2.pdf - 2:31 [The advice that I can give to ..] (9:1729-9:2959) (Super)
Codes: [Adopting a non-judgemental attitude]
No memos

The advice that I can give to others to the other for example, the other colleagues is that it is very important when we admit the patients, we must admit our patients with love, and then we sssss, not have attitudes, all these attitudes that we are having as nurses and treat them as human beings and with us, leave this thing of judging, when the patient comes we must never judge and say this is so and so, the so and so, we must take everybody as human being and er when we see them we must address them as Mr and Mrs or er if it's a student,

it's a student and then we must never, never er call these people by names. So let's give them that love and treat them comprehensively and then give them whatever they came er whatever the problem they came in with, let's solve those problems and forget er this thing of judging. So, it's very important, so I'm advising you people, some of our colleagues "let's treat er our patients er with love, so let us not judge, call these people with names, so I think it's very important, let's treat these patients as human beings, they are all human beings of God. So, I think that will help other and then we can get a.... a good nation and a proper nation, okay.

P 2: Nurse 2.pdf - 2:45 [So let's give them that love a..] (9:2364-9:2959) (Super)
Codes: [Adopting a non-judgemental attitude] [Treating everyone the same]
No memos

So let's give
them that love and treat them comprehensively and then give them whatever they came er whatever the problem they came in with, let's solve those problems and forget er this thing of judging. So, it's very important, so I'm advising you people, some of our colleagues "let's treat er our patients er with love, so let us not judge, call these people with names, so I think it's very important, let's treat these patients as human beings, they are all human beings of God. So, I think that will help other and then we can get a.... a good nation and a proper nation, okay.

P 3: NURSE 4.pdf - 3:28 [the person has to come back, t..] (5:2621-5:2849) (Super)
Codes: [Adopting a non-judgemental attitude]
No memos

the
person has to come back, the person will either stay out and exposing themselves to risks which—which could have been prevented, they could have been—they could have been prevented if—if our attitudes was different, yah

P 3: NURSE 4.pdf - 3:54 [Uhm, I—I would wish to think i..] (6:357-6:933) (Super)
Codes: [Adopting a non-judgemental attitude]
No memos

Uhm, I—I would wish to think it's--it's my...maybe it's my personality, uhm--I think I am, I think I'm soft and I think that is what a *exute to them and—and—and uhm although I can be mom, uhm, they—and I always tell the students when they come "Look, I can be mom because you are my children's age, but when I'm sitting in this chair I'm not mom, I'm a medical professional and I'm not here to judge anyone, because if I'm going to judge you then I'm going to sit here for the whole year without seeing anyone cos I am here to--to try and make a difference at least."

P 4: Nurse 5.pdf - 4:10 [You see I, looked back into th..] (2:3014-2:3433) (Super)
Codes: [Adopting a non-judgemental attitude]
No memos

You see I, looked back into the pledge of service "Why did I choose to become a nurse, to help people, in accordingly, in appropriate to what are the symptoms, not to be judgemental, because if you—you need to li—to—to put up your listening skill-skills upfront, and then you give the patient to ventilate, the main reason, sometimes you see for—you reach out to the patient who's there for a certain main reason

P 4: Nurse 5.pdf - 4:13 [I think we need to give them b..] (3:921-3:1072) (Super)
Codes: [Adopting a non-judgemental attitude] [Treating people with respect]

ADDENDUM N: FIELD NOTES

Participant 4 interview field notes: 10/11/2017

Context	Content	Meaning
• Physical setting.	The setting where the interview took place was an office at the clinic. The office had one door and was well ventilated. The office was very private as the only people that were there were the researcher and the participant. The participant arrived on time for the interview. On arrival he looked relaxed and comfortable as he was familiar with the office. It is the same office where the initial briefing about the interview took place two weeks before the actual interview.	Participant looked relaxed and it looked like he was ready for the interview
• Physical characteristics	Participant was well kept. He had his hair plated in corn rows. He wore a tight jean with a see through top and sandals. He had light make up on his face and his nails were polished with red nail polish He spoked in a soft and low pitched voice.	During the interview he confirmed that from his feminine appearance, many people presume that he is gay
• Expressive body movements.	At some point he wanted to check if the researcher was homophobic or not but expressing humour	Throughout his engagement he could detect that the researcher was not homophobic, however he sarcastically wanted to ensure that he was sharing his sensitive information with someone who was LGBTI sensitised.
• Behavior	During the interview he kept o fiddling with hands and looking down especially where he had to refer to his boyfriend	It could be an indication that whatever that he was sharing with the researcher made him anxious and the subject was uncomfortable to discuss
• Language		
• The order in which events unfold	He related to two separate incidents which took place at different clinic. The first encounter, the nurse was insensitive	

