Mental health challenges among the Lesbian, Gay, Bisexual,Transgender and Intersex community in Gaborone, Botswana

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DECLARATION

I David Sidney Mangwegape, declare that “Mental health challenges among the Lesbian, Gay, Bisexual, Transgender and Intersex community in Gaborone, Botswana” is my original work and the sources used have been properly acknowledged and that this work has not been submitted at another university for any degree.

Student Name: David Sidney Mangwegape

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Date signed:

DEDICATION

The research project is dedicated to human beings that continue impacting on the welfare of the maligned and those who are discriminated; you are heroes and heroines!

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ABSTRACT

Studies worldwide have highlighted that there is high prevalence of depression, anxiety, suicide and substance use among Lesbian, Gays, Bisexual, Transgender and intersex (LGBTI+) community. Very few studies have been conducted in Botswana (Ehlers *et al.* 2001: Selemogwe *et al.* 2013) and one study recommended the need to explore factors that may predispose the LGBTI+ to mental health challenges. The study was aimed at exploring and describing the mental health challenges experienced by some members of the LGBTI+ community in Gaborone, Botswana. The study further described how the challenges affect the mental health of some of the individuals identifying as LGBTI+.

A qualitative, descriptive phenomenological design was followed in carrying out the study. 15 research participants were identified through snowball sampling with the assistance of the advocacy organisation, Lesbian, Gays and Bisexuals of Botswana (LEGABIBO).

Data were collected following written permission from the HREC and Ministry of Health and Wellness in Botswana. Qualitative data were collected through in-depth unstructured individual interviews which were done telephonically. Collaizi's method of data analysis was used to analyse data with the researcher and co-coder doing the analysis independently.

It is evident from the findings that some individuals identifying as LGBTI+ experienced mental health challenges like depression, gender dysphoria, loneliness, isolation. Stigma and discrimination, being misgendered, poor coping mechanism are some of the factors expressed by participants as impacting adversely on their mental health. Some members of the LGBTI+ community have challenges with accessing health services and problems that are linked to their identity like challenges with gender markers that are different from the gender one identifies with. Recommendations were formulated for nursing education, nursing research and nursing practice.

Key words: Lesbian, Gay, Bisexual, Transgender, Intersex, depression, gender dysphoria, discrimination, misgendering

TABLE OF CONTENTS

LIST OF TABLES

LIST OF ACRONYMS AND ABBREVIATIONS

APA - American Psychiatric Association

BONELA- Botswana Network of Ethics and Law on AIDS

DSM- Diagnostic and Statistical Manual of Mental disorders

GD - Gender dysphoria

HIV- Human Immunodeficiency Virus

HREC-health Research Ethics Committee

HRT- Hormonal Replacement Therapy

LEGABIBO- The Lesbians, Gays and Bisexuals of Botswana

LGB-Lesbian, Gays and Bisexuals

LGBT-Lesbian, Gay, Bisexual and Transgender

LGBTIQ-Lesbians, Gays, Bisexual, Transgender and Queer

LGBTI+- Lesbian, Gays, Bisexual, Transgender, Intersex and others denoted by+

MOHW- Ministry of Health and Wellness

MSM - Men who have Sex with Men

SALC - Southern African Litigation Centre

USA- United States of America

WHO- World Health Organisation

CHAPTER 1 OVERVIEW OF THE STUDY

1.1 Introduction

This chapter discusses the background to the study, problem statement, research questions and objectives, paradigmatic perspectives, research methodology and ethical considerations for the research study.

1.2 Background of the study

The general population is composed of many diverse groups regarding sexual orientation (Moleiro & Pinto, 2015:1). Some are in the minority such as the Lesbians, Gays, Bisexual, Transgender, Intersex, and others who deem themselves asexual are commonly known under the acronym LGBTI+ (Australian Human Rights Commission in Healy *et al.,* 2016:389). The acronym represents people with diverse sexual orientations who are classified as sexual and gender minorities and usually experience stigmatisation and discrimination (Muller, 2017:2).

The discrimination on the LGBTI+ has been an issue of discussion with its roots as old as the evolution of humankind (Acharya *et al*., 2017:1). The LGBTI+ community is marginalised, harassed, victimised and experience structural, institutional, and individual discrimination across the world (Meer *et al.,* 2017:6). The issue of the discrimination of individuals identifying as LGBTI+ rose to prominence in the 1960s. During that period, homosexuals were classified as having sexual disorders in the United States of America according to the 9th International Classification of Disorders (ICD 9). The American Psychiatric Association (APA), classified homosexuality as a “sociopathic personality disturbance” in their Diagnostic Statistical Manual of Mental Disorders-I (Russell & Fish 2016:3). This historical classification perpetuated stigmatising tendencies.

Sandfort and Keddy (cited in Meer *et al*., 2017:41) assert that religious establishments have a huge influence in social unacceptance of homosexuality in Africa. Social unacceptance often facilitates issues which are significantly detrimental to LGBTI+ well-being.

As in the rest of the world; the lesbian, gay, bisexual, and transgendered citizens of Botswana have experienced rejection and victimisation at the hands of fellow compatriots

(Morupisi, 2015:1). There are individuals who identify as LGBTI+ in Botswana who have for a long time been discriminated and stigmatised. The researcher witnessed such discrimination during many years of public health practice as a psychiatric nurse.

The advent of homosexuality came to the fore in Botswana around 1994 after a Motswana male was charged with committing an unnatural act of same-sex intercourse with another male (Quansah, 2004:202). Quansah (2004:202) continues to indicate that the Magistrate court pronounced that the act was contrary to section 164 of the Botswana constitution. The case was taken to the Court of Appeal as a constitutional challenge by Ditshwanelo (a civil rights group) who advocated for non-discrimination based on same sex conduct but was dismissed (Tabengwa & Nicol, 2003:339). After the case, the sexual minorities continued facing discrimination on account of their gender identity and sexual orientation (BONELA, 2008:2). The next act was to deny registration of advocacy organisations like The Lesbians, Gays and Bisexuals of Botswana (LEGABIBO) which was founded in 1998 (Morupisi, 2015:1).

Given the challenges experienced by individuals identifying as LGBTI+, several efforts have been made to address. One such is the removal of homosexuality as a disorder from both the ICD and DSM classifications in 1973 (Russell & Fish, 2016:3). There have been other good strides pertaining to the LGBTI+ welfare as Ireland, the USA and Australia have legalised and recognised same-sex marriages (Healy *et al*., 2015:389). Other countries like South Africa have also legalised same-sex marriages (Yarbough, 2017:1093).

In Botswana, there have been successful efforts in improving the plight of the LGBTI+. The ban on registration of LGBTI+ advocacy organisations was successfully contested in November 2014 and was duly registered in 2016 (Meer *et al.* 2017:7). A welcome development is that the advocacy organisation has effectively participated in policy-making forums related to HIV/AIDS issues and has liaised with the Ministry of Health and Wellness (MOHW) in most events. Furthermore, Botswana President in a national address called for the respect and protection of LGBTI+ persons' rights in a recent event. The following is part of the statement by the president during the 2018 state of the nation address:

> There are also many people of same-sex relationships in this country who have been violated and have also suffered in silence for fear of being discriminated. Just like other citizens, they deserve to have their rights protected. (Mooka: 2019:9)

The statement offers a new dawn of hope on the plight of the LGBTI+ population. As head of government, his sentiments can help shift policy focus towards the marginalised populations including the LGBTI+ community and reduce rampant stigma and discrimination.

Despite all these efforts, those who identify as LGBTI+ continue to suffer prejudice, stigma, discrimination, and human rights violations (Bolderstorn & Ralph, 2016:208). Duhaylungsod *et al.* (2018:1) in a study conducted in the Philippines noted that stereotyping, gender discrimination and oppression still exists towards the LGBTI+ community. The gesture of legalising same sex marriages has however not helped shift people's attitudes on the LGBTI+ community as personal prejudice on LGBT+ individuals has remained unchanged (Moorley & Neville, 2016:3413).

Meer *et al*. (2017:6) observed that in a majority of Southern African countries the practice of same sex is criminalised creating a barrier of lack of accessibility to public health facilities. They continue to highlight that Lesotho and Mozambique have just de-criminalised same-sex activities with South Africa being the only country that constitutionally protects citizens from discrimination on sexual orientation. The researchers concluded by acknowledging that there is research on Human Immuno-deficiency Virus (HIV) but very little on the mental health concerns of the LGBTI+ community.

A dire situation regarding discrimination still exists in Botswana as there is an ongoing legal matter between the Botswana Government and a Motswana young man (Thobega, 2019: 6). The article further asserts that the young man identifies as gay and feels that his freedom is curtailed and thus challenges the government of Botswana to decriminalise homosexuality by revising of section 164 and 167 of the constitution. The aforementioned sections view same-sex as unnatural (Thobega, 2019:6). In the case, the Advocate representing the government expressed the statement, "homosexuality is un-African and does not correlate with the traditions of Botswana" (Mooka, 2019:9).

According to Semlyen *et al.* (2016:8), LGBTI+ people are more likely to develop a mental disorder than heterosexual individuals. Muller (2017:2) observed that people who identify as LGBT face numerous challenges in accessing public health facilities largely because of systematic discrimination brought about by persisting homo- and transphobia. Findings from a study conducted by Moreland *et al*. (2019:196) revealed that women who identify as lesbian and bisexual in Rwanda experienced substantial violence at the workplace as well as discrimination and stigma.

Health problems are of a serious concern among the LGBTI+ population as brought about by issues of stigma and discrimination (Lewis *et al.* cited by Hunt *et al*. 2017:2). The LGBTI+ population constitutes a minority group as earlier indicated. Nonetheless, Cyrus (2017:194), posits that there is overwhelming evidence that discrimination and alienation negatively impact on the mental and physical health of the minority groups. Furthermore, Meyer (2003:674) observes that "the minority stress model links the increased risk of substance use to the discrimination, marginalisation and oppression that sexual minority groups endure in often homonegative and heterosexist environments."

The LGBTI+ community suffer the fate of increased psychiatric problems ranging from anxiety disorders, depression, and substance abuse (Acharya *et al*., 2017). A study by Dawson *et al.* (2018:295) in the United States of America (USA) indicated that adults identifying as transgender were more likely to be diagnosed with depression and anxiety at a young age, which is in stark contrast to those who identify as heterosexual men or women but of the same age.

There is ample evidence of mental health challenges being experienced by LGBTI+ community in Africa. A Nigerian study by Makanjuola *et al.* (2018:379) indicated presence of minority stress among men who have sex with men (MSM). The study further established that the stresses experienced, adversely impacted on the respondents' mental health. Another study in Nigeria by Oginni *et al* (in Makanjuola *et al.,* 2018:376) revealed that MSM were three to four times more likely to be depressed and having suicidal ideas than heterosexual men.

A study by Muller and Daskilewicz (2018:271) indicated that depression, substance use, anxiety, and suicide among LGBTI+ people in Kenya, Lesotho, South Africa, and Swaziland were significantly higher than in the general population. In the study above,

46% of respondents showed signs of depression, 55% displayed signs of anxiety, and 12% displayed signs of alcohol dependence with 22% having attempted suicide. The results from the South African context showed that 27% attempted suicide, 57% had signs of depression whilst 66% displayed signs of anxiety. All these results demonstrate that the LGBTI+ population are adversely affected by mental health problems.

In Botswana, few studies to assess the mental health challenges experienced by the LGBTI+ community have been conducted. A review by Selemogwe and White (2013:409-410) reported that lesbians, gays and bisexuals (LGB) experienced mental health challenges like suicide. The review focused on the study that was done by Ehlers *et al*. (2001:848-855) which investigated the level of wellbeing of gays, lesbians, and bisexuals in Botswana. The results of the study indicated that 29.8% reported suicidal ideation, 63.8% reported some form of emotional distress, but did not identify the underlying factors that predispose them to mental health challenges (Ehlers *et al*. 2001:852).

1.3 Problem statement

Studies cited earlier in the background have demonstrated that some individuals who identify as LGBTI+ have significantly high rates of depression, suicide, and anxiety than their heterosexual peers (Acharya *et al*. 2017: Dawson *et al.* 2018:295: Muller & Daskilewicz, 2018:271). Su *et al*. (2016:12) indicated that the LGBT population in Nebraska (in the USA) have borne a disproportionate increase in the burden of mental health problems compared to the general population.

The researcher observed in several incidents during clinical practice that family and community rejection on individuals identifying as LGBTI+ led to mental health challenges. In one observation, an individual identifying as lesbian attempted suicide because of family rejection linked to her sexual orientation. The results in the studies above and anecdotal evidence are a clear demonstration that the LGBTI+ community are vulnerable to mental health challenges.

There have not been many studies in Botswana on the phenomenon. The study by Ehlers *et al*. (2001:848-856) investigated the level of well-being of gays, lesbians and bisexuals in Botswana, highlighted mental health problems in the LGBTI+ population but fell short of determining the challenges. Furthermore, the already mentioned study only covered the lesbians, gay and bisexuals and did not include other gender diverse groupings.

Selemogwe and White (2013:409) recommended following their overview of LGBTI+ situation in Botswana that research must be done to explore factors that may predispose LGBTI+ population to mental health issues including substance use. Meer *et al.* (2017:58) concurred with their views that "there is a need to explore the mental health impact of heteronormativity on LGBTI people."

The mental health challenges of some individuals identifying as LGBTI+ were described and explored. The effects of the challenges on the mental health challenges of individuals identifying as LGBTI were also described.

1.4 Research aim

- The aim of this study was to explore and describe mental health challenges of individuals from the LGBTI+ community in Gaborone, Botswana and how these challenges affect their mental health.

1.5 Research objectives

- To explore and describe the mental health challenges of the LGBTI+ community in Gaborone
- To describe how these challenges affect the mental health of individuals identifying as LGBTI+

1.6 Research questions

- What are the mental health challenges experienced by individuals identifying as of the LGBTI+?
- Describe how these challenges affect their mental health?

1.7 Significance of the study

The findings could inform nurse educators on content to include in the nursing curriculum. Davy *et al.* (2015:136) contend that lack of knowledge by health care providers compromises care rendered thus the findings will help inform nursing care and approaches. It is recommended that individuals who identify as LGBTI+ participate in decision making and policy development on issues relating to them.

1.8 Paradigmatic perspectives

The meta-theoretical, theoretical, and methodological assumptions make up the paradigmatic perspective of this study.

1.8.1 Meta-theoretical assumptions

The meta-theoretical assumptions primarily refer to the beliefs of the researcher on human beings, society, and general orientation about the world (Botma *et al*. 2010:187). The meta-theoretical assumptions reflect the researcher's perceptions and viewpoints on a person, the environment, mental health and nursing.

1.8.1.1 View of a person

Roper *et al.* (1990 cited by McKenna, 2005:4) define a person as "an unfragmented whole who carries out or is assisted in carrying out those activities that contribute to the process of living."

The researcher agrees with this and for the purpose of this study defines a person as a human being who must be seen as a whole being and not discriminated upon.

1.8.1.2 View of the environment

According to Henderson (cited by McKenna, 2005:5) environment is "that which may act in a positive or negative way upon the client."

Taking into consideration this definition, the researcher in this study defines the environment as an avenue that can promote mental health or influences the development of mental illness.

1.8.1.3 View of mental health

Townsend (2018:3), defines mental health as a successful adaptation to stressors from the internal or external environment evidenced by thoughts, feelings and behaviours that are age appropriate and congruent with local norms.

For this study, mental health is defined as a state of emotional well-being positively influenced by the environment in which an individual lives, with the individual able to interact productively with the environment.

1.8.1.4 View of nursing

Nursing is defined by Henderson (cited by McKenna, 2005:4) as a "profession that assists the person sick or well in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he or she would perform unaided, given the necessary strength, will or knowledge." Nursing is for the purpose of this study defined as is being able to render encompassing, indiscriminate care to individuals and their families to optimal functioning.

1.8.2 Theoretical assumptions

The study adopted the minority stress model to explain mental health challenges among the LGBTI+ community. Meyer (2003:674-697) developed the model to explain the high rates of mental health disorders amongst LGBTI+. The model posits that sexual and gender minorities experience chronic stress because of stigma and discrimination, social exclusion and marginalisation associated with stigmatised identity status (Meyer 2003 cited by Woodhead *et al*., 2015:1). Wilder (2018:12) reiterates by highlighting that Meyer's proposition was that "the high rates of mental disorders were caused by stressors because of one's minority status. The LGBTI+ community constitutes a minority in Botswana as earlier indicated and thus their mental health challenges were explored to determine if they were consistent with the assumptions of this model.

1.8.2.1 Conceptual definitions

Conceptual definitions are meanings that help in delimiting concepts to be used in a study. (Polit & Beck, 2014:44). The following concepts will be defined as applied in the study.

Lesbian

This is a term used to describe women who are emotionally, romantically or sexually attracted to other women (Human Rights Campaign, 2017)

For this study, lesbian refers to a woman sexually attracted to or having a sexual relationship with other women and resides in Gaborone.

Gay

This a term used to describe a male who is emotionally, romantically, or sexually attracted to members of the same gender (Human Rights Campaign, 2017).

In the context of this study, gay describes a male person who is sexually attracted to or having a sexual relationship with another male and resides in Gaborone.

Bisexual

This is a term describing a person who is emotionally, romantically, or sexually attracted to more than one sex, gender, or gender identity though not necessarily simultaneously, in the same way, or to the same degree (Human Rights Campaign, 2017).

Bisexual in this study refers to a person sexually attracted to more than one sex at various points and resides in Gaborone.

Transgender

An umbrella term for people whose gender identity and expression are different from cultural expectations based on the sex they were assigned at birth (Human Rights Campaign, 2017)

In this study, transgender refers to a person who has assumed a new gender from the one at birth and resides in Gaborone.

Intersex

Intersex people are individuals born with several variations in sex characteristics such as chromosomes, genitalia, and hormones (Open Society Foundations, 2019)

In the context of the study, intersex describes an individual who possesses characteristics that neither meet the criterion for men and women anatomy and resides in Gaborone.

+

This symbol will in the context of the study denote individuals who do not conform to societal constraints of sexual orientation and those exploring their gender or sexual orientation.

The symbol has been used to include many of other individuals who do not identify within the grouping of LGBTI. The acronym however differs across the sources as it is dependent on the grouping involved in particular studies, therefore sources that do not include the symbol did not include other sub groupings.

Mental health

Townsend (2018:3), defines mental health as a successful adaptation to stressors from the internal or external environment evidenced by thoughts, feelings and behaviours that are age appropriate and congruent with local norms.

In the context of this study, mental health is defined as a state of emotional well-being positively influenced by the environment in which an individual identifying as LGBTI+ lives, with the individual able to interact productively with the society.

1.8.3 Methodological assumptions

According to Botma *et al*. (2010:188), methodological assumptions explain what the researcher believes good science practice is. On the basis that this is a qualitative study, the principles of social constructivism were applied (Creswell, 2014:38). Furthermore, constructivism is characterised by the research aim and purpose being addressed to answer specific methodological questions (Creswell, 2014:9).

In addition, the nursing research model of Botes (cited by Du Plessis, 2008:13), was adopted by the researcher in formulating the methodological assumptions. The following order will apply in this study;

- The first order is about the practice of the nursing discipline and in this case the researcher will be exploring the mental health challenges of the LGBTI+ population

- The second order represents the adopted methodology of the research. The research will be conducted to address the enquiry in the first order through the research process.
- The third order represents the meta-theoretical assumptions which are entrenched on the researcher's beliefs, theoretical assumptions, and conceptual frameworks.

1.9 Research methodology

Research methodology covers the steps in the research process that aid the researcher in achieving aims and objectives (Polit & Beck, 2014:8). The population, sampling procedure, recruitment of research participants, data collection process and data analysis make up the research methodology. These methods will be discussed in the sections that follow.

1.9.1 Research design

This study followed a qualitative, descriptive phenomenological design in which the mental health challenges of the LGBTI+ people as well as how the challenges affect their mental health were explored and described within context. The design assisted the researcher to explore and describe the challenges experienced by the LGBTI+ as well as the meaning that they attach to their experiences. As posited by Polit & Beck (2012:226), the design aims at exploring and describing the phenomena in detail to answer the research question.

1.9.2 Study context

The study was conducted in Gaborone, the capital city of Botswana. The place was deemed to be suitable as it is highly populated, has a dynamic culture of people and groupings. A detail discussion of the context of this study will be provided in Chapter 2.

1.9.3 Population and sampling

1.9.3.1 Population

In this study, the research population comprised of adults identifying as LGBTI+ and staying in Gaborone, Botswana, having attained the age of 18 years and above as well as affiliated to the organisation LEGABIBO.

1.9.3.2 Sampling

The sampling technique, sample, and sample size, including the inclusion criteria are hereunder described.

1.9.3.2.1 Sampling technique

Snowball sampling was used by the researcher to select participants. According to Kumar (2014:244), snowball sampling is the “process of selecting a sample using a network.” Individuals identified give information and are asked to identify others who will give further data until data are saturated. Further discussions on the sampling technique are in Chapter 3.

1.9.3.2.2 Sampling size

Interviews were conducted with 15 research participants and was discontinued when data was saturated. Data saturation will be discussed in detail in Chapter 2.

1.9.3.2.3 Sampling criteria

1.9.3.2.3.1 Inclusion criteria

The study included individuals who:

- Are identifying themselves as LGBTI
- Are above the age of 18 years.
- Are staying in Gaborone and
- Have disclosed their identity to the advocacy organisation LEGABIBO.
- Will voluntarily participate and can communicate in English and/or Setswana

1.9.3.2.3.2 Exclusion criteria

The study excluded individuals not identifying as LGBTI+ who were below 18 years and were not residing in Gaborone and were not a citizens of Botswana.

1.9.4 Recruitment of participants

After being granted ethical approval by the Faculty of Health Research Ethics Committee (HREC), the gatekeeper was contacted telephonically and per email. The Chief Executive Officer in the LGBTI+ advocacy organisation was used as a gatekeeper to identify a mediator who in turn helped identify those that met the eligibility criteria. After the gatekeeper had appointed the mediator, she was then contacted telephonically to be orientated about the study to execute the recruitment process. The telephonic conversation was followed by an email that contained all the information about the study. Having signed a confidentiality agreement, the mediator identified research participants and those willing to participate consented to the study and subsequently referred others through snowball sampling. As new potential participants were referred to the mediator, they were given contact information of the independent person. The gatekeeper was not related to the researcher. The independent person was appointed by the gatekeeper and was neither acquainted to the LGBTI+ individuals nor the researcher himself. His role was mainly to facilitate the informed consent process. During the recruitment, the COVID -19 protocols were in place hence the whole process of recruitment was undertaken by means of telephonic communication, which was the means of communication preferred by the research participants.

The roles of the key stakeholders in recruitment are summarised as in Table 1-1 below.

Table 1-1: Key stakeholders in the recruitment and data analysis

Key stakeholder	Description	Responsibility
Gate keeper	Independent person whom has no vested interest in the study.	Offered goodwiil permission and identified a mediator
Mediator	Independent person who has no vested interest in the study	Mediator identified the research participants whom met the eligibility criteria

Independent person	An individual neither acquainted to the researcher nor participants	Facilitated the informed consent process
Co-coder	Independent person qualified at Master's Degree level, experienced in qualitative data analysis and has no vested interested in the research	Did co-coding of the transcribed data independently from the researcher

1.9.5 Data collection

Data collection was commenced following ethical clearance and after research participants had given informed consent. Qualitative data were collected through an in-depth unstructured individual interview through telephonic communication. The interviews lasted for about ±60 minutes. In collecting data, two open-ended questions were posed to the participants:

- Tell me about the mental health challenges if any, that you experience as a person identifying as LGBTI+?
- How do these challenges affect your mental health?

The researcher audio-recorded the interview through an audio recorder which was followed by verbatim transcribing of the tape recordings. The researcher had put the phone on a loud speaker in a private room so that the conversation could be recorded, with participant consent. According to Streubert and Carpenter (2011:91), verbatim transcriptions help in increasing data collection accuracy. Field notes were also taken during the interview (see Annexure J).

1.9.5.1 Data collection tool

The researcher served as a data collection tool. As observed by Polit and Beck (2017:568), "in qualitative studies, researchers are the data collecting instruments as well

as the creators of the analytic process." The researcher was the one collecting data using interview guide with the interview question (see Appendix G and H).

1.9.6 Data analysis

The researcher analysed data using Colaizzi's method of data analysis (Streubert & Carpenter, 2011:79). The method is used to analyse phenomenological data hence suitable for this study. The procedural steps of analysis are discussed in detail in Chapter 2.

1.10 Trustworthiness

Trustworthiness is the extent of confidence bestowed by qualitative researchers on the collected data. Bradshaw *et al* (2017:5) view it as a measure of quality in research; meaning that it is the gauge as to whether data are believable or trustworthy.

In ensuring trustworthiness, the characteristics of credibility, transferability, dependability, and confirmability were observed. The concept of trustworthiness is explained in detail in Chapter 2.

1.11 Ethical principles

Ethical principles were adhered to by soliciting informed consent from the study participants and maintaining privacy and confidentiality throughout the study.

1.11.1 Probable experience of participants

The research participants could experience emotional distress such as anxiety, shame, and guilt whilst some might experience emotional discomfort following catharsis of feelings. There could also be social stigma and discrimination for identifying as LGBTI+. The participants may experience fatigue due to the 60 minutes long interviews.

1.11.2 Risk and precautions

There is potential for psychological harm. The study may arouse self-disclosure which may provoke feelings of anxiety, anger, or sadness brought about by participants reliving experience. In mitigating against this, debriefing was to be done by the researcher and a prompt referral to a clinical psychologist on standby.

Individuals from the LGBTI+ community are vulnerable because of their perceived stigma and discrimination. They may experience social stigma for identifying as LGBTI+. In mitigating against this, confidentiality, anonymity and privacy were ensured and maintained throughout the engagements with participants.

1.11.3 Anticipated benefits

The research could offer societal benefits in the sense that it may influence policy change towards addressing mental health needs of the LGBTI+ population. There were indirect potential benefits emanating from the study in the context of allowing the research participants a catharsis of life experiences.

1.11.3.1 Direct benefits

There are no direct benefits from the study.

1.11.3.2 Indirect benefits

Even though there are no direct benefits, the indirect benefits positively affect the welfare and interest of the research participant. The participation in the research by the participants afforded them an opportunity to share life experiences, vent out and reflect. The research participants shared their real first-hand experiences and challenges which may change the negative societal perceptions by individuals, community, and researchers.

1.11.4 Risk/ benefit ratio analysis

The study is reasonable and medium risk in view of anticipated benefits. The benefits outweighed the risks. A comprehensive list of strategies were employed to minimise the anticipated risks hence the study outcomes were achieved.

1.11.5 Experience, skills and competency of researcher(s)

The researcher had successfully completed a research methodology module and ethics training. The researcher is competent in qualitative interviewing and data analysis and was guided by supervisors who have vast experience on qualitative studies.

1.11.6 Ethical approval

Following ethical clearance from Health Research and Ethics Committee (HREC), permission was solicited from the Health Research Unit in the Ministry of Health and Wellness in Botswana; and was subsequently granted.

1.11.7 Goodwill permission / consent

Goodwill permission was granted by the advocacy organisation for the LGBTI+ LEGABIBO. The organisation served as gatekeepers and appointed a mediator. Their premises were used for consent signing for the research participants.

1.11.8 Process of obtaining informed consent

After being granted ethical approval by the HREC, the researcher liaised with the mediator to send the information together with the consent forms to eligible potential participants. The information contained the contact details of the independent person whom they should contact should they be interested in participating.

For other participants, the mediator sent the names and contact numbers of those who responded positively to the independent person who then organised for the signing of the consent. The consent forms were sent by e-mail and after signing they scanned them and sent to the researcher. The potential risks and benefits, reimbursements, confidentiality and privacy information and the self determination to participate in the study as well as the right to withdraw or withhold information was part of the information given to potential participants. They were assured that there will be no negative consequences for those who do not participate.

Individual informed consents were sought from individual participants. Both verbal and written consent were solicited from the research participants. This was done having the research participants' prior access to the informed consent form document which was emailed. Before the beginning of the interview, the independent person ensured that the consent was signed, or the evidence thereof presented if signing was done electronically. The two parties will then find a way to have them sign the form together at a later date.

The process was repeated in all subsequent participants identified and then asked to give both written and verbal consent. Permission was also requested from the participants for voice recording of the in-depth unstructured interview.

1.11.9 Vulnerable participants

As per South African Department of Health (DOH) 2015 NHREC guidelines, the research participants may become vulnerable as per the social determinant model basically because of stigma and discrimination as well as identifying as same sex relations (Greeff, 2015:17). Vulnerable research participants need extra protection and thus the following sections will discuss how harm against them were guarded as well as how confidentiality and privacy were ensured throughout the study.

1.11.10 Respect for participants

Respect for participants was conveyed by welcoming, accepting and displaying non-judgemental attitude with regard to culture. Anonymity and the right to respect were accordingly maintained. The participants were granted autonomy to self-determine their participation in research. The research participants were reimbursed for their time, inconvenience, and transport expenses.

1.11.11 Measures to ensure privacy / confidentiality

Privacy and confidentiality were protected in the context of location, context, timing of recruitment and enrolment. The interview with the participants was done telephonically without divulging the identity of the participant to other stakeholders like co-coder. The informed consent forms were signed in a private room at the offices of the LGBTI+ advocacy organisation.

Confidentiality was ensured through signing of confidentiality agreements by co-coder. In addition, the data obtained from the interview were coded in order to avoid the information to be traced to participants. The transcribed data were saved in a computer encrypted with a password.

1.11.12 Anonymity

As noted by Polit and Beck (2017:147), anonymity is the means to an end in ensuring that there is no linkage of data to research participants. Anonymity was achieved during the transcription process by use of code names to conceal the identity of the research participants.

1.12 Data management

Data captured from research participants were shared with a co-coder and supervisor for analysis. These data were provided in voice recorded format, transcribed and saved on a password protected computer of the researcher. The documents were password protected. During data collection, only the student, the co-coder and supervisor had access to the database.

1.12.1 Data management plan

After the data was analysed, it was handed together with informed consent forms and recordings to the institution and stored as per the Northwest University guidelines.

1.12.2 Dissemination of research results

The results will be published in an accredited journal and presented at a reputable research conference(s).The participants were personally informed of the results of the study. A public lecture will be organised so that members of the media can get to know the results of the study and disseminate to the rest of the society. Additionally, pamphlets with a summary of findings will be shared.

1.12.3 Conflict of interest

There was no conflict of interest by the researcher during the research study. The researcher was not in any way related or had direct links with the potential participants. There was no relationship with the gatekeeper and the independent person.

1.13 Outline of the chapters

- Chapter 1: Overview of the study
- Chapter 2: Research methodology
- Chapter 3: Research findings
- Chapter 4: Conclusion, Limitations and recommendations

1.14 CONCLUSION

The chapter provided a detailed description and background of the research problem. This chapter precedes chapters on research methodology and study findings.

CHAPTER 2 RESEARCH METHODOLOGY

2.1 Introduction

The previous chapter focused on the overview which encompassed introduction, background, rationale, problem statement, research questions and objectives. In addition, significance, paradigmatic perspectives, study design, research methodology, trustworthiness, ethical considerations and outline of chapters were also discussed. In this chapter, research design, research methodology, trustworthiness and ethical considerations of the study will be discussed in detail.

2.2 Research design

The research design aims at exploring and describing the phenomena in detail to answer the research question and attach meaning to the phenomena (Polit & Beck, 2017:226; Gray *et al.*, 2017: 52). A qualitative, descriptive phenomenological design was followed in order to understand the lived experiences of the research participants which in the context of the study are the mental health challenges of individuals identifying as LGBTI+. There was further exploration of how the challenges affect the individuals' mental health were explored and described within context.

2.3 Study context

The setting of the study, the research participants and the phenomenon to be studies make up the context of the study (Botma, 2010:195).The study setting was Gaborone, which is the capital city of Botswana and situated in the southern part of the country (Chatibura *et al*. 2021: 38). According to Statistics Botswana (2015: 41), the projected population for Gaborone was 258, 726. Based on the above statistics and on the fact that Gaborone is a city that has people from diverse backgrounds, the researcher deemed the place to be suitable for this study.

2.4 Research methods

Research methodology is described as the steps followed in the research process with the aim of achieving research aims and objectives (Polit & Beck, 2014:8). A detailed discussion of the sections under research methodology that include the population, sampling

procedure, recruitment of research participants, data collection process and data analysis follows.

2.4.1 Population

Gray *et al*. (2017:53) defines population as a group of people that are representative of the interest being studied. In the context of this study, individuals identifying as LGBTI+ and staying in Gaborone, Botswana, having attained the age of 18 years and above were the population.

2.4.1.1 Sampling

It is essential that researchers clarify the sample of the study and justify the reason behind such a selection (Drisko, 2018:591). Sampling method for this study comprises of the sampling technique, sample and sample size, the inclusion and exclusion criteria which be discussed below.

2.4.1.1.1 Sampling technique

Snowball sampling entails the research participants making referrals for other participants to be involved in the study (Polit & Beck, 2014:284). The research participant who underwent an unstructured interview was asked to identify other individuals who can give information until data saturation was achieved. Individuals identifying as LGBTI+ are hard to reach because of issues of stigma and discrimination and thereby snowball sampling was a suitable technique (Gray *et al*. 2017:346).

2.4.1.1.2 Sampling criteria

2.4.1.1.2.1 Inclusion criteria

The research participants in a phenomenological study need to have experienced the phenomenon being investigated (Polit & Beck, 2014:287). The following criteria was used to for the research participants who took part in the study:

- were identifying themselves as LGBTI+
- were above the age of 18 years.
- were staying in Gaborone
- Had disclosed their identity to the advocacy organisation LEGABIBO.

- would voluntarily participate and could communicate in English and/or Setswana.

2.4.1.1.2.2 Exclusion criteria

The study excluded individuals not identifying as LGBTI+, below 18 years, and not residing in Gaborone. Furthermore, individuals who are not citizens of Botswana were not included in the study.

2.4.1.1.3 Sampling size

Data saturation is defined as a principle whereby data collection reaches a point whereby no new information or themes are obtained from the research participants (Gray *et al.* 2017:255: Polit & Beck, 2014: 286). In the current study, interviews were conducted on 15 research participants and were stopped when they did not yield any new information.

2.4.2 Recruitment of participants

In this study, following ethical approval HREC (see annexure A), the advocacy organisation LEGABIBO was contacted telephonically and by email. The Chief Executive Officer in the LGBTI+ advocacy organisation as a gatekeeper appointed a mediator who identified those who met the eligibility criteria for the study.

The mediator was telephonically orientated about the recruitment process on the backdrop of COVID-19 regulations. An email was sent to the mediator who was able to sign the confidentiality agreement after being requested to do so.

The mediator contacted those who were interested in the research and linked them with the independent person for the consent process. An independent person was an individual who had no interests in the study and was tasked with assisting the research participants to sign consent forms.

Since the COVID -19 protocols were in place at the time of recruitment, the whole process was undertaken by means of telephonic communication as preferred by the participants.

Other research participants willing to consent to the study helped refer others through snowball sampling. As new potential participants were referred to the mediator, they were linked with the independent person who facilitated the signing of the consent documents before the participants could be interviewed by the researcher.

2.4.3 Process of obtaining informed consent

In the context of the current study, after the researcher was given ethical approval (see annexure A) as well as the goodwill permission (see annexure C), there was liaison with the mediator to send the information together with the consent forms to eligible potential participants. The information also contained the contact details of the independent person whom some interested participants contacted. Other participants had given the mediator the contact numbers to the independent person who organised for the signing of the consent. To comply with COVID-19 regulations, consent forms were sent by email for them to sign (see annexures E and F).

The participants were given information on the potential risk and benefits, reimbursements, confidentiality and privacy. Furthermore, they were given information that they can decide on whether to get involved in the study or not, have the right to withdraw from the study or withhold any information. Those that refused to participate in the study were assured that there will be no negative consequences for doing so.

The research participants were given an opportunity to self-determine whether they wanted to be part of the study or not; and those who consented were required to sign, scan, and send to the researcher. The signing was done at the offices of the advocacy organisation in a room with adequate lighting, proper seats, and comfortable temperature.

COVID-19 protocols were followed by maintaining a 2 metre social distance between independent person and research participant, sanitise hands prior to entering the venue and after the use of the pen. The research participants made their own travel arrangements and were reimbursed for the costs incurred.

The process was repeated with all subsequent participants identified and then asked to give both written and verbal consent. Permission was also requested from the participants for voice recording of the in-depth un-structured interview.

2.4.4 Data collection

Data collection comprises the acquisition of data for the researcher to understand and describe the phenomenon (Bradshaw *et al.,* 2017:4). Data were collected through telephonic contact after consent had been granted by the researcher. The process of data

collection commenced after the research participants had given informed consent through a process explained in the previous section, 2.4.4.

Qualitative data collection was done through an in-depth unstructured individual interviews which lasted for about 60 minutes each. Unstructured interviews are suitable for phenomenological studies as they allow for spontaneity and free flow of the conversation (Gray *et al.* 2017: 259). Polit and Beck (2014:290) reiterates that an unstructured interview also helps researchers to not bring pre-conceived thoughts into the data collection process. In collecting data, the research participants were asked two open-ended questions which follows.

- Tell me about the mental health challenges if any, that you experience as a person identifying as LGBTI+?
- How do these mental challenges affect your mental health?

During data collection, an unstructured interview started with exchange of pleasantries, outlining of the purpose of the research and the role of the researcher, the time the research interview was to take place and emphasis of issues of confidentiality. Consent was also sought for the interview to be audio-recorded.

Data collection was followed by verbatim transcription of the tape recordings. The researcher transcribed the data. According to Streubert and Carpenter (2011:91), verbatim transcriptions help in increasing data collection accuracy.

2.4.4.1 Data collection tool

In qualitative studies, the researchers serve as instruments to collect data and they also play a role in the data analysis process (Polit and Beck. 2017:568: Creswell, 2014:237). Additionally, an interview guide was used in the process of data collection (Creswell, 2014:234). The guide helped direct the researcher on what to ask (see Annexure G, H).

2.4.5 Data analysis

The researcher analysed data using Colaizzi's method of data analysis (Streubert & Carpenter, 2011:79). The method was chosen because it has been consistently used to

analyse phenomenological data hence suitable for this study. The following procedural steps constituted the data analysis process:

- Describe the phenomenon of interest
- Collect participants' descriptions of the phenomenon
- Read all participants' descriptions of the phenomenon
- Return the original transcripts and extract significant statements
- Try to spell out the meaning of each significant statement
- Organise and then aggregate the formalised meanings into clusters of themes.
- Write an exhaustive description
- Return to the participants for validation of the description
- If new data are revealed during the validation, incorporate them into an exhaustive description

Data analysis was also done by an independent co-coder who was well experienced in analysing qualitative data. The researcher and the co-coder both reflected on the themes and categories by comparing notes in order to reach a consensus. During data analysis, the two did the same chronological steps for the analysis.

2.5 Ensuring trustworthiness

Trustworthiness is defined as the degree to which qualitative researchers put on the data and data collection process (Polit & Beck, 2017: 747). Bradshaw *et al.* (2017:5) also views it as a measure of quality of research; meaning that it is the gauge as to whether data is believable or trustworthy. Trustworthiness is comprised of the characteristics of credibility, transferability, dependability, and confirmability which will be discussed in detail.

Credibility

Credibility is seen as a key criterion that highlights the believability in the data and interpretation of the data (Lincoln & Guba cited by Polit & Beck, 2017:559). In ensuring credibility the researcher had a prolonged engagement by spending reasonable time with participants to get rich data and got detailed field notes (Wu *et al*, 2016:496; Shenton, 2004: 65) (see Annexure J for field notes). As observed by Polit and Beck (2017:559),

having adequate time with research participants facilitates understanding and dispels misinformation and distortions.

A wide range of research participants were used to ensure rich data of the experiences. After data saturation at 10 participants, 5 more participants were interviewed (Shenton, 2004: 66). Participants were given an opportunity to be part of the study or not which helped the investigator interview research participants who were willing to be part of the study.

During the data collection process, the interviews were recorded and thereafter transcribed verbatim (Thomas & Magilvy, 2011:153). After interpretation, the themes were discussed with the participants to verify if they were representative of them (Anney, 2014:277).

In addition, a pilot interview was done in order that the research supervisor can advise on the improvement of the research interview. After the pilot interview, the interview was transcribed verbatim by the researcher and sent to the supervisor for feedback. Debriefing sessions were done with the supervisor to improve the quality of the study results (Anney, 2014:276). The researcher was given approval to continue with other subsequent interviews.

An independent co-coder was also engaged to ensure the integrity of the findings (Anney, 2014:277). The co-coder, who was experienced in qualitative was engaged to analyse data using the same steps as the researcher.

Transferability

Transferability is the ability for the research findings to be applicable in other settings (Polit & Beck, 2017: 560). In the current study, the researcher provided adequate account of the study context, setting, sampling technique which will make the reader decide whether the results are transferable or not. The process of sample selection was clearly defined in order that it can be applied in a different setting. (Shenton, 2004:70).

Dependability

Dependability is another criterion proposed in the Lincoln-Guba framework (Polit & Beck, 2017:559). Dependability entails the consistency of data being achieved when a study is replicated in a similar context (Polit & Beck, 2017:559). To ensure dependability of the study, steps were undertaken to ensure that records of what transpired in the study process are available. An audit trail was ensured by availing operational details of data gathering and a systematic process of data analysis were also followed (Shenton, 2004: 71).