	when he found that he was gay The second encounter the nurse was sensitive and wanted to know more about gay people and their lifestyle	

ADDENDUM O: LIST OF QUESTIONS FROM MEMOS

Theoretical Questions from memos

- What are the significant experiences, values and beliefs?
- How do they affect your interaction with LGBTI patients?
- What other factors influence your perception and interaction with LGBTI patients?
- What does it mean to specifically care for LGBTI patients
- What factors do you think help or prevent NPs from taking the best possible care of LGB patients?
- Which strategies will you employ to mitigate the effects of your values patient interaction?

ADDENDUM P: ETHICS APPROVAL UNIVERSITY OF PRETORIA

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

11/09/2014

Approval Certificate
New Application

Ethics Reference No.: 333/2014

Title: Facilitating lesbian, gay, bisexual, transgendered and intersexed youth-inclusive primary health care in Tshwane district, Gauteng province, South Africa: A constructivist grounded theory study

Dear Mrs Annah Sefolosha

The **New Application** as supported by documents specified in your cover letter for your research received on the 1/08/2014, was approved by the Faculty of Health Sciences Research Ethics Committee on the 11/09/2014.

Please note the following about your ethics approval:
- Ethics Approval is valid for 1 year.
- Please remember to use your protocol number (**333/2014**) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics approval is subject to the following:
- The ethics approval is conditional on the receipt of 6 monthly written Progress Reports, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

Additional Conditions:
Provisionally approved:
- Pending receipt of permissions from The Director, Student Health and Wellness Clinic, Tshwane University of Technology and The Director, Student Health and Wellness Clinic, University of Pretoria;
- The researcher may not commence with the study until sufficient funding has been secured .

We wish you the best with your research.

Yours sincerely

Dr R Sommers; MBChB; MMed (Int); MPharMed.
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

☎ 012 354 1677 🖷 0866516047 deepeka.behari@up.ac.za http://www.healthethics-up.co.za
✉ Private Bag X323, Arcadia, 0007 - 31 Bophelo Road, HW Snyman South Building, Level 2, Room 2.33, Gezina, Pretoria

*** Kindly collect your original signed approval certificate from our offices, Faculty of Health Sciences, Research Ethics Committee, H W Snyman South Building, Room 2.33 / 2.34.*

ADDENDUM Q: ETHICS APPROVAL TSHWANE UNIVERSITY OF TECHNOLOGY

Tshwane University of Technology

We empower people

10 Years 2004 - 2014

Senate Committee for Research Ethics

The TUT Senate Committee for Research Ethics is a registered Institutional Review Board (IRB 00005968) with the US Office for Human Research Protections (IORG# 0004997) (Expires 9 Jan 2017). Also, it has Federal Wide Assurance for the Protection of Human Subjects for International Institutions (FWA 00011501) (Expires 22 Jan 2019). In South Africa it is registered with the National Health Research Ethics Council (REC-160509-21).

November 17, 2014

Ref #: SCRE/2014/09/007
Name: Sefolosha A
Student #: 99242232 UP

Ms A Sefolosha
C/o Prof NC van Wyk
Department of Nursing Science
University of Pretoria

Dear Ms Sefolosha,

Decision: Final Approval

Name: Sefolosha A
Proposal Title: *Facilitating lesbian, gay, bisexual, transgendered and intersexed youth-inclusive primary health care in Tshwane District, Gauteng Province, South Africa: A constructivist grounded theory study*
Qualification: D Phil Nursing Science, University of Pretoria
Supervisor: Prof NC van Wyk
Co-Supervisor: Dr AE van der Wath

Thank you for submitting the revised project documents for ethics clearance by the Senate Committee for Research Ethics (SCRE), Tshwane University of Technology. In reviewing the documents, the comments and notes below are tabled for your consideration, attention and/or notification:

- **Interview Data Collection**
  - **Permission to conduct interviews.** The permission letter (undated) from the TUT Director: Health and Wellness, MTP Makgabo, to conduct interviews with TUT nurses in the Directorate Health and Wellness is in order and duly noted.