Confirmability

Polit and Beck (2017:559) define confirmability as the potential "congruence" by two independent people on the meaning, relevance, and accuracy of the data. The researcher ensured this characteristic by making available for the auditing process raw data like verbatim transcriptions, field notes and documents used for data analysis. A step-by-step process of the research project has been outlined (Shenton, 2004:72). A reflective journal which included the personal reflections of the researcher in relation to the study was kept.

Transparency

The concept of transparency is the process of understanding what was done in the research and why it was done. The researcher ensured transparency by clearly describing recruitment of participants, data collection as well the data analysis process.

In addition to the above values, Blair (2016:8) posits that it is important for those conducting LGBTI+ research to reflect on assumptions and values as they may influence the angle of asking questions. The researcher as a data collection tool did bracketing to ensure truthfulness. Bracketing is the process of suppressing preconceived viewpoints on the study phenomena (Polit & Beck, 2017:471). A reflexive journal was kept was kept to write down the researcher's experiences after every interview which helped guard against the researcher being emotionally involved with participants as that could have possibly compromised data (Polit and Beck, 2014: 270).

2.6 Ethical considerations

The study ensured that ethical considerations were observed and put in place. As observed by Blair (2016:5), there is need for emphasis on the concepts of confidentiality,

privacy and harm reduction when doing research on individuals as LGBTI+. In the context of this study, such principles like confidentiality, soliciting informed consent from the study participants and maintaining privacy were done and will be discussed in detail.

2.6.1 Probable experience of the participants

The research participants were highly likely to experience anxiety, shame, and guilt whilst some may experience emotional discomfort following catharsis of feelings. There could also be social stigma and discrimination for identifying as LGBTI+. The participants were also at risk of experiencing fatigue due to the 60 minutes interviews.

2.6.1.1 Risk and precautions

The research participants did not experience any risk during the study. Table 2-1 summarises the potential risks in the study and how they were mitigated against.

Table 2-1: Table of risk and precautions

Risks	**Precautions**
Psychological risk; individual may relive bad experiences resulting in anxiety, emotional discomfort, anger and also that information is personal.	A clinical psychologist was placed on stand-by to do debriefing for participants who could have had psychological challenges. The debriefings were to be done telephonically in light of the COVID-19 situation but however, none of the participants experienced challenges.
Social risk in event of being identified as LGBTI+ in view of perceptions of stigma and homophobic tendencies.	This was mitigated by maintaining confidentiality and privacy at all times in the research process to protect the research participants. Consent signing was arranged at the offices of the

	advocacy organisation to mitigate against this.
Fatigue due to prolonged interviews	The participants were to be allowed a short comfort break during the telephonic interview, however that was done as no participant experienced fatigue.
COVID-19	Interviews were done telephonically. During the consent signing process, COVID-19 precautions were observed. The independent person who facilitated consent signing process sanitised those that were involved prior to and after signing. All individuals put on cloth faced masks and kept 2 meters social distancing.

2.6.2 Anticipated benefits

The research could offer societal benefits in the sense that it may influence policy change towards addressing mental health needs of the LGBTI+ population. There are indirect potential benefits emanating from the study in the context of allowing the research participant catharsis of life experiences.

2.6.2.1 Direct benefits

In this study, there are no direct benefits

2.6.2.2 Indirect benefits

Even though there are no direct benefits, the indirect benefits positively affect the welfare and interest of the research participant. The participation in the research by the research participants will afford them the opportunity to share life experiences, vent out and reflect.

The findings of the study could possibly influence possible policy changes regarding mental health care of the LGBTI+ community. The research participants will be sharing their real first-hand experiences and challenges which may change the negative societal perceptions by individuals, community, and researchers.

2.6.2.3 Risk/ benefit ratio analysis

The study was reasonable and medium risk in view of anticipated benefits. The benefits far much outweigh the risks.

2.6.3 Experience, skills and competency of researchers

The researcher has successfully completed a research methodology module and ethics training. The supervisor has vast experience in qualitative research hence mentored the researcher in qualitative interviewing and data analysis.

2.6.4 Ethical approval

Ethical clearance was solicited from the HREC (see annexure A). Subsequently, permission was given by the Health Research Unit in the Ministry of Health and Wellness in Botswana for the study to be undertaken (see annexure B).

2.6.5 Goodwill permission

According to Cresswell (2014:237), gatekeepers are essential in providing access to research participants. In the context of this study, the Chief Executive Officer of LEGABIBO through the Health and Wellness Manager provided the goodwill permission for the research to be carried out (see Annexure D).

2.6.6 Vulnerable participants

The Kipnis' taxonomy of research vulnerability under social classification places individuals identifying as LGBTI+ as vulnerable in an African context (Kruger *et al*. 2014:85). As described earlier, individuals identifying as LGBTI+ are stigmatised and discriminated which highlights this vulnerability. Greeff (2015:17) further assert that the research participants had increased vulnerability as per South African Department of Health (DOH) 2015 NHREC guidelines. Based on the foregoing, the research participants

of the current research needed extra protection in order to guard against harm and ensure confidentiality and privacy.

2.6.7 Respect for participants

As observed by Polit and Beck (2014: 289), one of the important attributes during a phenomenological study is encouraging candour and respect. Respect for participants was conveyed by addressing them by appropriate pronouns as well as a welcoming and non-judgemental attitude. Furthermore, respect for participants was demonstrated by maintaining anonymity and according them the right to privacy.

The participants were granted autonomy to self-determine their participation in research and were reimbursed for their time, inconvenience, and transport expenses when they went to the advocacy organisations for consent signing. Transport expenses were calculated by adding taxi fares to and from the research participant's place of residence.

The informed consent forms were signed in a private room at the offices of the LGBTI+ advocacy organisation, which had adequate seating arrangement, well ventilated and adequate lighting.

2.6.8 Measures to ensure privacy/confidentiality

It has been earlier highlighted that privacy and confidentiality are critical in the research process. Privacy and confidentiality were addressed in the context of location, context, timing of recruitment and enrolment. In the context of this study, the informed consent forms were signed in a private room at the offices of the LGBTI+ advocacy organisation LEGABIBO. Furthermore, the mediator, the independent person, independent co-coder signed confidentiality agreements.

The interview with the research participants was done through telephonic means without divulging the identity of the participant to the co-coder. Confidentiality was also ensured by the signing confidentiality agreements by independent person, mediator, and co-coder. The transcribed data was saved in codes to avoid the information being linked to participants. A computer encrypted with a password was used to save the transcribed data.

2.6.8.1 Anonymity

Anonymity strives to protect those involved in research from any harm and embarrassment that can emanate from publication or revelation of identity (Waltford, 2005:85). Polit and Becker (2017:147), further note that anonymity is the means to an end in ensuring that there is no linkage of data to research participants. Anonymity was ensured during the transcription process by use of code names to conceal the identity of the research participants.

2.7 Data management

Data management is a conduit through which research data can be integrated and reused after publication (Wilkinson *et al*., 2016:1). The researcher only had access to the data during data collection whilst during the process of analysing data, access to the data base was only permitted for the researcher, the independent co-coder and supervisor. As earlier discussed in section 2.6.8, data was transcribed and saved in a password protected computer of the researcher.

2.7.1 Data management plan

After the data have been analysed, they were handed together with signed informed consent forms, transcribed interviews and audio recordings to the institution and stored as per the Northwest University guidelines. The data will be stored in the original form and will be destroyed five years post research completion in line with the university guidelines.

2.7.2 Dissemination of research results

Wilson *et al*. (2010) defines dissemination as a process that entails the distribution of research findings to specified target audience and setting which culminates in the data influencing decision making in various forms. In this study, the results are earmarked to be published in an accredited journal and presented at a reputable research conference(s). The participants were personally informed of the results of the study. The media will disseminate information to the rest of the society following a public lecture that will be organised. Additionally, pamphlets will be shared with a summary of findings.

2.8 Conflict of interest

Conflict of interest is a phenomenon that can clearly tarnish the authenticity of the research findings. As posited by Curzer and Santillanes (2012:143), there may be temptations to act wrongly and compromise the objectivity of the study. In the context of the current study, there was no conflict of interest as the researcher in no way was related or had direct links with the research participants. .

2.9 Conclusion

The chapter gave an account of the research methodology. Research methodology encompasses aspects like research design, sample selection, data collection and analysis. The choice of the methods was justified in the discussion by the researcher. The next chapter will extensively cover the research findings.

CHAPTER 3 RESEARCH FINDINGS

3.1 Introduction

In the preceding chapter, an in-depth discussion of the research methodology was done. This chapter discusses the findings following the data analysis of 15 structured interviews that were conducted. Major themes, categories and sub-categories that emerged from the interviews will be discussed supported by the direct quotes of participants as well as literature confirmation. According to Marshall and Rossman (cited by Gray *et al*. 2017:252), an analysis can take place following data collection.

The aim of the study was to explore and describe the mental health challenges of the LGBTI+ community in Gaborone and how these challenges affect their mental health.

3.2 Profile of research participants

The total number of the research participants who participated in the study were 15. The research participants all shared and described their mental health challenges as part of the LGBTI+ community. During the interviews, it was established that the participants' identification within the LGBTI+ community were one (1) participant as gay, one (1) bisexual, two (2) lesbian, three (3) intersex and eight (8) transgender men and women (two of them were gender non-conforming).

3.3 Discussions of findings and literature control

After data were analysed, four (4) broad themes, categories and sub-categories were established. The themes were, mental health challenges experienced by individuals identifying as LGBTI+, reasons for experiencing mental health challenges, experiences of challenges in accessing health care as well as social challenges of everyday life. These were arrived at with the consensus agreement with an independent co-coder. In this chapter, the themes will be discussed supported by actual quotes of participants and confirmed with literature. The overview of themes, categories and sub-categories are as reflected in Table 3.1.

Table 3-1: Table of themes

Themes	Categories	Sub-categories
1.Mental health challenges experienced by individuals identifying as LGBTI+	1.1 Experiences of Depression	1.1.1 Suicide attempts
		1.1.2 Low self esteem
		1.1.3 Not being fully themselves
	1.2 Experiences of gender dysphoria	
	1.3 Loneliness and Isolation	
2. Reasons for experiencing mental health challenges	2.1 Experiences of stigma and discrimination	2.1.1 Lack of support and having to cope with the situation alone
		2.1.2 Experiences of rejection
		2.1.3 Difficulty in keeping and obtaining employment
		2.1.4 Experiences of having to belong to a family as an LGBTI
		2.1.5 Difficulty in maintaining romantic relationships
	2.2 Experiences of being misgendered	
		2.3.1 Healthy coping mechanisms
		2.3.2 Self-acceptance

	2.3 Coping mechanisms used to deal with the challenges	2.3.3 Talking with supportive friends and support groups
		2.3.4 Unhealthy coping mechanisms
3. Experiences of challenges in accessing health care	3.1 Avoiding health care due to stigma	3.1.1 Experience of insecurity to seek counselling 3.1.2 Experiences of having to undress unnecessarily or being asked inappropriate questions
4. Social challenges of everyday life	4.1 Problems related to issues of identity	4.1.1 Hormone treatments and gender affirming surgery
		4.1.2 Difficulty in affording expenses related to hormone treatments and surgeries.
		4.1.3 Frustration in managing romantic intimate relationships
		4.1.4 Having to deal with people not familiar with transgender identities

3.3.1 Theme 1: Mental health challenges experienced by individuals identifying as LGBTI+

The participants expressed experiences of mental health challenges. From this broad theme, experiences of depression, gender dysphoria, loneliness, and isolation emerged. The categories will be discussed below.

3.3.1.1 Experiences of depression

During the interview with the research participants, the experiences of depression emerged. A range of emotions were displayed during the telephonic interviews and that included sadness, frustration, stress, and worry. The participants self-reported having had depression and below are the extracted quotations.

P1: I was staying alone without any one to offer comfort and support and ended up having depression which nearly disabled me.

P4: And I started having too much anxiety and depression because I was asking myself on what if after lockdown I am going to go into the society and look very different from how I was before lockdown commenced. It was very depressing.

P8: That also contributed to my depression because after that I felt unsafe at all.

P9: "When I am a bit depressed, I wouldn't want people to know. I am always laughing even though I am not okay.

The participants' range of emotions when describing the experiences of depression, substantiated the reports of having endured depression. Literature supports that depression is one of the outcomes experienced by the LGBTI+ community which has been highlighted in this study. LGBTI+ community has been said to be increasingly vulnerable to depression and suicide in a systematic review of studies in Italy (Mongelli *et al*. 2019: 47). The findings of the current study are also like a study in Western Kenya which highlighted that 26.1% of the participants reported symptoms of depression (Harper *et al*. 2021:9). Furthermore, a study by Muller and Daskilewicz (2018:271) also highlighted that research participants in Kenya and South Africa had a rate of 46% and 57% respectively showing signs of depression.

Some participants attributed depression to the consequences of COVID-19 (P4). During the early days of the pandemic under the strict lockdown, they could not access medical facilities for their medication supply and were mostly staying alone as they could not get support hence susceptibility to depression. Other factors that led to depression were on account of negative attitudes of healthcare workers by constantly questioning the LGBTI+

on transitioning and the brutality and incivility of the police-officers over the identity card that contrasts with the physical appearance (P 4).

The contributing factors to depression as expressed by some of the participants are confirmed by the literature. COVID-19 as a risk factor has been well documented in various studies across the globe. In a study in Toronto, Canada by Abramovich *et al*. (2021:8), 66 % of participants reported experiencing moderate to severe symptoms of depression over the course of the pandemic. Salerno *et al.* (2020:721), argues that COVID-19 brought psychological issues and the stressors that the LGBTI+ experience.

The researcher concludes that some members of LGBTI+ community are vulnerable to depression not on account of being in the minority but because of factors like the discriminatory attitudes of the health care workers and the police. These circumstances heighten their risk to depression as discussed in this category.

The following sub-categories emerged under the category of experiences of depression being suicide attempts, low self-esteem and not being fully themselves will be discussed as below.

3.3.1.1.1 Suicide attempts

During the unstructured interview, the research participants expressed having attempted suicide on account of various situations. The participants were emotionally charged and frustrated at discriminating tendencies of the community shared experiences with suicide as below.

P1: I wanted to commit suicide. The question was why this was happening to me God, why is the community shooting me like this, where I should go. Why me?

P10: Saying from personal experience I have tried to commit suicide three times thank God because it failed. Being me in this society is something like you are an outcast or something that is unusual by the society.

P11: This was either I die or stop living.

P13: Time of the incident I was doing Form 3, my mom and dad were undergoing divorce. I felt that because I am their child, they are doing it because of me. Because I realised

that I was the only one with disability issues. I ended up feeling that I should get away from them. I drank several substances and was admitted but manged to recover.

The findings highlight the LGBTI+ community's increased vulnerability to suicide which is asserted by several studies. Rood *et al.* (2015: 272), did assert that discrimination and victimisation increased the suicide intent for some individuals identifying as transgender in a study conducted in the USA. In the current study, P1 and P10 identified as transgender and reported having attempted suicide which is consistent with the study of Rood *et al.* (2015:272) although done in different contexts.

In a study by Muller and Daskilewicz (2018:271), 27 % had attempted suicide in South Africa whilst 22% did the same in Kenya. A Botswana based study by Ehlers *et al.* (2001:848), also highlights that there was high prevalence of thoughts about suicide which was noted in 29.8 % of participants.

The statements by the participants and the findings highlight the LGBTI+'s community's increased vulnerability to suicide that could be attributed to the rejection by family members and discriminating tendencies of the community which leaves participants feeling as outcasts. Furthermore, some participants expressed that having suicidal ideations was attributed to the inappropriate gender marker in the identity document. Lack of acceptance of the LGBTI+ by the general community and family is one of the major risk factors to LGBTI+ individuals attempting suicide.

3.3.1.1.2 Low self esteem

In this sub-category, research participants expressed having low self-esteem which affected them mentally. The participants attributed low self-esteem to being unable to do gender affirmation surgery (GAS). There is also a feeling among the participants that people look through them and can see that their gender is different from how they portray themselves which makes them feel low of themselves. Other factors that aggravate self-esteem are they are being questioned on identifying as LGBTI+ as well as stigma from community members. Some of the participants' views are expressed as in the following verbatim quotes.

P3: I ask myself that is it really the right discovered life that I should be living as in like is being gay okay, is being who I am okay, maybe I am doing something wrong and again get to a point of questioning and say if I say or they say I am wrong why didn't God make me normal like they say?

P5: Make you to look down upon yourself and see yourself as worthless.

P9: Some of the things is low self-esteem, which other people don't experience.

P14: At senior school all was fine, but I found myself having low self-esteem because of ball sports.

The research participants expressed that they feel less of themselves and worthless and feel as failures. The derogatory words used against them aggravates their low self-esteem. A study in Canada by Taylor *et al.* (2019:19) found that homophobia and transphobia result in significant loss of self-esteem; this is consistent with the findings of the current study as most of the participants highlighted being affected by the stigmatising tendencies.

Bridge *et al.* (2019:4) further add that minority stress aggravates the advent of low self-esteem. In the current study, minority stressors include concealment of identity and fear of victimisation, which evidently can lead to low self-esteem. Based on minority stress theory, low self-esteem is thus a psychological risk for negative mental health outcomes.

A study in Brazil contrasts the findings of the current study by highlighting high rates of self-esteem in 80.9 % of the respondents (Canali *et al*. 2013: 4509). The participants who scored low in self-esteem had other adverse factors apart from the fact of being a gender minority which adds to the complexity of the comparison. An example of adverse factors in the study included shame and rejection of one's sexual orientation.

The findings and subsequent literature clearly highlight the experience of low self-esteem among the LGBTI+ individuals. The researcher concludes that self-esteem stands out as the protective factor to mental health.

3.3.1.1.3 Not being fully themselves

This section deals with the sub-category of LGBTI+ not fully being themselves. This is another sub-category related to experiences of depression which highlighted the feelings of disappointment and dejection that were deduced from field notes during the interview. The participants expressed not being able to fully express themselves and suppressing themselves due to societal pressures. The following quotes reflect what some participants had to say.

P1: *I wanted to identify as transwoman, but because of the circumstances in my life I couldn't be the full woman I wanted to become thus I chose to be gender non-conforming minority group within the LGBTI community*.

P3: *This idea, whole attitude or triggers of how people react when they see us, it got me to a point where I ended up having to change to the person I am right now.*

P5: *I fell for a girl but I ignored the feeling because of what society and my parents will say as they were openly critical of that.*

P15: *I have always not fully displayed my affection with partner publicly; in other words, I respect the community.*

The participants highlighted societal expectations that hindered them to fully be what they are and express themselves to avoid being judged or discriminated upon. The current study findings do conform to findings of a study by Rood *et al.* (2017:8), who found that transgender individuals can conceal identity in social context of avoiding stigma and discrimination.

The LGBTI+ not being what they are is a source of psychological stress and it is associated with high incidences of generalised anxiety and depression (Rood *et al.* 2017:710; Feinstein *et al*, 2020:8). It must however be noted that concealment or failure to be fully self does not always lead to negative mental health outcomes. A study by Feinstein *et al.* (2020:8) demonstrated that those who concealed their gender identity over concerns of being judged had higher rates of depression in comparison to those who revealed their gender based on having a central identity. Concealing gender identity for intrapersonal purposes was not a contributor to negative mental health outcomes.

Moreover, Beeman and Rankin (cited by Hendricks & Testa, 2012:463) highlight that transgender individuals can hide their identity so that they are not intimidated or stigmatised. In the current study, the research participants had heightened risk for negative mental health outcomes as they conceal identity for interpersonal purposes, that is, for fear of being judged by other people.

3.3.1.2 Experiences of gender dysphoria

In this study, some participants reported having gender dysphoria (GD) and most notably among the transgender community. The participants expressed feelings that on several occasions they felt some incongruence with their body. The participants' transcriptions are as below.

P4: The condition that I told you about earlier on called gender dysphoria. It results in me being depressed and having a bit of anxiety and I had to be given antidepressants to avoid situations where I become suicidal because of the way I am.

P6: The way you appear and the way you feel do not match. It is stressing… It is like a fight between your mind and body.

P7: The biggest challenge before transition was that I was born in the wrong body.

P11: It's a feeling that I am born in the wrong body.

The APA through DSM-5 describes GD as an incongruence between the gender marker assigned at birth and the one expressed by an individual. Individuals diagnosed with GD present with distress in school, occupationally and in social circles for at least six months (Townsend & Morgan, 2018: 646). In contrast to this definition, Lindley and Galupo (2020:6) assert that GD can be used to refer to both a diagnosis and a symptom. In the context of this study, GD was taken as a diagnosis.

Most of the research participants who self-reported GD identified as transgender (P4, P7 P11). This is consistent with views expressed by Byne *et al.* (2018: 60) who stated that it is not automatic that people identifying as transgender will be diagnosed as GD but only those having clinically significant symptoms. Hall *et al.* (2021:7) also observed that individuals identifying as transgender endure distress which is clinically significant for a diagnosis of GD.

Some of the participants did experience having a diagnosis of gender dysphoria and still experienced anxiety and depression. The findings are consistent with existing literature that has found that transgender individuals have a higher risk of psychiatric morbidity and often associated with mood disorders (including depression), anxiety disorders (Freitas *et al*. 2019:101). Transgender on account of other challenges like family rejection, stigma and discrimination have increased vulnerability for mental health challenges and having risk for GD complicates their mental health outcomes.

3.3.1.3 Loneliness and isolation

Loneliness and isolation emerged as another category under this theme. Some research participants found it hard to interact with people and felt some inadequacies within themselves. They felt that somehow, they did not belong hence the stance to isolate themselves. It was evident from the research participants' emotional reaction of frustration that this was a challenge. This is what the participants had to say.

P1: Felt lonely, I felt I wanted to be loved; I felt left out.

P2: When I get home, I get to discover that I am alone.

P8: I didn't want to socialise, I didn't want to do nothing, I didn't want to participate in anything either in family gatherings or picnics. I will just be always home.

P10: It is a personal experience, I am okay on my own because I don't wanna be questioned, I don't wanna be ridiculed, I don't wanna be finger pointed at.

P12: The thing is when I was with the other boys, I did not feel that I am part of the crew because when it came to some conversations I will keep shut, I can't comment.

Loneliness as defined by Gardner *et al.* (2018:148) is the individual perceptions of lacking connection with others. This definition affirms the findings of the current study as some participants expressed not being connected with other people. This is consistent with the current study as some participants expressed fear of interacting with others on the backdrop of being judged or people getting to know the little "secrets" like about being intersex (P13).

In a national student survey in Norway, individuals identifying as transgender reported loneliness when compared to cisgender (Andersen *et al.* 2020:4). This is consistent with the findings of the current study as participants (P1, P2, P8, P10), who expressed loneliness, identified as transgender.

According to Perone *et al.* (2020:12), the LGBTI+ experience heightened risk for social isolation which confirms the current study findings. Isolation is the lack of sustained meaningful connection with other people (Gardner *et al*. 2018:148). In the current study, participants found it difficult to connect and interact with others; with one not feeling part of the "crew" because of being intersex (P12, P13, and P14). The LGBTI+ community isolate themselves to avoid being further stigmatised by the community. Isolation is often an outcome borne from the concealment of being an LGBTI, prejudice and negative internalisation of the societal viewpoints (Heck, 2015:3). The LGBTI+ community experience many obstacles that hamper social connections and thus are susceptible to being isolated and being lonely. The researcher concludes that loneliness and isolation lead to poor mental health outcomes of the LGBTI+ and thereby are one of the challenges associated with negative mental health hence the next theme of reasons of experiencing mental health challenges.

3.3.2 Theme 2: Reasons for experiencing mental health challenges

The second theme that emerged from the data analysis is that the LGBTI community expressed their reasons for the mental health challenges. This theme is further realised as the following categories namely, experiences of stigma and discrimination, lack of support and having to cope with the situation alone, experiences of rejection, research participants highlighted reasons that lead to their poor mental health. Under this broad theme, several sub-categories emerged and are discussed below.

3.3.2.1 Experiences of stigma and discrimination

The participants highlighted stigma and discrimination as one of the factors that adversely affected their mental health. The participants highlighted issues of stigma and discrimination among the communities through public transport and even in social media. Stigma and discrimination were through various forms being verbal, non-verbal, physical, and sexual. Some members of the LGBTI+ community in the context of the study are called a range of discriminatory names and disparaging words like "bastards," "those that

stop rain," *dibatana* (creatures) and sinners. Below are the verbatim extracts of what participants said.

P1: Discrimination is one of the things that affect our mental health in the LGBTQI community, all of it! A person would not want to share a seat in a taxi as when you board it, they disembark.

P2: On social media, I saw a nurse who works in a local psychiatric hospital, but I can't mention his name; he suggested that gays be infected by corona to die.

P3: It happens in public transport; we are suffering people as people are abusing us.

P4: "My mental health can also be influenced by what we see on social media. What I try to do is spend time with my boyfriend and stay away from my phone".

The findings are consistent with those of Dolan *et al.* (2020:150), who maintained that stigma can adversely affect individuals' mental well-being. Similarly, in a study by Zeeman *et al. (*2018:974) stigma and discrimination were identified as contributors to mental health challenges in the LGBTI+ community. Another study in Mexico by Lorzano-Verduco *et al.* (2017:224), found that depressive symptoms and substance use among the LGBTI+ community were heavily linked to discrimination. The current study findings and existing literature clearly demonstrate that stigma and discrimination influence the mental health status of the LGBTI.

There is however contrasting view in relation to the findings. A research report by Meer *et al.* (2017:10) suggest that people of Botswana are relatively tolerant of the LGBTI+. They argue that only the laws of Botswana are the ones that stigmatise the LGBTI+ individuals are intolerant which is in stark contrast to views expressed by the research participants. The participants clearly expressed being stigmatised by the community. Stigma and discrimination are clearly a factor that compromises the mental health of the LGBTI+ community. Stigma on the LGBTI+ aggravates several stressors that leads to poor mental health.

The discussion will then focus on the subcategories that include lack of support and having to cope with the situation alone, experiences of rejection, difficulty in keeping and

obtaining employment, experiences of having to belong to a family of LGBTI and difficulty in maintaining romantic relationships which will follow.

3.3.2.1.1 Lack of support and having to cope with the situation alone

Lack of social support emerged as a sub-category that was highlighted by several research participants. The participants with implied frustrations, highlighted several situations that did highlight lack of support. Participants expressed that because of lack of significant support they had to deal with the situation by themselves. The following quotes support what participants expressed in this regard.

P2: I can't even ask for money from her, and I am craving for her support that I don't get.

P3: You end up dealing with issues on your own.

P6: You cannot get the full support from the family; you cannot get full support from friends.

P7: I have never been supported and I have gotten used to it.

The research participants were frustrated at what was mostly viewed as sabotage from family members for support. There is substantial evidence that affirms lack of support as contributory to mental health problems, which is consistent with the findings of the current study. A study by Bayrakdar and King (2021:10) affirms that there are incidents of discrimination, violence and harassment which are related to diminished support from within the LGBTI+ community. Similarly, another study by Olson *et al.* (2016:5), concluded that those who are supported in their gender identity have reduced affinity for psychopathological consequences.

Social support is one of the protective factors against mental health problems for the LGBTI+. The researcher concludes that having support helps individuals including those identifying as LGBTI+ catharsis of feelings, hence easing the emotional burdens and also offers security and comfort. However, it was not the case with participants of this study, which case is aggravated by being rejected.

3.3.2.1.2 Experiences of rejection

The participants expressed their experiences of rejection by the society with their tone during the telephonic interview underlying their disappointment. They further highlighted how feelings of worthlessness are brought by the perceived rejection. Below is what they had to say:

P1: When somebody identifying as LGBTI fought, there is drama at the police station. They would cause drama; they wouldn't help you like they are helping a human being.

P3: You don't feel accepted, you don't feel like you belong

P5: The major challenge is the lack of acceptance by the society and thus will need someone to help in nurturing self-worth.

P6: We are not taken or accepted as ordinary people from family and friends or people we don't know from the community and stuff…….You find yourself having grown up with people then they get to realise that you are no longer that person then they distance themselves from you.

LGBTI+ individuals face rejection from some members of the society. The perceived rejection diminishes their feelings of self-worth. The findings are supported by existing literature. A study in Australia by Jones and Hillier (2013:287) affirmed rejection to being a trigger of emotional distress amongst the LGBTI+ community.

In most instances there was no acceptance which directly relates to mental health challenges. A report by Flores (2019:5) indicates that lack of acceptance by others have ramifications for poor mental health. Camp *et al.* (2019:2353) noted that lack of acceptance and/ or rejection was associated with a high level of minority stress. It is evident that being rejected as an LGBTI+ individual is a risk factor to mental health challenges. Whilst other participants endured rejection, other had difficulties in keeping and obtaining employment which will be discussed in the next sub-category.

3.3.2.1.3 Difficulty in keeping and obtaining employment

The participants shared that because of stigma and discrimination they have difficulties in either finding employment or keeping it. They cited several issues in this sub theme

that they deem to be making difficult for them to either keep a job or reluctant to apply. Some participants highlighted those parents of the kids that they worked with were against them working with their kids whilst another was not given an opportunity for modelling services based on her gender identity. They also expressed that the identity document that was not aligned with the gender marker was a barrier to employment and even got involved in sex work as there are no jobs. Below are what they had to say:

P1: I will be told that I will influence kids to be LGBTI and I should do this, and I shouldn't do this.

P2: There is this other guy that I sent my profile if he needs modelling services, I am available anytime, he told me that I am a devil, he does not want a curse in his business, does not want his things to get mixed up.

P11: The choices that I have made because there were even times when money was tight because I couldn't get a job. I was applying and people see my ID and then lay low because they are confused……It was difficult to find a job, so sex work was something that I will find money with.

P13: Beard started growing when I long finished schooling. As a result of this I am unable to find employment.

Several literature points to issues about employment challenges of the LGBTI+ community. According to the ILO (2012:1-2) there is discrimination in accessing employment. A review by Valfort (2017:4) indicated that the LGBTI face hiring discrimination which is consistent with the findings of the current study. Similarly, Flores (2019:7) found that the LGBTI+ experience exclusion when they seek employment and if they are employed, they are stigmatised and harassed. Furthermore, a study by Hughto *et al.* (2015:5), demonstrates that access to employment is limited by trans-stigma which is consistent with the current study findings.

Whilst the participants were worried and discontent with the predicaments they were facing, it is worth noting that regarding employment, dismissal of those identifying as LGBTI+ based on gender identity is not allowed by the Amended Employment of 2010 (Meer *et al*. 2017:10).

ILO (2012:2) notes that transgender women may as a survival strategy resort to sex work which is consistent with some statements made by the participants over having to sell their bodies in order to make ends meet.

The issue of the gender marker on the identity card have been significantly reported to improve mental health as transgender individuals have the gender marker that is identical to their gender identity, which results in stressors being eliminated (Restar *et al*, 2020:1). The researchers further assert that having a proper gender marker in the identity card is a protective factor against mental illness which substantiates the views of the research participants who were interviewed

3.3.2.1.4 Experiences of unhealthy family relationship

Participants in the study partially attributed their poor mental health to lack of support from family members. With a tone of disappointment, they shared that they have their families disowning and kicking them out of the homes. Mothers are mostly the ones in the forefront in disowning family members. LGBTI+ individuals are also estranged from their siblings and had no relationships whatsoever. The participants expressed that they need their families for moral support as well as financial support when transitioning. Family members did not participate in counselling sessions to deal with some of the participants mental health challenges. Below are the verbatim quotations of what the participants had to say:

P1: I have never had that good acceptance from family. My family have long rejected me when I was 18 years maybe let me say when I was growing.

P2: Ooh; homophobia starts at family level from your parents not accepting that you are trans, they don't accept you and are negative towards you. They neglect you.

P7: It does not really mean that we have a relationship, we don't talk. I don't see them much; we grew up constant communication with each other. When we see each other is just exchanging greetings and then that's it. We have never talked about me transitioning or anything like that.

P10: There was a time I was called for counselling with both my family members, and they showed that they don't care, they don't wanna do anything with me.

Research participants expressed devastating and frustrating account of belonging to a family that is homophobic towards the LGBTI+ community. A study Klein and Golub (cited by Watson & Veale, 2018:115), highlights that family rejection worsened the substance misuse situation of individuals who identified as transgender and gender non-conforming when other variables were controlled. Additionally in the same study, suicide increased with increase in family rejection of the participants.

The family is a protective factor against mental health problems and cushions against depression and suicide ideations (Ryan *et al*. 2010:210). Furthermore, with family acceptance and support, there is enhanced self-esteem. The studies clearly confirm the findings of the current study; that lack of support from aggravates negative mental health outcomes.

The researcher concludes from the findings that family is an important factor in promoting the mental health of the LGBTI+ community. As expressed by some participants, the family is needed for emotional, physical and financial support for the LGBTI+ individuals to have self-acceptance and lead fulfilling lives. It is important that strategies to bring family members on board in the upkeep of the LGBTI+ are established.

3.3.2.2 Experiences of being misgendered

Misgendering is the phenomenon of being labelled with a different gender that an individual identifies with (Cooper *et al*. 2020:5). Misgendering can either be done by members of the community and health care professionals (Goldberg *et al*. 2019:67). The participants were irate and vehemently opposed to being misgendered. Participants expressed being hurt by being misgendered and that it facilitates development of mental health problems The participants insisted on proper use of pronouns when being addressed and expressed those parents often call them with names that they used before transitioning, which is disappointing. Below is what they had to say.

P2: I indicated the pronoun to address me with so that you don't get confused addressing me as a male, you understand? We have pronouns.

P4: When they get back home people are surprised you have breasts, you have changed the way you dressed and they start questioning that and that on its own can cause a mental breakdown because nothing hurts like being misgendered.

P9: The other issue is that of names, there are names within the ID that I don't want addressed to me. People will continue the name but since it's in the ID you have nothing to say.

P10: You are always cautious, you always trying not to let misgender you in any way possible.

Being misgendered is being assigned a gender that one does not identify with and participants indicated negative mental health outcomes on account of such undertaking being done to them. A study by Russel *et al.* (2018:3) highlighted that chosen name use was associated with reduced depression and suicidal ideation. This is consistent with the current study as the participants who expressed being misgendered had depression and had attempted suicide on several occasions. Moreover, Kattari *et al*. (2020:5) posit that health care providers who use proper names and pronouns nurture clients to have comfort when being rendered care. The health care workers need to be educated on this aspect to ensure dignity of the clients as well as to promote healthy relationships with the LGBTI+ community.

The phenomenon of misgendering is common among the transgender people, even in the context of the current study. There is evidence that the mental health of transgender individuals has been negatively affected by being misgendered (Dolan *et al.* 2020: 150).

Another study by McLemore (2014:5) demonstrated that participants who were misgendered had negative affect and additionally felt less authentic. Further evidence points to the fact that when one is repetitively misgendered, they are highly likely to have psychological distress (McLemore, 2018:53). This clearly demonstrates that being misgendered can hugely influence mental health outcomes among the LGBTI+ that leads to the need for coping with these challenges.

3.3.2.3 Coping mechanism used to deal with the challenges

The category of coping mechanism used by the LGBTI+ individuals to deal with the challenges will be discussed with focus on the sub-categories of healthy coping mechanisms, self-acceptance, talking with supportive friends and support groups and unhealthy coping mechanisms.

The participants shared coping strategies that were either negative or positive. This is consistent with findings in a study in Rwanda for lesbian and bisexual women who highlighted that they utilised coping strategies which were positive and negative (Moreland *et al*. 2019:208).

3.3.2.3.1 Healthy coping mechanisms

The participants confidently expressed the healthy coping mechanisms that they use to deal with the many challenges they encounter. These coping mechanisms are vital to improve their mental health. In this sub-category they shared their healthy coping strategies as follows.

P2: I do exercises, play netball; that is what makes me busy.

P3: And then funny enough I talk to God about it a lot, I just talk to God on my own I don't go to church or pastor or whoever.

P9: Yeah, I use prayer when I am overwhelmed.

P10: Honestly its outdoor gym. I run; I lift just that.

The participants used healthy coping mechanisms that has as well been used by other LGBTI+ participants across the globe. The participants were involved in brisk walking, and active sporting activities like netball. A study in USA indicate that physical activity is one of the health promoting initiatives that are encouraged for the LGBTI+ community (Fredriksen-Goldsen *et al*. 2015:185)). Physical activity yields mental health benefits such as improved sleep and mood.

Some research participants used prayer as a coping strategy. Even though they were discriminated against in most cases at church, they nevertheless found refuge in prayer (P3 and P9). The findings expressed by the participants are supported by a study by Seelman *et al.* (2018:12) which highlighted that some research participants looked up to their spiritual connection for comfort and to cope with negative issues. The LGBTI+ community just like the rest of the society, needs involvement in health promotion activities that are geared towards their general well-being to facilitate their self-acceptance.

3.3.2.3.2 Self-acceptance

Research participants shared that having accepted self, made it easier for them to deal with the challenges that they encountered. They acknowledged finding it difficult to accept themselves especially during the period when they reached puberty, but gradually they did manage which made them to function optimally in the society. This is what they had to say.

P2: I have accepted myself. It all starts with self-acceptance; if you have accepted self, everything goes well.

P3: Accepting who you are, and not necessarily internalising what people are saying out there is the beginning of you finding yourself and having what you want to become and finally being happy.

P12: The moment I started to accept myself I started to realise that they are confused they can't be certain that am I a boy or girl.

P15: I accepted myself and started dating other women.

Self-acceptance is a strength that is helpful to the LGBTI+ community in view of the challenges that they endure as a minority group. A review of 13 studies by Camp *et al.* (2020:365), indicated that better mental health is facilitated by self-acceptance of sexuality. This finding of self-acceptance as a strength that is supported by existing literature (Levitt & Hiestand, cited by Horne *et al*. 2014). According to a study Su *et al.* (2016:19), lack of self-acceptance on being LGBTI was associated with depressive disorders.

Some participants expressed that the negative societal attitudes affect them which conforms to findings by Meyer (2003:678), which asserts that self-acceptance is impaired by negative attitudes expressed by the society, including friends

3.3.2.3.3 Talking with supportive friends and support groups

Another sub-category linked to the category of coping mechanism is the act of talking to friends and support groups. The participants sounded optimistic when expressing how

having supportive friends and involvement in support groups cushioned against the stressors they endured. This is what they had to say.

P1: Looking for my own house and meeting other LGBT community members as myself to get to get comfort or at least to say I have people with similar characteristics.

P2: Socialise with people who are positive on me; those with positive vibes that can advise that we can sit together and discuss life matters.

P6: I believe in dialogue if at all I have problem. I can talk to my partner or talk to my mom or talk to my friends.

P7: It's very important to have support system that is very solid and well established.

The LGBTI+ community's involvement in support groups and their ties with friends have proven to be helpful to counter risk factors to mental health challenges. A study by Higa *et al*. (2014:14) did demonstrate that peer networks were associated with positive wellbeing for the LGBTI+ community which is consistent with this study findings. As further observed by Daewele *et al.* (cited by Horne *et al.* 2014), LGBTI+ individuals usually experience rejection from their families but find comfort in reliable friends instead of family members. Whilst participants adopt healthy coping mechanisms, there are those that use unhealthy coping mechanisms.

3.3.2.3.4 Unhealthy coping mechanisms

The participants of this study despite using healthy coping mechanisms also shared to the contrary, that they sometimes use substances like smoking cigarettes and drink alcohol to cope with stressors. A substantive number indicated that they drink for social reasons whilst others were adamant that for them they need to drink heavily in order to cope.

P1: It's like when I drink, I get to contain my habit, protect yourself, avoid those who make you sad, avoid those who does this to you. That's it.

P10: There is substance abuse. Substance abuse, drug abuse is common. I think it mainly it's because if you are marginalised or if people cast you aside it's common that you use something to cope replacing social connections or networks with drugs……I have

conditioned my mind that I can't deal with my anxiety without weed (dagga). I have conditioned my mind that I can't talk to people without taking weed.

P12: Yeah, it helped a lot that time because of that stress; if you take a puff you forget about your troubles.

P13: When I am drunk, I get happy. I get to see my problems and feel that I have overcome them.

Some research participants (P1, P2) clearly expressed experiences of having unhealthy coping habits. The research participants express unhealthy coping by smoking of cigarettes, dagga and use of alcohol to cope with challenges and thus are consistent with the existing literature. The findings in the current study conform to a study in the USA which highlighted substance use as strategy to stressors related to gender identity (Felner *et al.* 2020: 118)..

Some research participants expressed smoking cigarettes. Evidence is abounding that smoking cigarettes is higher amongst individuals identifying as LGBT than amongst heterosexual people (Delahanty *et al*. 2019:164). This conforms to the current study findings as smoking amongst the LGBTI+ individuals were expressed. Dagga was also used by some of the participants in the study. According to a study by Buchting *et al.* (2016:4), there was significant use of tobacco use among individuals identifying as transgender which is consistent with the current study findings as P1 and P10 identify as transgender.

There is evidence of increased alcohol misuse amongst individuals identifying as LGBTI+. Another study in New Zealand found that alcohol use among the gender and sexually diverse which include the LGBTI+ individuals was to help them deal with stress and help them socialise which is consistent with what some participants expressed (Adams *et al.* 2021:6-8).