- **Information Leaflet & Informed Consent, Nurses**
  - **Inclusion Criteria**. The clarification regarding the professional nurse categories that are targeted as research participants is in order.
  - **Employment vulnerability**. The inclusion of the employment vulnerability statement is in order.
  - **Contact persons**. The inclusion of the contact information for the UP and TUT Ethics offices respectively is in order.

- **Information Leaflet & Informed Consent, LBBTI Youth**
  - **Contact persons**. The inclusion of the contact information for the UP and TUT Ethics offices respectively is in order.

The Chairperson of the Senate Committee for Research Ethics (SCRE), Tshwane University of Technology, reviewed the revised project documents. **Final approval** is granted to the project. The decision will be tabled at the next SCRE meeting on Dec 1, 2014, for notification.

The proposed research project may now continue in the TUT environment with the proviso that:

1) The researcher/s will conduct the study according to the procedures and methods indicated in the approved proposal, particularly in terms of any undertakings and/or assurances made regarding the confidentiality of the collected data.
2) The proposal will again be submitted to the Committee for prospective ethical clearance if there are any substantial changes from the approved proposal.
3) The Committee must be promptly informed of any serious adverse event and/or termination of the study.
4) The researcher will act within the parameters of any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.
5) The current ethics approval expiry date for this project is **December 31, 2015**. No research activities may continue after the ethics approval expiry date. Submission of a duly completed Research Ethics Progress Report (available at: http://www.tut.ac.za/Other/rninew/ResearchEthicsCommittees/Pages/default.aspx) will constitute an application for renewal of SCRE ethics approval.

Note:
The reference number [top right corner of this communiqué] should be clearly indicated on all forms of communication [e.g. Webmail, E-mail messages, letters] with the intended research participants.

Yours sincerely,

WA HOFFMANN (Dr)
Chairperson: Senate Committee for Research Ethics
[Ref#2014=09=007=Sefolosha A]

ADDENDUM R: PERMISSION LETTER FROM GAUTENG PROVINCIAL DEPARTMENT OF HEALTH

Kuyasheshwa! Gauteng Working Better

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

243 Pretorius Street, Chr. Thabo Sehume & Pretorius Street, Manaka Building, Pretoria 0001 South Africa.
Tel: +27 12 406 0237
Enquiries: Mr. Peter Silwimba.
e-mail: peter.silwimba@gauteng.gov.za

TSHWANE RESEARCH COMMITTEE

CLEARANCE CERTIFICATE

Meeting: N/A

PROJECT NUMBER: 03/2015

Title: Facilitating lesbian, gay, bisexual, transgendered and intersexed youth-inclusive primary health care in
Tshwane district, Gauteng province, South Africa: A constructivist grounded theory study

Researcher: Anna Sefolosha

Co-Researcher:

Supervisor: Prof. NC van Wyk

Department: Public Health

DECISION OF THE COMMITTEE

Approved

NB: THIS OFFICE REQUESTED A FULL REPORT ON THE OUTCOME OF THE RESEARCH DONE

Date: 25/03/15

.....
Mr. Peter Silwimba
Chairperson Tshwane Research Committee
Tshwane District

.....
Mr. Pitsi Mothomone
Chief Director: Tshwane District Health
Tshwane District

NOTE: Resubmission of the protocol by researcher(s) is required if there is departure from the protocol procedures as approved by the committee.