The findings of a study in Ireland demonstrates that being LGBTI was associated with mental health problems like anxiety and depression and not with problematic substance use (Travers *et al.* 2021:5) which contrasts with the current study findings. There is however overwhelming evidence which points to the fact that substance use is a maladaptive coping strategy by the LGBTI+ community. The LGBTI+ community are

susceptible to use substances because of minority stress and thus the need for strategies targeted at this problem.

The strategies to tackle substance use are often facilitated by health care workers hence the need to explore their accessibility to health care services hence the next theme.

3.3.3 Theme 3: Experiences of challenges in accessing healthcare services

The third (3) theme that emerged from the analysis was that of experiences of challenges in accessing health care services. Emotions experienced by the participants were of hurt, anger, frustration regarding access to healthcare. The theme had only one category of avoiding health care services and the sub-categories of experience of insecurity to seek counselling and experiences of having to undress unnecessarily or being asked inappropriate questions.

3.3.3.1 Avoiding healthcare due to stigma

Some research participants expressed their frustrations in accessing healthcare given the predominant stigma in the community, thus avoiding healthcare institutions. Under this category, the sub-categories of experience of insecurity to seek counselling and experiences of having to undress unnecessarily or being asked inappropriate questions will also be discussed and backed with literature control. This is what the participants had to say.

P3: When I need health services I never go to the doors of the hospital unless I know a friend of mine is on duty.

P7: I don't want to put myself in a situation of having to a government clinic and start experiencing controversies. They will start looking at me thinking of how they can help me. I avoid as much as possible to go to a clinic that doesn't have my history.

P11: Because we have lost hope in the medical, mental health system of this country.

P13: When I know that a certain professional once said something that I did not approve, when I find the person, I leave the facility.

Some of the participants expressed that they are not accessing services based on lack of trust on healthcare workers (P3, P13). Furthermore, they expressed misgivings about

going to practitioners that are not conversant with their medical history as well as those that display transphobia and homophobic tendencies as well as inadequate skills to provide LGBTI+ aligned care. The findings in the current study are consistent with a study by Guldal *et al.* (2019: 195) who noted that homosexuals experience homophobia in the healthcare services and on those bases decide not to use them. Another study found that participants had fears of disclosure of their gender identity status to health care professionals (Applegarth and Nuttall 2016:1). It is clear from the current study and existing literature that access to health services by the LGBTI+ community is potentiated by stigma and unavailability of LGBTI sensitive services (Mcnair & Bush, 2016: 1)

Healthcare professionals themselves have prejudicial attitudes towards LGBTI+ community (Ellis *et al*. 2015:1; Muller, 2017:1). Romani *et al.* (2020:240) asserts that being treated based on gender identity is one of the factors that lead to non-use of health facilities. Furthermore, Byne *et al.* (2018: 57), indicate that individuals who are gender diverse often question their health providers' views regarding their gender status. In Botswana, a report by the Southern African Litigation Centre (SALC) (2016:22) highlights those medical personnel have transphobic views and not believing that being transgender is an intrinsic gender identity. The views by SALC are consistent with the findings of this study.

3.3.3.1.1 Experience of insecurity to seek counselling

According to Wilson *et al.* (2014:1), psychotherapies are essential to help individuals attain autonomy and pursue self-identification. In this study however, research participants highlighted adverse issues regarding counselling services. They expressed not being comfortable and being frustrated with going for counselling because the health workers lack confidentiality in the counselling space. Some avoid going for counselling because of judgement by professionals and not knowing what to really expect in counselling. Their views are as reflected below.

P1: I went to seek help for my mental health, and somebody sees me there and goes on to tell people that I am mad.

P3: The next thing after this guy finishes with his counselling, he goes on to tell us about his church and that his prophet can deliver homosexuality so he is inviting us to his church so that we are delivered because we can't be living this kind of lifestyle.

P5: We will be in a relationship and having fights but fail to seek counselling services because we will not be received openly. We will not be treated in the same manner as those from heterosexual relationships.

P11: I am afraid that I might be exposing myself to people who are dangerous and that will increase my vulnerability by telling them that I am trans and they may use this to hurt me.

The findings of the current study highlight damning attitudes by counsellors; that include judging clients and imposing religious views upon clients. The imposing of religious views further substantiates rejection within church context that was discussed earlier in section 3.3.2.3.1. The findings are consistent with a Malaysian study which demonstrated that one of the challenges by counsellors is the expertise limitation of the counsellor and counsellor's values (Jamal, 2018:954). According to Muller (2017:6), individuals identifying as LGBTI+ were subjected to religious views by professionals which is consistent with the current study findings.

The findings highlight the gesture of avoiding counselling by the research participants. The research participants were not keen to access counselling services. Berke *et al.* (2016:1) has contrasting views to the findings as they highlight higher utilisation of psychological services by the LGBTI+ community. This is however a USA based study; with USA and Botswana experiencing different cultural contexts as regards counselling.

Counselling is vital to help LGBTI+ individuals to deal with their challenges. As expressed by some of the individuals identifying as LGBTI+ in Gaborone, Botswana, having no access to counselling services is counterproductive as their mental health challenges are not addressed. The consequence of not seeking counselling due to stigmatisation by healthcare workers include deterioration of the mental health status.

3.3.3.1.2 Experiences of having to undress unnecessarily or being asked inappropriate questions

The last sub-category that is directly under the category of avoiding health care due to stigmatising tendencies is that of experiences of having to undress unnecessarily or being asked inappropriate questions. The participants in a rather disappointed tone indicated how they had to be often asked inappropriate questions that do not relate to what they

have brought to the health facility. The participants saw the whole process as “infuriating, disappointing and gut wrenching”. Furthermore, they are made to undress by the healthcare workers “so that they get to see what it is like to be an individual identifying as LGBTI+”. This is what they had to say:

P1; Am trying to deal with my health and the issue asked by somebody of how we do it? When you have sex, how do you do it? How does it feel when you kiss another man?

P2: You want to go for consultation, they will ask irrelevant questions and postulate why you are transforming yourself into a woman, yet you are male.

P11: When I access services like HIV/AIDS prevention and care, the nurses at the clinic and hospital in our city, are very rude and ask lots of unnecessary and very uncomfortable questions…….They choose the path of mostly asking uncomfortable questions like what is between your legs, which at the time is completely unrelated or unnecessary because I want to be treated for headache and they will ask me what is in between your legs.

P13: “Once they realize that it’s the first time to meet a certain condition, they will want to see. Even if you have brought headache, they undress you so that they see.”

The research participants expressed disappointment at being asked questions that are irrelevant to the health status that has brought them to the health facility.

Similarly, they are often asked to undress during physical examination even when there is no basis to do so. The current study findings are consistent with a study by Ellis *et al.* (2015:1), who indicated that there can be intrusive and unnecessary questioning by health care practitioners when dealing with some transgender individuals which adversely leads to minority stress. In a study conducted by Zway and Boonzaaier (2015:15) in the Western Cape Province, South Africa, teachers were reported to tell learners to undress for the same reason. The minority stressor in this context is the experience of prejudicial event of undignified, intolerant health assessment.

Experiences of having to undress unnecessarily or being asked inappropriate questions aggravates the feelings of indignity among the LGBTI+ community. The feeling of not being valued and respected can adversely affect the mental health of the LGBTI+ and

contribute immensely to them not accessing health services which may also be counterproductive as there may be other social challenges they experience.

3.3.4 Theme 4: Social challenges of everyday life

The fourth (4) theme to be discussed is the social challenges that the LGBTI+ individuals experience in everyday day life. The main category is the experience of problems related to identity and several sub-categories that include hormone treatments and gender affirming treatments, difficulty in affording expenses related to gender affirming treatments as well as the frustration in managing romantic relationships are also discussed.

3.3.4.1 Problems related to issues of identity

Research participants indicated being stressed by gender markers in the identity card that do not conform to the gender identity they identify with. The participants voiced frustrations and anger at being questioned by the police and stripped off naked to verify if it is them because of their physical changes after transitioning. Below is what the participants had to say:

P4: When people or it can start raising eyebrows when I provide my identity card because. people become curious as to why is your identity card written male even though I see a woman standing in front of me.

P7: I am a true man that has beard and everything, and everything unfortunately my identity documents indicate I am a female.

P8: I went to seek medical attention I found some woman who took my ID and insisted that she wants to see the owner of the ID; she went on to show other nurses and they were laughing, and they came to me. It was uncomfortable and I left without being assisted.

P10: Like identity document change for instance 'I have an ID and my ID says I am female. If you look at me, I will look different from what my ID says. Identity document change is one of the mental health challenges that we experience. I don't know whether you want me to go on.

P12: Aah, others address me as a female, when they check the ID, they realise that I am not female.

A study in Massachuttes by Restar *et al.* (2020:6) found that legal tender affirmation among transgender people was positively linked to reduction in mental health problems like depression and gender mistreatment. Another study in the USA established that those who had their identity documents aligning with gender they identify with had lower prevalence of serious psychological stress (Scheim *et al.* 2020: e201).

As highlighted by a report by the SALC and LEGABIBO (2020: 8), identity documents are part of the day-to-day requirements in many dealings for services, and that leaves the transgender individuals compromised if they do not have an identity document that suits that preferred gender and name. This is consistent with the findings in the current study as the research participants expressed challenges with the identity documents. As an example, some of the participants were expected to produce documents at police road blocks and during job applications.

The issue of a proper gender marker on the identity card that aligns with the preferences of a transgender individual have been significantly reported to improve mental health. Having a proper gender marker in the identity card is a protective factor against mental health challenges.

The discussion on the sub-categories of hormone treatments and gender affirming surgery, difficulty in affording expenses related to hormone treatments and frustration in managing romantic intimate relationships follows.

3.3.4.1.1 Hormone replacement therapy

Research participants indicated that they were undergoing hormonal replacement therapy (HRT) for a variety of reasons. To some participants it was essential as it improved their mental health. The participants also indicated challenges with accessing the HRT in government facilities. The participants further voiced frustration at not being able to get HRT from public health facilities due to lack of knowledge on its provision by health care workers. This is what they had to say:

P4: It (HRT) is not offered in government facilities, you see?

P4: But I was given a letter that indicated I can go for government services. Eish, they are not aware of how to assist because they keep on telling me different things.

P7: As much as we differ, for some of us that are transitioning medically our mental health improves compared to before transition.

P8: There are times that I am fine but when hormones are low, I feel low as well.

The transgender individuals undergo HRT to alleviate the discrepancy between the biological sex and their preferred gender (Unger, 2016: 884). In the context of this study, transgender and intersex individuals were the ones who had enrolled for HRT.

The participants shared the experiences of their renewed hope and positive satisfaction brought up by HRT. A review article by Unger (2016:877) also highlighted the positive physical and mental effects that are derived from hormone therapy. Collizi *et al.* (cited by Unger, 2016:885) further posits that perception of stress was reduced in individuals who enrolled in HRT in Italy which is consistent with the findings of the current study. Another Italian study by Fisher *et al*. (2016:4267) highlighted the importance of HRT as those who were on treatment reported improved psychological health as they were more content with their bodies which can improve their self-esteem.

The participants highlighted that hormone treatment is not available in government facilities forcing them to buy it from private facilities. This contrasts with a report by the Southern African Litigation Centre (2016:22) which highlights that hormonal therapy is available at government and issued at the discretion of the medical personnel.

HRT is essential to affirm the gender of transgender individuals who are eager to transition. It is however a challenge for individuals to access HRT in Botswana as it not easily accessible and this can adversely affect the mental health outcomes of those that cannot access it.

3.3.4.1.2 Difficulty in affording expenses related to HRT

Participants had some emotional distress attributable to the access to HRT. The fact that the participants do not get HRT from government facilities was frustrating as they had no resources to get it in private facilities. One participant expressed that they spend a lot and

go to the extent of sex work in order to have money for HRT. Below is some of their verbatim quotations.

P2: I speak for transgender women and trans men. They need hormonal replacement tablets, but they are expensive.

P9: It really gives me stress. It is like we are not doing anything for ourselves, we are always thinking of hormonal therapy; there is nothing you can do for yourself, you can't buy yourself anything.

P10: Because currently in Botswana transgender people change through medicine, it is costly. Those things, you can go for three months without taking them because you are broke. When you don't take testosterone, it brings hormonal imbalance.

P11: The thing is, when you can't access HRT services in the country, I have realised gore we resort to sex work. Because sex work is criminalised, is unsafe, we are not able to get condoms and all of those, we engage in survival sex work which is unsafe and contract HIV to pay for HRT in private institutions……We use a lot of money because we are not getting it from the government…it is not affordable and sustainable.

Accessing gender affirming hormones is a problem that is experienced worldwide. A study by Haire *et al*. (2021:7) showed that the participants had challenges in accessing hormones. Furthermore, a German study by Guethlein *et al.* (2021:6) also highlighted significant challenges in integrating the transgender community into the medical system. This is consistent with the findings of the current study as cost is an impairment to accessibility of HRT.

Economic hardship was expressed by those that use HRT. Having to fend on their own created substantial challenges which is like a study by Haire *et al. (*2021:8). Furthermore, participants were not in fulltime work and had financial challenges which proven to be a barrier to access of healthcare services (Haire *et al*. 2021:1). Some participants highlighted involvement in sex work to deal with issue of cost of HRT (P11).

It emerged from the discussions that the transgender individuals cannot afford costs to pay for costs of HRT at private facilities. This adds to the mental health challenges of the transgender individuals and thus the need to investigate policies regarding HRT access.

3.3.4.1.3 Frustration in managing romantic and intimate relationships

The discussion on the theme social challenges of everyday life with particular focus on the sub-category of frustration in managing romantic and intimate relationships which is directly related to the issue of identity documents. The research participants verbalised disappointment, sadness and frustration when expressing views on relationships. The participants described having relationship problems with establishing relationships. This what they had to say.

P1: Somebody will get attracted to me and show love to me, the same society they are going to take him back from me. They will tell him unpleasant news. Telling him about being a faggot and this and that.

P4: My boyfriend, this is his very first relationship with a trans gender woman, He is still learning a lot of things and he is still learning my comfortability with my genitals or my private parts.

P7: Irrespective of being trans or gay, relationship is a relationship as we have the same problems.

P10: So it's really difficult to find a partner who is not within the LGBTI; because some people are clueless or ignorant and only people know of gays and lesbian when you talk of trans they don't know.

P13: When I am having sexual intercourse, I am not free; not knowing what I will tell my partner as to what that is.

The participants shared several problems relating to their relationships. The findings are consistent to those of a USA based study by Macapagal *et al*. (2015:11) which noted that that LGBTI identities facilitated some stresses in particular relationships. Another study in the same context, emphasises that relationships can cushion against mental illnesses (Whitton *et al.* (2020:11). The study highlighted that compared to those who were single, the sexual and gender minorities who were in romantic relationships had fewer symptoms of depression and anxiety.

The participants mostly identifying as transgender expressed challenges of partners getting to know them and others preferring to have partners within the LGBTI+ community

for fear of being judged by cisgender partners. According to Marshall *et al.* (2020:373), transitioning can bring about challenges to both the transgender person and the partner. Mao *et al.* (2018) observed that transgender individuals were considered less attractive in comparison to cisgender counterparts which could explain some of the problems they encounter with relationships. As highlighted by Hendricks and Testa (2012: 463), relationships amongst transgender individuals are hugely impacted by minority stressors.

Participants who identify as intersex also had their own share of challenges. They concealed their gender and one participant (P13) had to even implant fake breasts and had sex in the dark so that partner doesn't get know of her being intersex. Below is what P13 expressed on the issue.

P13: Yeah, the other thing is that I can't undress when my partner is watching. I switch off lights first, and I sleep with some clothes on top because I have faked my breasts. You see?

The current study findings and existing literature point out that relationships' problems among the transgender and intersex population lead to negative mental health outcomes which can be aggravated further by people not being familiar with transgender identities

3.3.4.1.4 People not familiar with transgender identities

In the unstructured interview it was apparent that community members were not familiar with transgender identities which is an issue directly related to the identity document. The participants mostly voiced frustration and were emotionally charged with high pitched voice when they expressed this. This is what the participants had to say:

P1: To make it worse is when you are in Botswana, most people won't even know what trans people are, you see.

P8: At first they thought I am just a gay person, so they were fine with gay because our hood was full of gays back then. It was fine, and I transitioned to be a woman and people started being nasty, discriminative and they started to have this hatred towards me.

P9: They don't know. They see me as a cisgender man.

P11: People were not aware of transgender people, and they were having nasty reactions towards trans people.

The knowledge deficit regarding transgender people is consistent with global views as research on public opinion amongst the transgender highlighted that 26.1 % in America indicated that they have never encountered or known transgender people (Luhur *et al*. 2019:4). Muller (2017:6) also notes that there is lack of knowledge about LGBT identities and health needs which is consistent with findings of the current study.

People are mostly not aware of the existence of the transgender people which is emotionally distressing for them. The lack of knowledge about the transgender community aids in people discriminating and stigmatising them as participants expressed being discriminated upon and being pelted with abusive words. As highlighted by Jobson *et al.* (2012:160), the issue of the society not being unfamiliar with the transgender people can be arguably linked to the fact that there is increased violence and victimisation resulting in the transgender individuals not coming in the open especially in the African context.

A study by McConnell *et al.* (2016: 7) disputes the findings as it established that having knowledge on LGBTI+ communities enhances support and reduces rejection by parents. This highlights how critical knowledge on the transgender individuals is important for their well-being. Using the findings and literature as a basis, the researcher concludes that lack of familiarity with transgender individuals aggravates stigma and discrimination and impairs their accessibility to health care services.

3.4 Conclusion

The chapter gave an account of the research findings and literature integration. The findings of this study described the mental health challenges that the LGBTI+ community experience. Verbatim quotations enriched the discussion on the mental health challenges as well as the field notes. The next chapter will discuss the conclusions, limitations, and recommendations of the research in nursing education, nursing research and nursing practice.

CHAPTER 4 CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

4.1 Introduction

The previous chapter highlighted the findings of the study regarding mental health challenges experienced by the LGBTI+ community. The aim of the study was to explore and describe the mental health challenges of the LGBTI+ community in Gaborone and how these challenges affect their mental health. Verbatim quotations extracted from the transcriptions were put forth to support the findings. This chapter will make conclusions on the findings, address limitations of the study and make recommendations which will be specific to nursing practice, nursing education as well as nursing research.

Following data analysis, four (4) themes were identified after 15 unstructured interviews with those identifying as LGBTI+. The themes were extensively discussed in Chapter 3. The conclusions seek to provide meaning on the mental health challenges experienced by the individuals identifying as LGBTI+ and how those challenges affect their mental health. The conclusions on major themes will be discussed as below.

4.2 Conclusions drawn from the findings

The study showed that there are rampant mental health challenges among some of the members of LGBTI+ community. The mental health challenges that were highlighted include experiences of depression, gender dysphoria, loneliness and isolation.

LGBTI+ participants also experienced emotions such as hurt, anger, frustration, stress, anxiety, being overwhelmed, embarrassment, sadness, worried, aggression and trauma which affirms the challenges they were experiencing. Of these, fear and anxiety are the most prominently experienced by individuals. It could therefore be concluded that the LGBTI+ individuals experience mental health challenges like depression, gender dysphoria, loneliness, and isolation as well as low self-esteem.

LGBTI+ individuals do use healthy coping mechanisms like exercise, playing sports, talking with support groups and friends, and having self-acceptance of their gender identity and sexual orientation augurs well for their mental health. There is however other LGBTI+ individuals who use unhealthy coping like substance use which end up worsening

their mental health. It could therefore be concluded that the mental health challenges for the LGBTI+ community are influenced by factors like experiences of stigma and discrimination, being misgendered and poor coping mechanisms to deal with the challenges.

Stigma and staff attitudes of healthcare workers contribute to individuals identifying as LGBTI+ avoiding health services due to the attitude displayed by health professionals. It could be concluded therefore that some individuals identifying as LGBTI+ experience challenges with accessing health services and avoid accessing facilities due to stigma from healthcare professionals.

The findings and literature highlight that some individuals identifying as transgender and intersex have social challenges that impact on their mental health. Individuals identifying as transgender have challenges with gender markers that are not aligned to the gender preferences and do not have access to HRT as they must get it from the private as it is not provided in the government system. This adversely affects their mental health. The researcher could then conclude that individuals who identify as transgender and intersex have problems related to issues of identity which adversely affect their mental health

Overall, this study has notable strengths as it has established the mental health challenges of some of the members of the LGBTI+ community in Gaborone, Botswana. The research aim and objectives were to explore and describe the mental health challenges of the LGBTI+ community in Gaborone as well as how these challenges affect their mental health. Based on the findings it can be generally concluded that the aim and objectives of this study were achieved. The Minority stress theory which was the theoretical framework was supported by the findings.

4.3 Limitations

The identified limitations are as follows;

- COVID-19 was a major challenge for the study. The researcher had to change from qualitative face-to face un-structured interviews to a telephonic interview through which non-verbal cues of the research participant could not be observed. Given the sensitivity of the type of participants, it would have yielded richer results

to have observed their behaviour and emotional reaction during the interview. These could only be heard by the researcher which also limited the field notes.