ADDENDUM S: PERMISSION LETTER FROM CITY OF TSHWANE DEPARTMENT OF HEALTH

CITY OF TSHWANE
IGNITING EXCELLENCE

Health

Room 2051 | 2nd Floor | FF Ribeiro Clinic | East wing, Sammy Marks Building | Cnr Madiba and Sisulu Streets | Pretoria | 0002
PO Box 440 | Pretoria | 0001
Tel: 012 358 4585 / 012 358 4586 | Fax: 086 225 9932
Email: MphoK@tshwane.gov.za | www.tshwane.gov.za | www.facebook.com/CityOf Tshwane

My ref:
Your ref:
Contact person: DR E OOSTHUIZEN
Section/Unit: INFORMATION AND KNOWLEDEGE MANAGEMENT AND CAPACITY BUILDING

Tel: 012 358 8605
Fax:
Email: Elfredao@tshwane.gov.za

To: The Clinic Manager
Sefolosha 2 Clinic

02/03/2017

RE: PERMISSION FOR MS ANNAH SEFOLOSHA TO CONDUCT PhD RESEARCH STUDY

Approval is hereby granted to Ms Annah Sefolosha to conduct the required research study in your Clinic. This study has already received final approval from the University of Pretoria and the Department of Health Research Ethics Committees (see attached letters of approval).
The topic is **"Facilitating lesbian, gay, bisexual, transgendered and intersexed youth-inclusive Primary Health Care in Tshwane District., Gautend Province, South Africa. A constructivist grounded theory study.** The aim of the study is to develop a substantive theory that will describe the basic social processes involved in facilitating LGBTI youth-inclusive PHC in Tshwane District, Gauteng Province, SA.

Your clinic has been identified as one of the suitable sites where data collection involving nurses is planned to be conduct at Tshwane District in Gauteng Province, South Africa in line with the ethics approval. The nurses will be expected to participate in a ±60 minutes interview at a time and setting convenient for them, so that the clinic functioning is not compromised. Should you require further information about this study, please don't hesitate to contact the researcher as follows: Mrs Annah Sefolosha 082 411 1091 or alternatively contact her study supervisor, Prof Neltjie van Wyk at 082 776 1649.

Your cooperation in this regard will be highly appreciated.

Yours faithfully

DR E OOSTHUIZEN
DIRECTOR: INFORMATION AND KNOWLEDGE MANAGEMENT & CAPACITY BUILDING

DATE

[Name – lower case, not bold]
[DESIGNATON – capital letters, not bold]

On request, this document can be provided in another official language.

ADDENDUM T: PERMISSION LETTER FROM MANAGER OF UNIVERSITY-BASED CLINIC 1

Tshwane University of Technology
We empower people
10 Years
2004-2014

Student Affairs and Extracurricular Development
Directorate: Health and Wellness

The Director
Student Health and Wellness
Tshwane University of Technology
Private Bag x680
Arcadia
0007

Dear Sir/Madam

PERMISSION TO CONDUCT RESEARCH AT THE STUDENTS HEALTH AND WELLNESS CENTRE OF YOUR UNIVERSITY

The Director Health and wellness acknowledges receipt of your letter dated 06 October 2014 requesting for permission to conduct research at the Health and Wellness centre.

This letter serves to inform you that permission has been granted for you (Ms Annah Sefolosha) to conduct research at the student Health and Wellness Centre of the Tshwane University of Technology. Permission is granted in accordance with all requirements as outlined by the Senate Committee for Research Ethics in their correspondence to you dated 04 October 2014 and the University of Pretoria's approval certificate dated 11 September 2014.

The directorate wishes you the best with your research.

Yours sincerely,

M.Tebogo.P. Makgabo
Director: Health and Wellness
Tshwane University of Technology
Pretoria West Campus
Tel: (012) 382 6613
E-Mail: makgabomtp@tut.ac.za

ADDENDUM U: PERMISSION LETTER FROM MANAGER OF UNIVERSITY-BASED CLINIC 2

Market Research Office

Survey Application Form

Requests to conduct a survey within the scope of the Survey Coordination Committee approval process must be submitted by using this form. The form should be completed by the proponent or their delegate. The Market Research Office will evaluate the information provided in this form against survey policy and will then make a recommendation on the proposed survey to the Survey Coordination Committee.