- There are several groupings within the LGBTI+ community which complicated the data analysis because of varying challenges even though there were common universal needs. The study would have yielded more results had it focused on a particular grouping and explored their specific challenges.

4.4 Recommendations for nursing education, practice and nursing practice

Based on the research findings, literature and conclusions, the following recommendations pertaining to nursing education, nursing research and nursing practice are made:

4.4.1 Recommendations for nursing education

- Nursing education should aim to incorporate LGBTI+ health concepts into the nursing curriculum to improve nurse attitudes and knowledge on the LGBTI+ community.
- Nurses should be given training on LGBTI+ affirming care so that they may offer culturally sensitive care. The training should include the important use of pronouns, the dangers of misgendering the LGBTI+ clients.

4.4.2 Recommendations for nursing research

- More research should be done in the local context to explore the mental health challenges on specific groupings within the LGBTI+ community. The focus of the studies could be on the transgender and the intersex communities which from the reflections of the study are more vulnerable to mental health challenges than the rest of the groupings.
- Research could be done to explore the knowledge, skills, attitudes of nurses about nurses who render care to individuals identifying as LGBTI+ in Botswana.
- There is need for research exploring the LGBTI+ curricular content of nursing programmes.
- More research should be done to explore coping strategies of the LGBTI+ community.

4.4.3 Recommendations for nursing practice

- As expressed by some participants, lack of accessibility to health services contribute to poor mental health thus accessibility to services of the LGBTI+ community should be improved.
- Provision of LGBTI+ aligned healthcare. This could be done by proper use of pronouns and reduce the advent of micro-aggressions that are often directed at the LGBTI+ community unconsciously by the LGBTI+ community.
- Avail specialised services inclusive of nursing and counselling for the LGBTI+ community to addressing the issue of accessibility to health services.
- Capacitate nurses on HRT to address the knowledge deficit that was highlighted by several of the participants.
- Change policy framework to allow for provision of HRT in several health facilities.

4.5 Conclusion

The aim of the study was to explore and describe mental health challenges of the LGBTI+ community in Gaborone, Botswana and how these affect their mental health. It is clear from the findings that there is need to improve mental health outcomes of the LGBTI+ community. Comprehensive recommendations that are likely to improve accessibility to health services and reduce stigma and discrimination were suggested.

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ANNEXURE A: NWU-ETHICAL CLEARANCE

Private Bag X1290, Potchefstroom
South Africa 2520

Tel: 086 016 9698
Web: http://www.nwu.ac.za/

North-West University Health Research Ethics Committee (NWU-HREC)

Tel: 018 299-1206
Email: Ethics-HRECApply@nwu.ac.za (for human studies)

20 June 2021

ETHICS APPROVAL LETTER OF STUDY

Based on approval by the North-West University Health Research Ethics Committee (NWU-HREC) on 21/06/2021, the NWU-HREC hereby approves your study as indicated below. This implies that the NWU-HREC grants its permission that, provided the general conditions specified below are met and pending any other authorisation that may be necessary, the study may be initiated, using the ethics number below.

Study title: Mental health challenges among the Lesbian, Gay, Bisexual, Transgender and Intersex community in Gaborone, Botswana
Principal Investigator/Study Supervisor/Researcher: Prof ME Manyedi
Student: DS Mangwegape - 34348875

Ethics number:

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Institution				Study Number						Year			Status	

Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation

Application Type: Single study
Commencement date: 20/06/2021
Expiry date: 30/06/2022

Risk: **Medium**

Approval of the study is provided for a year, after which continuation of the study is dependent on receipt and review of an six-monthly monitoring report and the concomitant issuing of a letter of continuation. Monitoring reports are due at the end of February and June annually until completion.

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, the following general terms and conditions will apply:

- *The principal investigator/study supervisor/researcher must report in the prescribed format to the NWU-HREC:*
  - *six-monthly on the monitoring of the study, whereby a letter of continuation will be provided annually, and upon completion of the study; and*
  - *without any delay in case of any adverse event or incident (or any matter that interrupts sound ethical principles) during the course of the study.*
- *The approval applies strictly to the proposal as stipulated in the application form. Should any amendments to the proposal be deemed necessary during the course of the study, the principal investigator/study supervisor/researcher must apply for approval of these amendments at the NWU-HREC, prior to implementation. Should there be any deviations from the study proposal without the necessary approval of such amendments, the ethics approval is immediately and automatically forfeited.*
- *Annually a number of studies may be randomly selected for active monitoring.*
- *The date of approval indicates the first date that the study may be started.*
- *In the interest of ethical responsibility, the NWU-HREC reserves the right to:*
  - *request access to any information or data at any time during the course or after completion of the study;*
  - *to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process;*

- *withdraw or postpone approval if:*
  - *any unethical principles or practices of the study are revealed or suspected;*
  - *it becomes apparent that any relevant information was withheld from the NWU-HREC or that information has been false or misrepresented;*
  - *submission of the six-monthly monitoring report, the required amendments, or reporting of adverse events or incidents was not done in a timely manner and accurately; and/or*
  - *new institutional rules, national legislation or international conventions deem it necessary.*
- *NWU-HREC can be contacted for further information via Ethics-HRECApply@nwu.ac.za or 018 299 1206*

Special conditions of the research approval due to the COVID-19 pandemic:

Please note: Due to the nature of the study i.e. (online collection of qualitative data via in-depth unstructured individual interviews with LGBTI+ individuals from Botswana), this study will be able to proceed during the current alert level, following receipt of the approval letter. No additional COVID-19 restrictions have been placed on the study except that the researcher must ensure that before proceeding with the study that all research team members have reviewed the North-West University COVID-19 Occupational Health and Safety Standard Operating Procedure.

The NWU-HREC would like to remain at your service and wishes you well with your study. Please do not hesitate to contact the NWU-HREC for any further enquiries or requests for assistance.

Yours sincerely,

Digitally signed by
Prof Petra Bester
Date: 2021.06.22
12:20:49 +02'00'

Chairperson NWU-HREC

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20 August 2019
File Reference: 9.1.5.4.2

ANNEXURE B: MINISTRY OF HEALTH AND WELLNESS ETHICAL CLEARANCE

PRIVATE BAG 0038
GABORONE
BOTSWANA
REFERENCE:

TEL: (+267) 363 2500
FAX: (+267) 391 0647
TELEGRAMS: RABONGAKA
TELEX: 2818 CARE BD

REPUBLIC OF BOTSWANA

MINISTRY OF HEALTH AND WELLNESS

REFERENCE NO: HPDME 13/18/1 **31 March 2021**

Health Research and Development Division

Notification of IRB Review: **New application**

David Sidney Mangwegape
P O Box 309
Lobatse

Dear David Sidney Mangwegape

Protocol Title: MENTAL HEALTH CHALLENGES AMONG THE LESBIAN, GAY, BISEXUAL, TRANSGENDER AND INTERSEX COMMUNITY IN GABORONE, BOTSWANA

HRDD Approval Date:	31 March 2021
HRDD Expiration Date:	30 March 2022
HRDD Review Type:	Expedited Review
HRDD Review Determination:	Approved
Risk Determination:	Minimal risk

Thank you for submitting new application for the above referenced protocol. The permission is granted to conduct the study.

This permit does not however give you authority to collect data from the selected sites without prior approval from the management. Consent from the identified individuals should be obtained at all times.

The research should be conducted as outlined in the approved proposal. Any changes to the approved proposal must be submitted to the Health Research and Development Division in the Ministry of Health for consideration and approval.

Furthermore, you are requested to submit at least one hardcopy and an electronic copy of the report to the Health Research, Ministry of Health and Wellness within 3 months of completion of the study. Approval is for academic fulfillment only. Copies should also be submitted to all other relevant authorities.

Continuing Review
In order to continue work on this study (including data analysis) beyond the expiry date, submit a Continuing Review Form for Approval at least three (3) months prior to the protocol's expiration date. The Continuing Review Form can be obtained from the Health

Research Division Office (HRDD), Office No. 7A.7 or Ministry of Health website: www.moh.gov.bw or can be requested via e-mail from Mr. Kgomotso Motlhanka, e-mail address: kgmmotlhanka@gov.bw As a courtesy, the HRDD will send you a reminder email about eight (8) weeks before the lapse date, but failure to receive it does not affect your responsibility to submit a timely Continuing Report form

Amendments

During the approval period, if you propose any change to the protocol such as its funding source, recruiting materials, or consent documents, you must seek HRDC approval before implementing it. Please summarize the proposed change and the rationale for it in the amendment form available from the Health Research Division Office (HRDD), Office No. 7A 7 or Ministry of Health website: www.moh.gov.bw or can be requested via e- mail from Mr. Kgomotso Motlhanka, e-mail address: kgmmotlhanka@gov.bw . In addition submit three copies of an updated version of your original protocol application showing all proposed changes in bold or "track changes".

Reporting

Other events which must be reported promptly in writing to the HRDC include:

- Suspension or termination of the protocol by you or the grantor
- Unexpected problems involving risk to subjects or others
- Adverse events, including unanticipated or anticipated but severe physical harm to subjects.

If you have any questions please do not hesitate to contact Mr. K. Motlhanka at kgmmotlhanka@gov.bw, Tel +267-3632751. Thank you for your cooperation and your commitment to the protection of human subjects in research.

Yours sincerely

Dr. P Masokwane
for /PERMANENT SECRETARY

MINISTRY OF HEALTH AND WELLNESS
RESEARCH DIVISION
31 MAR 2021
P/BAG 0038
GABORONE
REPUBLIC OF BOTSWANA

ANNEXURE C: GOODWILL REQUEST TO LEGABIBO

D.S Mangwegape

P O Box 382

Thamaga

19th February 2021

The Chief Executive Officer

LEGABIBO

P O Box 550430

Mogoditshane

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

I, David Sidney Mangwegape, the undersigned, is a part-time Master's degree in Psychiatric Community Nursing student at NUMIQ Research Focus Area at the North-West University, Potchefstroom campus. The title of the study is "***Mental health challenges among the Lesbian, Gay, Bisexual, Transgender and Intersex community in Gaborone, Botswana***." The aim of the study is to explore and describe the mental health challenges of the LGBTI+ community in Gaborone and how these challenges affect their mental health. The study will use a qualitative phenomelogical approach.

This serves to request permission to conduct the research using your facilities and having some of your members as research participants. The study procedure will involve you identifying a mediator whom will in turn help identify a participant who meet the eligibility criteria. After the gatekeeper has appointed the mediator he/she will then be contacted telephonically to be orientated about the study so that he/she could be trained on how to execute the recruitment process. The telephonic conversation will be followed by an email that contain all the information about the study. He/she will also be made to sign the confidentiality agreement. Those who have been identified and willing to consent to the study will help refer others.

As new potential participants are referred to the mediator he/she will give their contact information to the independent person for the consent process. The independent person will be appointed by the gatekeeper and will preferably be someone neither acquainted to the LGBTI individuals nor the researcher himself. His/her role will be mainly to facilitate the informed consent process. The whole process will be undertaken by means of social media, e-mails or text messages according to the means of communication preferred by potential participants.

Permission will also be requested from the participants for voice recording of the in-depth unstructured interviews that will be done telephonically. Confidentiality will be ensured by ensuring that the co-coder, the mediator and the independent person sign confidentiality agreements. In addition, the data obtained from the interview will be coded in order to avoid the information to be traced to participants. The transcribed data will be saved in a computer encrypted with a password.

The inclusion criteria for the study is that it will only include individuals identifying as LGBTI+ who are above the age of 18 years. The individuals should be staying in Gaborone and have disclosed their identity to your organisation.

The participation in the research by the participants will afford them the opportunity to share life experiences, vent out and reflect. There is medium risk of psychological discomfort that may occur as individual may relive bad experiences resulting in anxiety, emotional discomfort and anger. A clinical psychologist will be on standby to assist participants who have emotional discomfort during the interview process.

The organisation will be furnished with the final research report. In addition, the participants will be personally informed of the results of the study. Attached is the research proposal and the university provisional ethical clearance.

If you have any questions or concerns about the study, feel free to contact me at the following number: +26772367336/74077436 or via email (siddavman@gmail.com).

Yours faithfully

David Sidney Mangwegape

ANNEXURE D: GOODWILL PERMISSION FROM LEGABIBO

LESBIANS, GAYS AND BISEXUALS OF BOTSWANA
P O BOX 550430 Mogoditshane, Botswana
Tel: +267 316 7425 Fax: +267 316 7466
Email: legabibo@legabibo.org

16 April 2021

D.S Mangwegape
P O Box 382
Thamaga

Dear Mr Mangwegape

RE: GOODWILL PERMISSION TO CONDUCT RESEARCH

Reference is made to your later dated 19th February 2021. You are hereby granted permission and support to conduct the study titled "***Mental health challenges among the Lesbian, Gay, Bisexual, Transgender and Intersex community in Gaborone, Botswana.***"

We will also accordingly assist in identifying a mediator whom will in turn help identify research participants who meet the eligibility criteria. You may also use our facilities in the signing of consent forms as proposed.
Kindly provide us with a research report upon completion of the study.
We wish you success in your studies and looking forward to the findings which may aid in our advocacy for the plight of the LGBTIQ community.

Yours faithfully

Botshelo Moilwa
Health and Wellness Manager

ANNEXURE E: CONSENT FORM-SETSWANA

Private Bag X1290, Potchefstroom
South Africa 2520
Tel: +2718 299-1111/2222
Fax: +2718 299-4910
Web: http://www.nwu.ac.za

NWU-HREC Approval Date: 2021.06.20 13:50:05 +02'00'

NWU-HREC Stamp

MOKWALO YO O THUSANG BA BA RATANANG KA BONG KANA BA NA LE TLHAKANELO DIKOBO E E PHAROLOGANYO GO TSAYA TSHWETSO

SETLHOGO SA DIPATLISISO: Dikgwetlho tsa botsogo jwa thaloganyo mo bathong ba ba ratanang ka bong, le baba nang le keletso ya tlhakanelo dikobo e e pharologanyo

ETHICS REFERENCE NUMBER: NWU-00396-20-A1

MMATLISISI MOGOLO: Prof E. Manyedi

MOITHUTI: D.S Mangwegape

ADDRESS: North-West University, Mafikeng Campus, School of Nursing

CONTACT NUMBER: +26772367336

O lalediwa go tsaya karolo mo **dipatlisisong** tse e leng karolo ya dithuto tse dikgolwane tsa Masters mo booking jwa botsogo jwa tlhaloganyo.

Tsaya nako go bala mokwalo o, yo o tlhalosang ka dipatlisiso tse. Botsa motho yo o tlhalosang ka dipatlisiso tse dipotso fa o sa tlhaloganyeng ka teng. Go botlhokwa go tlhaloganya pele o ka tsaya tshwetso ya go nna karolo ya dipatlisiso. Tlhaloganya fa o na le boikgethelo jwa go tsaya karolo kana nnyaa. Fa o sa tseye karolo, ga o na go amega ka tsela epe. E re le fa go ntse jalo, o na le boikgethelo jwa gore e re dipatlisiso di tsweletse o tswe le fan ne o ntse o laotse gore o tsaya karolo.

Dipatlisiso tse, di letleletswe ke komiti ya Health Research Ethics Committee mo lephateng la Botsogo la Unibesithi ya North-West. Dipatlisiso tse di tla tsamaisiwa ka fa tlase ga molao wa lephata la Botsogo mabapi tsamiso e e maleba ya go dira dipatlisiso ka ditsetla tsa 2015 tsa lephata la Botsogo.

1 Dipatlisiso ke ka ga eng?

- Dipatlisiso tse di tla direlwa mo Gaborone mme di akaretsa ba ba ratanang ka bong, le baba nang le keletso ya tlhakanelo dikobo e e pharologanyo. Baitseanape ba dithutego tse di maleba batla tsamaisa dipatlisiso.
- Re eletsa go sekaseka dikgwetlho tsa botsogo jwa thaloganyo mo batho ba ba ratanang ka bong, le baba nang le keletso ya tlhakanelo dikobo e e pharologanyo. Maikaelo a matona ke go tsaya tsaya tlhaloso ka maitemogelo a bone.

2 Ke eng o lalediwa mo dipatlisisong?

- O akareditswe ka o le motho yo o ratanang le ba bong jaaka wena kana, le o na le keletso ya tlhakanelo dikobo e e pharologanyo.
- O na le dingwaga di le lesome le borobabobedi gape o nna mo Gaborone.
- O boleletse mokgatlho wa LEGABIBO fa o mongwe wa ba ba nang le pharologanyo mo tlhakanelong dikobo.
- O kgona go bua sekgoa kana Setswana.

3 Karolo ya gago ke eng mo go se?

- O solofelwa fa o tla arogana maitemogelo a gago mo potsolosong ya sebaka sa metsotso e le masome a marataro ee tla dirwang ka mogala. Potsoloso e tla be e gatisiwa ka tetla ya gago.

4 Ke eng se se ka go boelang mo dipatlisisong tse?

- Ga gona poelo e tsepameng mo dipatlisisong tse mme o tla kgona gonna le sebaka sa go ntsha mahatlha a gago le maitemogelo a gago.
- Maduo a dipatlisiso a ka thusa go mo go tsa tsamaisomabapi le tlhokomelo ya batho ba ba ratanang ka bong, le baba nang le keletso ya tlhakanelo dikobo e e pharologanyo.

5 A gona le bodiphatsa mo dipatlisisong le gore di ka hemiwa jang?

- Dipotsoloso fa go dirwa dipatlisiso di ka kgobera maikutlo fa motsayakarolo a botsoloswa. Go ka nna le tshakgalo kana kutlobotlhoko fa motsayakarolo a ntsha mahatlha a gagwe. O tla sidilwa maikutlo ke yo o rutetsweng go sidila maikutlo go fokotsa tlhakatlhakano ya maikutlo.
- Batho ba ba ratanang ka bong, le baba nang le keletso ya tlhakanelo dikobo e e pharologanyo ba tshabelelwa ke kgetholo ka jalo ba tla sirelediwa thata ka go seke go ntshiwe maina.
- Dipatlitliso tse di boela thata gona le bodiphatsa.

6 Go tla dirwa jang go dibela sephiri sa maduo a dipatlisiso?

- Ke netefatsa fa nna le baeteledipele bame Proff Eva Manyedi le Rre Boitumelo Molato re tla dibela sephiri sa dipuisano. Ga rena go supa maina a gago mo mokwalong wa dipatlisiso. Maduo a puisanyo e e tla bo e tsewa ka sekapamantswe a tla sireletswa ka go lopa batlhotlhomisi botlhe go ikana. Maduo a puisanyo a tla bewa fa go sireletsegileng a ba a tsenngwa mo sebalamakgolo go fitlhela ngwaga tse tlhano. Sepe fela se se mo sekapamantsweng se tla sutlhwa morago ga selekanyo sa ngwaga tse tlhano.

7 Go tla diragalang ka maduo a dipatlisiso?

- Maduo a tla tsenngwa mo mokwalong wa dipatlisiso gape a kgaoganwe le batlhotlhomisi babangwe ka mekwalo.
- Maduo a tla dirisediwa dipatlisiso tse di le nosi fela.

8 Re ka itse jang maduo a dipatlisiso?

- Le tla fiwa maduo a dipatlisiso fa di feletse.
- Motlhotlhomisi o tla le itsise ka sepe fela se se maleba mo dipatlisisong.

9 A go na le dituelo dingwe kana ditshenyegelo tse di go amang?

- Ga gona dituelo dipe ts go tsaya karolo mo dipatlisisong
- Ga o na go nna go nna le ditshenyegelo dipe fa o tsaya karolo.
- Ditshenyegelo tsa mosepele di tla duelwa ba ba tlang mo diofising tsa LEGABIBO go tla go baya monwana mo go tseneleleng dipatlisiso
- Puisanyo e ya go tsaya sebaka sa masome a marataro a metsotso.
- Ga o na go nna go nna le ditshenyegelo dipe fa o sa tseye karolo.

10 A go na le sengwe se o batlang go se itse?

- Fa go na le mathata kana dipotso, o ka ikgolaganya le Proff. Manyedi mo 0822020424 kana eva.manyedi@nwu.ac.za, kgotsa Mr Molato mo 0827426401 kana boitumelo.molato@nwu.ac.za, le Mr Mangwegape mo +26772367336 kana siddavman@gmail.com
- Oka ikgolaganya le komiti ya Health Research Ethics Committee ka mme Carolien van Zyl ka mogala wa 018 299 1206 kana carolien.vanzyl@nwu.ac.za fa o sa tlhaloganye sengwe kana o na le ngongora ka dipatlisiso tse.
- O tla fiwa mokwalo o le pampitsahana ye o tla ikannang mo go yone.

Maitlamo a motsayakarolo

Ka go baya monwana, ke le..... ke dumalana le tsaya karolo mo dipatlisisong tsa go **sekaseka dikgwetlho tsa botsogo jwa tlhwaloganyong mo bathong ba ba ratanang ka bong, le baba nang le keletso ya tlhakanelo dikobo e e pharologanyo mo Gaborone**.

Kei kana gore:

- Ke badile se ka puo e ke e tlhaloganyang.
- Mongwe wa ba dipatlisiso o ntlhaloseditse mabapi le se.
- Ke nnile le sebaka sa go botsa dipotso mm eke arabilwe.
- Ke tlhaloganya fa ken a le boikgethelo jwa go tsaya karolo kana nnyaa gape ga ke a patelediwa.
- Ke tla kgetha go tswa mo dipatlisisong ka nako nngwe le nngwe mme ga ken a go tsewa ka mokgwa ope
- Ke ka nna ka kopiwa go tswa mo dipatlisisong pele di fela, fa e le gore mmatlisisi o laola jalo kana ke sa sala tsamaiso morago.

Tshaeno (*lefelo*) ..... on (*letsatsi*) ..... 20....

....

Sekano sa moitlami **Sekano sa mosupi**

Maitlamo ka yo o tsayang tetla

Ke le *(leina)* ..... ke itlama gore:

- Ke tlhalositse mabaka a a mo mokwalong o ko go.....
- Ke dirisitse/ga ke a dirisa motoloki.
- Ke mo rotloeditse go botsa dipotso le go mo kgothatsa go tsaya nako go di araba.
- Ke kgotsofeste fa a tlhalogantse se se kwadilweng fa godimo.
- K emo file sebaka sa go buisanya le ba bangwe ka kgang e fa a na le keletso.

Tshaeno (*lefelo)* ..... ka (*letsatsi*) ..... 20....

....

Sekano ka yo o tsayang tetla **Sekano sa mosupi**

6 Go tla dirwa jang go dibela sephiri sa maduo a dipatlisiso?

- Ke netefatsa fa nna le baeteledipele bame Proff Eva Manyedi le Rre Boitumelo Molato re tla dibela sephiri sa dipuisano. Ga rena go supa maina a gago mo mokwalong wa dipatlisiso. Maduo a puisanyo e e tla bo e tsewa ka sekapamantswe a tla sireletswa ka go lopa batlhotlhomisi botlhe go ikana. Maduo a puisanyo a tla bewa fa go sireletsegileng a ba a tsenngwa mo sebalamakgolo go fitlhela ngwaga tse tlhano. Sepe fela se se mo sekapamantsweng se tla sutlhwa morago ga selekanyo sa ngwaga tse tlhano.

7 Go tla diragalang ka maduo a dipatlisiso?

- Maduo a tla tsenngwa mo mokwalong wa dipatlisiso gape a kgaoganwe le batlhotlhomisi babangwe ka mekwalo.
- Maduo a tla dirisediwa dipatlisiso tse di le nosi fela.

8 Re ka itse jang maduo a dipatlisiso?

- Le tla fiwa maduo a dipatlisiso fa di feletse.
- Motlhotlhomisi o tla le itsise ka sepe fela se se maleba mo dipatlisisong.

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- Ga gona dituelo dipe ts go tsaya karolo mo dipatlisisong
- Ga o na go nna go nna le ditshenyegelo dipe fa o tsaya karolo.
- Ditshenyegelo tsa mosepele di tla duelwa ba ba tlang mo diofising tsa LEGABIBO go tla go baya monwana mo go tseneleleng dipatlisiso
- Puisanyo e ya go tsaya sebaka sa masome a marataro a metsotso.
- Ga o na go nna go nna le ditshenyegelo dipe fa o sa tseye karolo.

10 A go na le sengwe se o batlang go se itse?

- Fa go na le mathata kana dipotso, o ka ikgolaganya le Proff. Manyedi mo 0822020424 kana eva.manyedi@nwu.ac.za, kgotsa Mr Molato mo 0827426401 kana boitumelo.molato@nwu.ac.za, le Mr Mangwegape mo +26772367336 kana siddavman@gmail.com
- Oka ikgolaganya le komiti ya Health Research Ethics Committee ka mme Carolien van Zyl ka mogala wa 018 299 1206 kana carolien.vanzyl@nwu.ac.za fa o sa tlhaloganye sengwe kana o na le ngongora ka dipatlisiso tse.
- O tla fiwa mokwalo o le pampitsahana ye o tla ikannang mo go yone.

Maitlamo a motsayakarolo

Ka go baya monwana, ke le..... ke dumalana le tsaya karolo mo dipatlisisong tsa go **sekaseka dikgwetlho tsa botsogo jwa tlhwaloganyong mo bathong ba ba ratanang ka bong, le baba nang le keletso ya tlhakanelo dikobo e e pharologanyo mo Gaborone**.

Kei kana gore:

- Ke badile se ka puo e ke e tlhaloganyang.
- Mongwe wa ba dipatlisiso o ntlhaloseditse mabapi le se.
- Ke nnile le sebaka sa go botsa dipotso mm eke arabilwe.
- Ke tlhaloganya fa ken a le boikgethelo jwa go tsaya karolo kana nnyaa gape ga ke a patelediwa.
- Ke tla kgetha go tswa mo dipatlisisong ka nako nngwe le nngwe mme ga ken a go tsewa ka mokgwa ope
- Ke ka nna ka kopiwa go tswa mo dipatlisisong pele di fela, fa e le gore mmatlisisi o laola jalo kana ke sa sala tsamaiso morago.

Tshaeno (*lefelo*) ..... on (*letsatsi*) ..... 20....

....

Sekano sa moitlami **Sekano sa mosupi**

Maitlamo ka yo o tsayang tetla

Ke le *(leina)* ..... ke itlama gore:

- Ke tlhalositse mabaka a a mo mokwalong o ko go.....
- Ke dirisitse/ga ke a dirisa motoloki.
- Ke mo rotloeditse go botsa dipotso le go mo kgothatsa go tsaya nako go di araba.
- Ke kgotsofeste fa a tlhalogantse se se kwadilweng fa godimo.
- K emo file sebaka sa go buisanya le ba bangwe ka kgang e fa a na le keletso.

Tshaeno (*lefelo)* ..... ka (*letsatsi*) ..... 20....

....

Sekano ka yo o tsayang tetla **Sekano sa mosupi**

Maitlamo a motlhotlhomisi

Ke le *(leina)* ..... ke ikana gore:

- Ke tlhalosi tsotlhe mabapi le mokwalo o ko go ..... **kgotsa** ke tlhalososeditse yo ke morutintshitseng go dira tiro e.
- Ke dirisitse/ga ke a dirisa motoloki.
- Ke mo rotloeditse go botsa dipotso le go mo kgothatsa go tsaya nako go di araba **kgotsa** ke ne ke le teng go mo letla go botsa dipotso .
- Yoo tsereng tetla mo go motsayakarolo e ne e le yo o senang seabe
- Ke kgotsofetse fa a tlhalogantse se se kwadilweng fa godimo
- Ke kgotsofetse gore o tsege nako go buisanya le bangwe ka fa a ne a eleditse ka teng

Tshaeno kwa (*lefelo*) ..... ka (*letsatsi*) ..... 20....

....

Sekano sa motlhotlhomisi **Sekano sa mosupi**

ANNEXURE F: CONSENT FORM-ENGLISH

Private Bag X1290, Potchefstroom
South Africa 2520

Tel: +2718 299-1111/2222
Fax: +2718 299-4910
Web: http://www.nwu.ac.za

NWU-HREC Approval Date: 2021.06.20 13:50:38 +02'00'

NWU-HREC Stamp

INFORMED CONSENT DOCUMENTATION FOR INDIVIDUALS INDENTIFYING AS LGBTI+

TITLE OF THE RESEARCH STUDY: Mental health challenges among the Lesbian, Gay, Bisexual, Transgender and Intersex community in Gaborone, Botswana

ETHICS REFERENCE NUMBER: NWU-00396-20-A1

PRINCIPAL INVESTIGATOR: Prof E. Manyedi

POST GRADUATE STUDENT: D.S Mangwegape

ADDRESS: North-West University, Mafikeng Campus, School of Nursing

CONTACT NUMBER: +26772367336

You are being invited to take part in a **research study** that forms part of my Masters in Nursing Science (Psychiatric Community Nursing).

Please take some time to read the information presented here, which will explain the details of this study. Please ask the researcher or person explaining the research to you any questions about any part of this study that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research is about and how you might be involved. Also, your participation is **entirely voluntary** and you are free to say no to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part now.

This study has been approved by the **Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU-00396-20-A1)** and will be conducted according to the ethical guidelines and principles of Ethics in Health

Research: Principles, Processes and Structures (DoH, 2015) and other international ethical guidelines applicable to this study. It might be necessary for the research ethics committee members or other relevant people to inspect the research records.

1 What is this research study all about?

- This study will be conducted in Gaborone and will involve individuals identifying as either lesbian, gay, bisexual, transgender, intersex. Experienced health researchers trained in ethics and research methodology will conduct the study.
- We plan to do research on mental health challenges of the LGBTI+ community in Gaborone. The main objective of the study is to explore and describe the mental health challenges of the LGBTI+ community in Gaborone and how these challenges affect their mental health.

2 Why have you been invited to participate?

- You have been invited to be part of this research because you identify as lesbian, gay, bisexual, transgender or intersex.
- You also fit the research because you have attained 18 years of age and reside in Gaborone
- You have disclosed sexual orientation to the advocacy organisation LEGABIBO.
- You will voluntarily participate and can communicate in English and/or Setswana.

3 What will be expected of you?

- You will be expected to share your experiences during an individual telephonic interview that will be approximately 1 hour in duration and that will be audio recorded

4 Will you gain anything from taking part in this research?

- There are no direct gains for you if you take part in this study but you will have an opportunity to share your life experiences.
- The other gains of the study is influence for possible policy changes in regard to mental health care of the LGBTI+ community. The research participants will be sharing their real first hand experiences and challenges which may change the negative societal perceptions.

5 Are there risks involved in you taking part in this research and what will be done to prevent them?

- The risks to you in this study are the potential for psychological harm. The study arouses self-disclosure which may provoke feelings of anxiety, anger, anxiety or sadness brought about by participants relieving experience. In mitigating

against this, debriefing will be done by a qualified clinical psychologist telephonically.

- The LGBTI+ maybe vulnerable as a result of their perceived stigma and discrimination. They may experience social stigma for identifying as LGBTI+. In mitigating against this; confidentiality, anonymity and privacy will be ensured and maintained throughout dealings with participants.
- There are more gains for you in joining this than there are risks.

6 How will we protect your confidentiality and who will see your findings?

- Anonymity of the data will be protected by me and my supervisors, Prof. Eva Manyedi and Mr. Boitumelo Molato. Your privacy will be respected by not revealing any personal information about you in the written dissertation. Our results will be kept confidential by all researchers. Only the researchers and co-coder will have access to the data and the co-coder will sign a confidentiality agreement. Only these individuals will be able to look at the data. Data will be kept safe, in electronic format that will be password protected. As soon as data has been transcribed, it will be deleted from the recorders and computer. Data will be stored for five years before being destroyed.

7 What will happen with the findings or samples?

- The findings of this study will be used in my dissertation and articles based on my dissertation. The findings will only be used for the purpose of this study.

8 How will you know about the results of this research?

- We will be providing you with a summary of the results of this research when the study is completed.
- You will be informed of any new relevant findings by the researcher.

9 Will you be paid to take part in this study and are there any costs for you?

- No remuneration will be provided for participation in the research.
- There will be no costs involved for you, if you do take part in this study.
- Travel expenses will be paid for those participants who have to travel to the LGBTI+ advocacy centre to sign consent forms.
- The interview sessions will last for about 60 minutes.
- There will thus be no costs involved for you, if you do take part in this study.

10 Is there anything else that you should know or do?

- If you have any further questions or have any problems, you can contact Proff. Manyedi on 0822020424, email address: eva.manyedi@nwu.ac.za or Mr Molato on 0827426401, email address: boitumelo.molato@nwu.ac.za or Mr

Mangwegape on +26772367336, email address: siddavman@gmail.com ; if you have any further questions or have any problems.

- You can also contact the Health Research Ethics Committee via via Mrs Carolien van Zyl at 018 299 1206 or carolien.vanzyl@nwu.ac.za if you have any concerns that were not answered about the research or if you have complaints about the research.
- You will receive a copy of this information and consent form for your own purposes.

Declaration by participant

By signing below, I ..... agree to take part in the research study titled: ***Mental health challenges among the Lesbian, Gay, Bisexual, Transgender and Intersex community in Gaborone, Botswana***

I declare that:

- I have read this information/it was explained to me by a trusted person in a language with which I am fluent and comfortable.
- The research was clearly explained to me.
- I have had a chance to ask questions to both the person getting the consent from me, as well as the researcher and all my questions have been answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be handled in a negative way if I do so.
- I may be asked to leave the study before it has finished, if the researcher feels it is in the best interest, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ..... on (*date*) ..... 20....

....

Signature of participant **Signature of witness**

Declaration by person obtaining consent

I *(name)* ..... declare that:

- I clearly and in detail explained the information in this document to

  .....
- I did/did not use an interpreter.
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I gave him/her time to discuss it with others if he/she wished to do so.

Signed at (*place*) ..... on (*date*) ..... 20....

....

Signature of person obtaining consent **Signature of witness**

Declaration by researcher

I *(name)* ..... declare that:

- I explained the information in this document to .....
  or I had it explained to who I trained for this purpose.
- I did/did not use an interpreter
- I encouraged him/her to ask questions and took adequate time to answer them

  or I was available should he/she want to ask any further questions.
- The informed consent was obtained by an independent person.
- I am satisfied that he/she adequately understands all aspects of the research, as described above.
- I am satisfied that he/she had time to discuss it with others if he/she wished to do so.

Signed at (*place*) ..... on (*date*) ..... 20....

....

Signature of researcher **Signature of witness**

ANNEXURE G: INTERVIEW GUIDE- SETSWANA

LENANEO LA POTSOLOSO

Potso ya pula madibogo:

- O kgothatswa ke eng go nna go nna o lebela botshelo ko pele?

Potso e e tsharabololang puisano:

- A ko o ntshedimosetse ka botshelo jwa gago o le motho yo o ratang le batho ba bong jo bongwe kana o na le kgatlhego e e pharologanyo ya tlhakanelo dikobo le dikgwetlho dingwe mabapi le botsogo jwa tlhaloganyo fa di le teng?

- Dikgwetlho di go amile jang?

Potso ya tshoboko:

A go na le sengwe se o ka se latlhelang mabapi le maitemogelo o le motho yo o ratang le batho ba bong jo bongwe kana o na le kgatlhego e e pharologanyo ya tlhakanelo dikobo?

ANNEXURE H: INTERVIEW GUIDE-ENGLISH

UNSTRUCTURED INTERVIEW SCHEDULE

Initial engagement question:

What motivates you to always look forward to another day?

Exploring questions:

- Tell me about the mental health challenges if any, that you experience as a person identifying as LGBTI+?

- How do these mental challenges affect your mental health?

Exit questions:

Is there anything else would like to add in relation to identifying as lesbian, gay, bisexual, transgender or intersex?

ANNEXURE I: EXAMPLE OF A TRANSCRIPT OF A PARTICIPANT IDENTIFYING AS LGBTI+

RESEARCHER	RESEARCH PARTICIPANT
(phone ringing) Hello	Dumelang
How are you?	I am fine
You requested that we do the interview after 30 minutes, can we continue with the interview?	Yes rra we can continue.
Like I said I am David Sidney Mangwegape, a Lecturer in Lobatse I.H.S and currently doing Masters in Psychiatric Community Nursing in North West University in South Africa. I am currently conducting a research that is titled “mental health challenges among lesbian, gay, bisexual, transgender and intersex community in Gaborone, Botswana; it’s the one for this interview.	Okay, yes rra
Like we are talking, the conversation will remain confidential between me and you. The only person that I will share with is my research supervisor, and I wouldn’t share details about you.	Yes rra, I do understand.

You are free to express yourself during the interview, if you are not free you will indicate so that we stop the interview. If you are emotionally distress you can also indicate to me.	Yes
Which language do you prefer that we use for the interview, Setswana or English?	I prefer English
You prefer English?	Yes
Okay. I will first like to establish the pronoun that you like to be addressed in?	She, hers is my pronoun
Okay, within the LGBTI community how do you identify?	Transgender
You identify as a transgender, as in transgender man or woman?	Transgender woman
I do understand. As an individual identifying as a transgender woman, what are the mental health challenges that you encounter on a day to basis?	As in what, the challenges?
Yeah, the mental health challenges that you experience?	As a transgender woman especially in Botswana there are experiences going about accessing mental health care services because I am transitioning on hormonal replacement therapy.

	I have found it very difficult to secure or locate particular people who are able to assist me as I go on with my transition within government hospitals. I also found out that in my experience when I accessed mental health services in a government hospital, the professionals were not really inclusive in the right way, they were not really inclusive in programming about people like myself. I also experience that there isn't a lot of research when it comes to mental health care needs of trans people which to my opinion will provide a large pool of knowledge for policy makers and so forth. So it has really been a challenge for trans people like myself. Most trans people have had to be, I will say victimization from family members to the society at large. It mostly occurs when I am vocal about my trans journey be it about my clothes or about what I am wearing when I am at home. And also they use words which are very derogatory from my uncles, is contributing to my mental instability because they took my confidence as a person.
Uh-uh-uh	And this is happening at a place where people need to feel and get the most love
Uh-uh-uh	When I access services like HIV/AIDS prevention and care, the nurses at the clinic and hospital in Gaborone, are very rude and ask lots of

	unnecessary and very uncomfortable questions and I will just go outside. My ID by the way is written male but is not whom I am. My body has entrusted me with a body I can call home. It is how I want the world to perceive me and I am fine with it. There is that mismatch between my ID and the way I look. When I get into a hospital or clinic the nurses are asking questions, they look confused, they don't know
Uh-uh-uh	Most of them when I ask them, have never had exposure to people who looks like me. In most cases it is the first time they came across. The choose the path of mostly asking uncomfortable questions like what is between your legs, which at the time is completely unrelated or unnecessary because I want to be treated for headache and they will ask me what is in between your legs stuff like that. That whole thing, the experience, it sorts of adds into the instability of my mental health. I had a breakdown because of depression because of the fact that prior to not getting services of a trained professional to assist me with my transitioning. This is something that a lot of trans people have experienced because access to transitioning health care is so bad, there is only one doctor, one practice in in all of Botswana that trans people can access. There is a lot of patients that the physician sees and sometimes we are not able to see him for

	consultations. And he does not even offer surgery, they are clinician only they are not even a psychiatrist or psychologist. So, we don't get a lot of counselling, we don't get a lot of services.
Uh-uh-uh	And we have also realized that when we form our own sort of associations or groupings, informal groupings, a lot of people within the community are not forthcoming so that they can be helped, their stories to be listened to. It stems from the idea that they have been broken and being beaten for a long time even exposing themselves to people who are untrustworthy people and being met with rudeness and palpable discrimination at you. It is a very interesting and difficult experience for being trans and a society that doesn't recognize trans-ness or doesn't validate trans-ness within established national health care system or health policy, we are not there, and we are not included in the health care system and hospitals. You go there they would say are you crazy, what are you saying?
Uh-uh-uh	Right, but somebody who is not trans who is cisgender maybe when they maybe go for breast reduction; they go to the hospital accessing the service they will be given but a trans man go there, they will be met with discrimination that breeds into the instability of our mental health experiences that we find ourselves in this country

Okay, I do understand you; you said a mouthful of what you have gone through as a trans woman; maybe let's get back to the health workers: you indicated that they are not inclusive, you indicated that they ask unnecessary questions like when you have a headache(quoting you verbatim) what is in between your thighs	Yes
Okay, you only experienced that only in government hospitals?	Yes, uhm, I have all my life gone to government hospitals and private hospitals and clinics alike but found out that with government hospitals is so bad that's where I experienced the most transphobia. It's my thinking and what they told me, it's never been taught about who transgender people are, what are their experiences at Institutes of training like I.H.S. there is no orientation at the hospital, they have not been briefed like in this hospital you are going to see patients coming and are transgender; they have never been orientated. I will say yes, I have only experienced transphobia in government hospitals and clinics only; private hospitals and other private clinics' service is absolutely amazing. They know my pronouns, sometimes they don't know my pronouns and mismatch but

	do apologise. That's like the quality of service we get from private hospitals
Uh-uh-uh. The other issue that you indicated is that you experienced stigma and discrimination from fellow family members, can you expand on that since you also mentioned that they also use derogatory; and also I would like to know those derogatory words?	So I am actually 26 years right now, I have been transitioning the last 6 years. So I started when I was 20. I am medically transitioning when I was to go for my first year at university but before that when I was in high school staying with my mother in college I was social transitioning not medical because I could not afford my medical transition. I always put on clothes that looked good on me that included female clothes and they really good on me and my mother will make comments like "paramoseseng" why are you doing this thing, this is actually against God, you are supposed to be a man, what you are doing gonna make you bad. Those kind of negatively charged hatred I still get from my mother. My father was very quiet, the thing about my father is that he was against my social transitioning and he only spoke about it during my third year of university. That's when we started telling me that, like I came back from a conference in Ivory Coast in my …attire and was wearing it home that's when he just snapped; what are you doing, you shouldn't be doing this, and my mother was with them like defending me. This has been eating my confidence for a long time and I tried encouraging myself. I remember at some point my mother agreed that

	we go to church in Palapye with my mother, and then when we got there the prophet started praying. What I like is the prophet was actually nice and we started talking about gender identity, talking about the position of God. It was actually nice and when we got out of there my mother was actually disappointed, she didn't get what she wanted, she was expecting that huge criticism was gonna take place. And when we got there we just talked about things; you being trans woman and all that. She still didn't understand and I tried to make a point that these things happen on their own its nature like cancer, cancer is a natural occurrence but it doesn't mean that it's okay. Being trans is natural, everything that is natural is okay. It doesn't mean being transgender is unnatural, giving the implication that everything that is natural is okay. I was trying to give her those kind of assertions because my sister was diagnosed with breast cancer and the way my family supported her until she beat the cancer. And it made me realise that they are not supporting me. Being transgender is who I am. I am sure my depression has come out of this.
Uh-uh-uh	This thing made me to stay with my mother. My mother was protective after I tried to commit suicide at Gaborone. I remember looking at the water and saying I am doing that. I wanted to medically transition but I couldn't afford it. My

	mother said if you use your medical aid I gonna cut you off. This was either I die or stop living. This was like a matter of life and death for me. Before that, I have tried to commit suicide like three times the first one when I was doing Form Three and the other one I was doing Form 5. I think, when I was doing form 5, I remember my father he kicked me out, because at the time he said I am gay, which is ridiculous, I am trans not gay.
Sorry, I didn't get you clearly your father kicked you out?	My father kicked me out of the house when I was doing Form 5.
Uh-uh-uh	Because he has heard like hear say you're your child is gay and is putting on dresses. I said what's happening, he said it's something that he said before and it embarrasses him. He came with a silly excuse when mom asked why you kicked my child out "your child does not want to be sent around to do errands. It just left me having no relations up to this point because we don't really talk. The only time we talk is when he has something negative to say about the choice of clothing, that's how far bad my father is. My mom has over the years tried, I wouldn't say she is there as she still addresses me by male pronouns that I don't like "bo he, tlhe rra," I feel so disgusted. It's always in my heart over that and she doesn't get that. And she would say I should look for a woman and get married. I don't

	know what a man does and I don't have the experience. I don't know what a man does because I started transitioning when I was 20. I didn't have to be here. People often say you are a man; I find it very difficult to accept that or even understand. So I think over the years working as an trans-activist, as a feminist, working with trans people, I have realized that there is illiteracy in this country. (Inaudible).
Sorry it's like your phone is cutting	Sorry
It's like your phone is cutting.	What are you saying?
Your phone is cutting a bit, but its fine now	Yeah
Maybe let me take you a little back, you were talking of a situation where you went to see the pastor with your mom and you say you related well with the pastor. He clearly understood the gender issues which somehow disappointed your mother; maybe expanding on that, when you go to church what is their reception on you?	Right now I really don't go to church, I am a very liberal person. My mother goes to fire churches that's where she goes. I used to go to church with her but will put on something feminine but she will want me to be put on a shirt and trousers. When I go there I won't be free but nobody knew I am trans. I don't really have seen a church that includes trans people so I kind of never went the previous year. I never had experience with since I went with my mother since high school at St Joseph. After working I have never been to church. I really wish to go and hear them say welcome, that's what I wish to hear.

Uh-uh-uh	So, what you need to understand is that when you get there, they treat you horribly, they will burn it on your throat by saying you are going to hell. I don't know of a trans person who is a believer but can only speak for myself; but amongst my friends I am not aware of who is a believer but who can blame them when the place that is supposed to give them love says they are going to hell? That's what they are told every single time. They don't feel the love but trouble and vile that pastors throw at people like myself. I was realizing that one way or the other, someday I wanna kill myself and it gonna happen and I really had to deal with such experiences; and as a feminist on top of that I was able to heal. I also had to forgive myself for the things I went through, the choices that I have made because there were even times when money was tight because I couldn't get a job. I was applying and people see my ID and then lay low because they are confused. It was very difficult to find a job so sex work was something that I will find money with, so I got into sex work. I will just stand by the hotel where they will just pick me up. It was kind of a transactional relationship type. I will get into a relationship with understanding that they maintain me and pay for my sexual gratification to do.

	I also did sex work as an online thing where I will send men nudes and they give me money, it helped a lot as I was able to pay for my transition and provide for myself because the family had cut me off at some point when they saw my pictures when I was coming from a conference at some point. They cut me off saying this is madness, you continuing with this, they didn't give me money, my allowance didn't sustain me that's when I found it conducive to be able to pass time by sex work. And even now, am not into sex work, I still believe that sex work is work; something that trans people like have gained sexual liberation, economic satisfaction and economic support from. Is something that I advocate for as well, the decriminalisation of sex work.
Uh-uh-uh. Currently you are working?	Currently I work for a transgender organization. It is like a grass root feminist organization that works with trans people and for trans people, so we have done social justice in this country, trans people living with HIV, trans people with disability, trans young people. I have been with it ever since and we have advocated for public inclusion in terms of policies for trans people, queer and so forth.
The experience of discrimination in your current work, how is it? Or it is	The fact that I am working in a trans organization, there is no discrimination at all. If I had a work in an organization that isn't trans or commercial

non-existent since you are working in a trans organization?	like in CBD, a 9-5 job, there will definitely be discrimination because my ID still reads male and going about change is a difficult process. I think I will experience that as well. And also like in terms of my social life generally I don't think working in a 9-5 job not in a trans organization I will be able to cultivate my work and be functional. I am of the view that homophobia, patriarchy, sexism, transphobia exists, I don't think I will fit well. Working with trans people is inspiring and empowering because I deal with my people, so yeah.
Uh-uh-uh; you are content with working with trans people?	Ooh, yeah
But what you are saying is you are not comfortable with working with non-trans people, non-LGBTI people you prefer to work with those within the trans family?	For now, I will prefer that, work with my community but because I am going for further training, after I come back I might try to get into ministry of health advocating for trans people working with non LGBTI people but I my life purpose is the advancement of the lives of trans people. I think it will change but for now I am so comfortable working with my people.
Okay, there is this other issue that you highlighted that you are HRT	Hormone replacement therapy

Yeah, you indicated that it is one of the instigators to your mental instability, maybe you can expand on how it contributes to your mental instability?	For trans people who are within the binary, binary I am talking about the male and female and on transition from either of the genders.
Uh-uh-uh	I see hormone replacement therapy working through oestrogen and testosterone blockers. When I don't take the medication, my gender dysphoria comes back. Gender dysphoria is where I get a lot of depression and it's like depression worsens because there is a mismatch right, it's a feeling that I am born in the wrong body. It's a situation that..have you ever gone to a place where you feel so unwelcome?
Aha	That's how I feel in my body when I don't take my HRT. When I take HRT my body becomes better. HRT is my comforter my body is welcoming. What I feel, what I am inside. I see myself you know, progressing in so many areas; my social relationships. I became more compassionate and more social because I was now able to look ahead, be able to deal with one thing that pulls me back which is my gender dysphoria. I wouldn't say I am cured because I am still on HRT. What I want to do I would like to do at the end of the year, hopefully go for private surgery which will be able to make my transition permanent. I think that's when I will cure from the dysphoria. Gender dysphoria is a medically recognized condition. It was removed from World Health

	Organisation list of mental disorders in 2017 but before that it was listed as a mental disorder but it was removed from the classification. Ever since then, clinicians, doctors and nurses haven't been serious about providing HRT to people. I haven't seen this service or advocacy in our country, in the mainstream medical health talking about it. I don't know may be transphobia but these resources that are needed but what I have realized is, the level of interconnectedness between HIV/AIDS infection rate in the country and our inaccessibility to HRT services. The thing is, when you can't access HRT services in the country, I have realized gore we resort to sex work. Because sex work is criminalized, is unsafe, we are not able to get condoms and all of those, we engage in survival sex work which is unsafe and contract HIV in order to pay for HRT in private institutions. There is that correlation. If we are to combat the high HIV infection rate we have to provide HRT in a matter of urgency. HRT that is sustainable and affordable.
Uh-uh-uh. All you are saying is that you use a lot of money to get your HRT?	Yes, we use a lot of money because we are not getting it from the government as well as mental health care and counselling. It is not affordable and sustainable, we only have one doctor in Gaborone who is quite expensive. If you don't have medical aid you end up paying like around 3000, 1200 to 3000 depending on whether you are trans man or woman, that's the range. That's

	a lot of money because most of trans people are unable to get conventional employment. The NGO don't give out huge salaries and you find that sex work helps many. Some men pay for sexual services and we get huge monies. There is that power dynamic at play.
Uh-uh-uh	Actually they don't have control over decisions on consent, decisions when it comes to condom use. You can't even negotiate condom use because you are not the one with buying power. Buying power 8s not there because you want money. They negotiate and without condom for higher prices. And most trans people we fall prey to that. And I have experiences where men would say I am allergic to condom, if used the price is reduced. That was very difficult as I had to pay rent so I ended sleeping with a man for money but still gave me meagre pay at the end of the day. I realized that I put myself in a very difficult and dangerous position. This is what happens to trans people every single day. They need the money, that's the only thing they know, yeah
Uh-uh-uh; you said a mouthful and looking at all these experiences that you highlighted; transphobia from family members, from the community, poor accessibility to health services for trans people, if you look at them and	All these issues I have raised, how do they affect me mentally?

reflect; how do these challenges affect you mentally?	
Yeah	For the issues that I have raised, I think they add onto my depression because we are not accessing health services, people are against you. Like the depression get worse that I can't go outside. And my anxiety gets so bad. I will look into the mirror and get so insane. There are instances that I have been attacked. That time when I was studying in UB I was sexually assaulted by security officers. That experience, when things are piling up it's like it's not getting better. That's how I view the world and see myself because I don't socialize as much. I think it was before covid and my depression will get worse because I was home most of the time, I missed job opportunities most of the time, not even bother to be there on social media when my friends called me up. It was difficult to motivate myself or to go at the door and grind. I think with my work I have been super getting there. I am meeting a lot of people in my feminism; it's been encouraging, empowering and uplifting. There are times when its gets so overwhelming like I have missed work and don't go out, that's how bad it gets. Especially when I receive very direct abuse like after talking to my mother and she has

	been misgendering me all the time, and it adds to my depression in some type of way.
Uh-uh-uh	Transphobia, like this morning. And the whole day will be boring and thumb sucking. It adds to my bad day. And this is something I could be dealing with the help of health authorities, like maybe I go to Marina at psychiatry and this doctor will help me without asking me why I don't want to be a man, don't even go there. I think I will be able to deal with these things and cope well in the society.
Uh-uh-uh. This depression that you are mentioning that you were diagnosed with depression and you indicated that you had several suicide attempts back then, now you are mentioning anxiety, can you elaborate how this anxiety comes in?	This anxiety comes about when I am in public places especially if it is a place where I am likely to be attacked, for example, in one mall. Every time I go to the mall I have anxiety because the security guard when I was at the loo, the guy attacked me, it ended when he was asked on why he was physically assaulting me, he said he was confusing me with someone. And ended with me not getting justice from that experience. Every time I get there I get anxiety, I get panic attacks. I remember incident when my brother picked me when I was unable to walk, I was crying and people were saying why am I sitting there? And I was there not knowing what to do. This fear is always going to be there. Also when I am walking, I think everyone has the anxiety especially as a woman.

Uh-uh-uh	Especially when a woman walks about, she gonna be attacked. Also when I am getting into a space; human like space, there are gonna be people here who gonna say no we are actually trans allies and they will try and infuse themselves especially civil society organisations. And in workshop, they would have gathered there and I am expected to sit there and expose myself gore kana I am a transgender woman.
Uh-uh-uh	If it's like that, I have fear that I might be exposing myself to people who are dangerous and that will increase my vulnerability by telling them that I am trans and they may use this to hurt me. I will try advocate for feminism then some girl stands out and says we have men who want to be women, who are taking women spaces, things that are actually painful. I get anxious about that as well. It is something that I am actually working through, every trans person knows it, and it's called self-therapy. Because we have lost hope in the medical, mental health system of this country we do self-therapy to cope with mechanisms that we tell each other, if you are in a situation as a trans person this is what you do and what you don't do and it mainly helps them a lot. We have lost hope gore because people who are not trans from the general community are able to go to hospitals to be assisted which is favorable but

	when we get there it's mixed up. We endure the worst.
Uh-uh-uh	Yeah; so it is one of those things.
Hmmnn. You just indicated that you have self-therapy, where there are ways you can use to cope. Maybe you can elaborate on aspects you raised?	Sure, yeah. Gladly. Right now in my organization we have a very large whatsapp group and everybody in this whatsapp group is a transgender person, we have trans men, transwomen, we have trans people who are gender non-conforming; who are trans but not transitioning. So we are in this group we teach each other strategies about going about things, this is how we do it when you going through transitioning, if you having parent problems this is how you do it., and with your parents not accepting this is how you do it, adverse situation this is how you can manouvre around it. You are having problem accessing health care these are the contact details of the doctor you can see. This is what we formed and we help each other. New trans people are welcome, and if they want to be added to the group we add you. In this group we have three generations of trans people. Trans people who are elder, young trans persons and we have trans adolescents in this group. We help each other and those in advanced ages tell us of their experiences that they encounter and the older people learn from the young people as well. Things were probably different back in the day.

Uh-uh-uh	It is a community of people who help each other and we give each other strength. Especially now this covid, we can't even meet.
Uh-uh-uh	And because of covid is impossible, now that we have these virtual platforms we can reach all and speak to one another. We can reach anywhere in Botswana.
Uh-uh-uh	Other people who are Batswana are in America. In October I am going to the October to the UK I will still be a member of this group. If you are not member of a group you end up believing the narrative that you an outcast "setlhodi", because you are the only one. If you see other people like you, it helps so much. It's a healing thing.
Uh-uh-uh; what you are saying is being with like-minded people is one other strategy that you do use; associating with people who you share experiences.	Absolutely, yeah
Uh-uh-uh. Are there any other ways you use to cope or maybe as a way of relaxing or dealing with situations? It's a rejoinder to the self-therapy you talked of.	I yes, I use alcohol. I do glasses of wine of sauvignon every now and then but sometimes it's get to a level where my depression has has re-occurred, that's when I will get orange river that will help me to forget. But it doesn't help per say, it helps me go through it.

	My family when I was at UB and they were threatening me, terminating me from medical aid. I did a wink; I did marijuana. I remember this guy he was working at a bank, he was gay. He will come to my room in one university, and bring weed and there is this other guy next door he made me do weed on weekends and I will miss classes. It was providing me with a temporary relief. And it is something, for now, that I don't necessarily do. With drinking I do drink but not a lot but occasionally. But I do know in the group there are those that are struggling with substance and alcohol abuse. People who do cocaine, and weed. I think weed has many users. Alcohol there are few that don't drink because they are minors. But majority drink, we drink! We drink alcohol and that today its covid its alcohol ban, President refused for sale of alcohol. So it's been so difficult to resort to our self-care; the mechanisms that we use are not available now.
Uh-uh-uh	It has now become difficult for us to deal with mental health consequences of that.
Okay	It has been quite difficult.
Uh-uh-uh. This statement that you made a few minutes ago, of a sexual assault, I didn't get clearly as to whether it was judicial officers or police officers?	I have never experienced sexual assault done to me by anyone with the group of police officers. My friend was the one who was assaulted when we were in university; but physical assaults are

	many. Those we met were security officers and not police officers.
Okay.	The other one was in university and the other in main mall where that happened. I think my first experience, I wouldn't say I was the problem child when I was 17, basically I was just going about finding myself, I met the wrong people and made the wrong choices. I was drunk and I remember going to this guy's house in Palapye; it was crammed thing, it was a barbaric thing so drunk because I did know that I was bought alcohol for providing sex in return; I did not, I will be living a lie, and I was also a child. When I remember now gore was it a rape or consensual; my understanding is it was non-consensual because I could not have consented through the entire activity because I was so intoxicated. I was so intoxicated I have blacked out. That was the first encounter with sexual assault. The person took advantage of my vulnerability because I was in a bad space at the time. I think it was at the time that I tried to commit suicide. The second one happened, I think I was homeless at the time my brother and I were not in speaking terms and even my family and I was sleeping in a hospital on the benches and I will sleep outside the church. The other time when I was in main mall; I think I spent like 13 days being homeless; my aunt and mom had decided to get me; there is this guy, he could see of my desperate situation

	as my bag had lotion and everything. He called me for that night saying he wants to talk to me. I was just there because I am homeless. I am shy, my family forced me to run away; next thing things are getting physical and he said let us go and see something in the toilet.; not that I blame myself for the sexual assault, it's just that I had a hand in it because I agreed to go with this man not knowing who he is.. He put himself on me. It was one of those that sort of happen. I remember I had to go to school the following day. I contemplated going to the clinic the next day to get my HIV, what you call prophylaxis.
Prophylaxis, yeah.	Yes. So that they prevent me from getting the virus. I went to a clinic the following day, and I remember that I went at around 12 midnight. I contemplated that I won't go in the afternoon because it gonna be horrible. And luckily I found two nurses, and they were so kind because they didn't know I was trans.
Uh-uh-uh	They said you are a woman, I didn't tell them I was trans. That's the reason there were so nice and so kind. I belief had I said I am trans they would have acted differently. I don't know, but maybe I judge nurses but that's how I feel. They processed my things and quickly went to a doctor who said I should see the police.

Uh-uh-uh. In terms of relationships are you in a relationship because you once talked of relationships?	I have come to a point in my life, I think because I am a feminist now I don't want to be with a man who is not feminist, this is problematic I always have that fear and anxiety. I have to find who is not transphobic, homophobic, he knows that there are human rights, he knows that there are equal rights for everyone, so this general understanding it doesn't exist. So, for me that's the standard that every man I came in contact with me and is courting me. I am not in a relationship. I have been in a relationship yes; but those men like I have said were not feminist for me or they were homophobic or transphobic. They said no you are the pretty one. Like when I go with you in the mall, people could not tell that you are trans. It hurts a woman but they would say I won't date a woman who doesn't respect me. I am stopping those things because those are not my principles.
Uh-uh-uh	Yeah.
Is there anything that you would like to share?	I have literally said everything but what I would say is this research is important which was like why I was open with this, I want you to know. I wanna know gore after you finish the research will we use it for our own use so that we sensitize people of what is happening in Botswana? It is very important we don't have research in Botswana, that why I am asking that after you finish we will have access to it somehow?

I will disseminate the information. I am going to do a hard copy and I believe that I will publish in journals for the study to be available. One of the things that I intend to do, COVID situation permitting is to do a public address where I will share my findings with the rest of the society in conjunction with stakeholders like LEGABIBO and Ministry of Health. Research is about sharing findings with those involved. We will do share the findings publicly for public consumption.	Yeah. Thank you so much.
On top I will like to assure you, as much as it is confidential I am going to share it publicly but not saying this but I am just going to generalize.	I think that with me, I own up my story. It is something for me that I share my story. Even if you share my name I wouldn't have a problem with it because that is part of who I am, my story. So if you want to mention my name I don't have a problem with. In fact, I encourage you to do it as it will add substance to it.
That is noted, thank you.	Yeah
Anything else that you will like to share?	Nothing. Thank you for this.
I will like to thank you for offering the opportunity to interview you. Because some don't find it comfortable to be	Yeah, I understand

interviewed, once you allow us to interview is really grateful.	
Thank you and have a wonderful day.	You to bye-bye.

ANNEXURE J: SAMPLE OF FIELD NOTES

Descriptive notes

The interview took place telephonically on the 26/08/2021 at 1044 hours. The research participant was phoned and the interview was recorded as per client's consent.

Even though interview was conducted telephonically, some cues were observed. The participant was relatively calm but started to speak passionately of her plight as someone who identify as a transgender woman.

Methodological notes

The researcher exchanged pleasantries and introduced self. The purpose of the interview was explained to the client. Issues of confidentiality were shared and participant given an opportunity of self-determining participation in the interview. A broad opening question was asked and client freely allowed to share experiences without being interrupted. The interview lasted for about I hour 6 minutes.

Personal feelings

After the interview, the researcher felt that the participant had adequately addressed the phenomenon being investigated. The researcher also clearly understood the proper use of pronouns on individuals identifying as LGBTI+.

Theoretical notes

The participant described challenges in accessing health services, society not recognising those who identify as LGBTI+ and challenges within the workplace.