1. Survey Information

Name of survey: Facilitating lesbian, gay, bisexual, transgendered and intersexed youth-inclusive primary health care in Tshwane district, Gauteng province, South Africa: A constructivist grounded theory study

Name of the organisational unit that will administer the survey

Student Health and Wellness

What are the primary aims of the survey?

To develop a substantive theory focused on the basic social processes involved in facilitating lesbian, gay, bisexual, transgendered and intersexed (LGBTI) youth-inclusive primary health care (PHC) in Tshwane District, Gauteng Province, South Africa (SA).

How does the survey fit into the strategic objectives of the University's strategic plan?

To enhance the health and wellbeing of the vulnerable and diverse group of students i.e. LGBTI students

What type of survey is it? (market quantification, client satisfaction, etc)

Client satisfaction, a qualitative study

How will the participants be informed about the survey?

LGBTI participants

The researcher will collaborate with the nurses in the clinics to assist her to recruit the most suitable participants. The nurses will brief the potential participants who meet the inclusion criteria about the study, emphasizing the aim and value thereof. The nurses will then provide potential participants with the researcher's contact details and leave the discretion up to the individuals who have interest in participating to contact the researcher.

Nurse participants

How is the survey to be distributed? (paperbase, electronically etc)

Interviews

2. Survey Methodology

Is it a one time survey?

Yes: x

No:

If no, what is the survey cycle?

Annual,

Biannual

Anticipated survey administration schedule?

Start Date: January 2015

End Date: June 2015

Are the dates flexible? Yes

Who is your target population? LGBTI students and nurses working at the Student Health and Wellness Centre

What is your sample size? 10 LGBTI participants and 3 nurses

How will you select your participants? **LGBTI participants**

The researcher will collaborate with the nurses in the clinics to assist her to recruit the most suitable participants. The nurses will brief the potential participants who meet the inclusion criteria about the study, emphasizing the aim and value thereof. The nurses will then provide potential participants with the researcher's contact details and leave the discretion up to the individuals who have interest in participating to contact the researcher.

Nurse **participants**

The researcher will collaborate with the nurse manager in the clinic to assist her to recruit the suitable participants.

How do you plan to analyze your data and who will conduct the analysis?

The researcher will conduct constant comparative analysis. Three types of coding will be employed namely: open coding, axial coding and selective coding

What resources will be used for conducting this survey?

Audio tape

How will you report back on the survey results?

(formal report, presentation etc.)

Formal thesis report and presentations at conferences

Describe the way in which results will be used?

The nurse manager will assist in the recruitment of potential participnats

Will the results be made public?

Yes

If yes where?

In nursing research journals and presentations at conferences. The thesis will be available in the library of the Faculty of Health Sciences, University of Pretoria, as a reference for students

3. Contact Details

Survey Sponsor:

(Faculty, Department, Committee etc)

Contact Name of Person responsible for survey:

Name: Annah Sefolosha

Phone number: 082 411 1091

Email: sefoloshaa@tut.ac.za

Signature of Dean / Director

Submit the electronic copy of the survey proposal application as well as the survey instrument to carlien.nell@up.ac.za

ADDENDUM V: EXTENSION OF ETHICS APPROVAL UNIVERSITY OF PRETORIA

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

18/08/2016

Mrs Annah Sefolosha
Department of Nursing Science
Steve Biko Academic Hospital

Dear Mrs Annah Sefolosha

RE.: 333/2014 ~ Letter dated 28 July 2016

Protocol Number	333/2014
Protocol Title	FACILITATING LESBIAN, GAY, BISEXUAL, TRANSGENDERED AND INTERSEXED YOUTH-INCLUSIVE PRIMARY HEALTH CARE IN TSHWANE DISTRICT, GAUTENG PROVINCE, SOUTH AFRICA: A CONSTRUCTIVIST GROUNDED THEORY STUDY
Principal Investigator	Mrs Annah Sefolosha **Tel:** 824111091 **Email:** SefoloshaA@tut.ac.za **Dept:** Nursing Science

We approved the following:

- Extension of study for 1 year given, on condition upon the Research Ethics Committee receiving a Progress Report.

This will be processed in due course and filed.

With regards

Dr R Sommers; MBChB; MMed (Int); MPharMed; PhD
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria