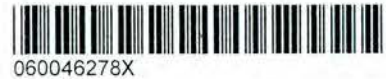


**A Managerial Investigation into Lesbians, Gays,
Bisexual and Transgenders' Needs in the North West
Province, Ngaka Modiri Molema District.**

L C Mahura

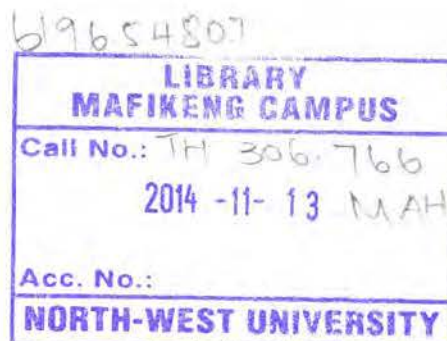


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Mafikeng Campus Library

Mini-dissertation submitted in partial fulfillment of the requirements
for the degree, Master of Business Administration in Marketing at
the Graduate School of Business and Government Leadership,
North West University, Mahikeng Campus.

Supervisor: Professor S Lubbe

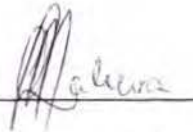
April 2012



DECLARATION

I, Lorato Charity Mahura, declare herewith that the mini-dissertation entitled "Managerial Investigation into Lesbians, Gays, Bisexuals and Transgenders' Needs in the North West Province, Ngaka Modiri Molema District" which I herewith submit to the North West University, Mahikeng Campus, as partial completion of the requirements set for the Master of Business Administration Degree, is my own work and has not already been submitted to any other university.

Signed By:



Date: 12.04.2012

Lorato Charity Mahura

Student Number: 17112141

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ABSTRACT

In South Africa, HIV and AIDS as a communicable diseases is difficult to eradicate. The government sector is advocating for comprehensive management thereof. Still the challenge is that the health sector tend to focus on the treatment pillar, pumping a lot of resources into treatment with minimal productivity. The point is, too much emphasis is put on post-intervention as opposed to pro-activity. Prevention is one of the under resourced pillars in terms of funding and capacity, but can bring about positive behavioural change in safe sex and deter other risk behavioural patterns that transmits HIV within our communities, thus combating further HIV infections. It is important to continually find gaps in the prevention techniques and markets when promoting or communicating HIV risks prevention. The study explores if the mainstream promotional and communication messages are reaching the Lesbians, Gays, Bisexual and Transgenders (LGBTs) and are soliciting positive behavioural change or discrimination. The study is qualitative and explores a probable social problem concerning the LGBTs in their natural setting. Probability, snowball sampling was used. Data were collected through structured questionnaires, and loaded into the Statistical Package for the Social Sciences (SPSS), a software for analysis. The measure of correlation used was the Spearman's Rho.

Definition of Terms

Lesbian	A woman whose primary sexual and romantic attraction is to other women.
Gay	A man whose primary sexual and romantic attraction is to other men.
Bisexual	A person who has sexual and romantic attraction is to both men and women.
Transgender	Some people describe themselves as transgender when they experience a gender identity different from their birth sex. For example a person born into a male body, but who feels female may live as a woman and may describe herself as transgender. Some transgender individuals alter their physical appearance through attire and/or use of hormones and surgery to match their internal sense of gender, including male-to-female and female-to-male.
Gender identity	One's internal sense of male or female.
Transsexual	A male or female who has gone through surgical procedure to alter or change their birth sex.
Bulldagger	An outdated term used by heterosexuals to describe cross-dressers, usually men who dressed as women, primarily in a negative context.
Intersex	Some one born with male and female organs.
Androgeneous	Exhibiting approximately equal proportions of masculine and feminine characteristics simultaneously.
MSM	Men having sexual relations with other men.

Sexual Orientation A descriptive term comprised of three elements – attraction, behaviour and identity. Many individuals have romantic or sexual relationships that correspond to their attractions, but attractions, behaviour and identity do not always match. A man who considers himself heterosexual or straight may occasionally have sexual relationships with other men. A woman who has relationships with other women, but who feels attraction for men, may identify as bisexual, lesbian, heterosexual or in some other way (Baird, 2010:5-6).

List of Abbreviations

LGBT	Lesbians, Gays, Bisexual and Transgender.
NDoH	National Department of Health.
NPO	Non-Profit making Organisation.
NWDoH	North West Department of Health.
HIV	Human Immuno Deficiency Virus (Cohen & Tate, 2005: 174).
SPSS	Statistical Package for the Social Sciences.

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Chapter 1

Overview of the Study

1.1 Introduction

Categorisation of people is a norm in many societies, inevitably, people are also categorised according to gender. Over the years, gender determined the services, resources and benefits accessible per category. There is an apparent expansion on or creation of the categories of people overtime (Rispel & Metcalf, 2009:133). This study, mainly pays attention to categorisation by gender identity and by sexual orientation or practices, which is homosexual and heterosexual.

The health sector in South Africa categorises its clientele in many ways for statistical purpose. The different categories enables tracking of services that are focused to specific target markets. Categorisation is done per health issue; gender, which is male and female only; target market and racial groups. The health sector for some reason has ignored to embrace gender or sexual identity (Rispel & Metcalf, 2009:133). There is no distinction between homosexuals and heterosexuals in service delivery. A setback in terms of decision making that takes into consideration the needs of the Lesbians, Gays, Bisexual and Transgenders (LGBTs). This fact may result in dissatisfaction on services provided.

This chapter introduces the reader to concepts and terms on the different sexual orientations; promotion and communication; the historical patterns of health service categorisation of groups of clients; and the historical patterns of health service delivery based on gender or sexual identity. A perceived problem that prompted the research is then derived out of what was discussed in this chapter.

1.2 Background

Disclosure of homosexuality is becoming the order of the day. Over the years, homosexuality is becoming acceptable as just another form of sexual expression (Satterfield & Crabb, 2010:49).

Inevitably, there is a move towards ensuring that all public services are friendly to homosexuals. The health sector seems to be under scrutiny of services that are not friendly to homosexuals at all times, may it be clinical treatment services at facility level and promotional services.

In this era, communities are adept to obtain information, to the advantage of global technology. Internet requires ability to distinguish between good and bad information and to identify a trusted advocate. Health promotion, should therefore be proactive in the involvement and guidance of LGBTs in using all the acquired information (Stott 2000:73). Again, Doring (2009:1094) observes that the majority of internet users now and then surf information on sex issues online, may it be on HIV or related topics. Kunaga and Rosenfeld (2004:1) state that 74% of today's youth have at some point navigated the internet to find health information. The myths are easily developed on the subject matter if no structure or institution is taking leadership of the messages.

The move towards the co-ordinated public response to HIV and AIDS dates back to 1992. The HIV & AIDS Strategic (2006:10-13) highlights four key priority areas in the national South African strategic document and they are: prevention; treatment; care and support; research; monitoring and surveillance; and human and legal rights.

Inevitably, the four key priorities referred to above are communicated or promoted to the public, for example, the prevention of HIV and AIDS, where to access treatment thereof and the continuous feedback on research development. Prevention is the strategic focus area of intrinsic value, as it is meant to combat the spread of HIV and AIDS. It is a competency of the health promotion and communications sections of all health sectors. The two sections play a support function to the line programmes managing HIV and AIDS, and other interventions. Put in simple terms, the health promotion and communication section gives guidance to the HIV and AIDS programme as far as prevention is concerned, and secondly provide communities with information necessary to access services.

In 2007 at three different meetings in South Africa, which are: The National Strategic Planning Meeting with the Health Minister; the Third South African AIDS Conference; and the Same Sexuality Conference, Rispel and Metcalf (2009:136) indicate that there was emphasis on lack of information on the LGBTs communities.

Health promotion is aimed at improving people's health, and Friedman and Nokwedi (1998:3) define it as a "process of enabling people to increase control over, and improve their health". The health promotion interventions are a combination of educational and environmental support. An environment that is hostile or not people-centred will not be able to respond to the people's needs. If the health promotion activities fail to target the LGBTs, it means there may be an apparent failure to control HIV and AIDS as a communicable disease. Public engagement is a precondition for change in health promotion as it attempts to change the mindset of communities, and ultimately, behavioural change. Such change is only achievable if the community perceptions are understood.

Upon considering the mainstreaming of the HIV and AIDS health promotion and communication activities into the health sector services to the homosexuality groups, the researcher will be able to highlight if such a service has positive or negative impact on the burden of HIV and AIDS, following that, proactive interventions may be deemed necessary. The study will investigate if the health sector is transforming with time, in comparison with other sectors on service delivery to homosexuality groups. If the effect is negative, there are intervention measures that need to be considered. Firstly, the management and intervention guidelines in the service area under scrutiny may have to be developed or amended to alleviate the burden of disease. Secondly, to find out if the subject matter has potential to raise public interest or is a public need, that may need to be addressed. Lastly, the study seeks to assist the health sector to uphold professional standards and not to uphold and hold on to the morality and beliefs of individuals within it.

Historically, what is noticeable is the apparent expansion on the sub-population categories overtime, that is, the variety in the terminology LGBTs, which is a recent construction, based on specific cultural, social, economic and political circumstances. Medhurst and Munt (1997:54) state that “the terms we use to define ourselves have no precise historical equivalents, every word used in relation to same-sex acts in the past has its own history. The term ‘homosexual’ (coined in 1869) and later ‘heterosexual’ did not pass into usage until in the 1980’s.” Baird (2010:6), further explains that the LGBTs do not prefer the term homosexuality, as it is associated with abnormality.

Maticka-Tindale *et al.* (2007:1), define sexuality as “a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction”. A further elaboration on sexuality was made based on their findings, Maticka-Tindale *et al.* (2007:1-11) whereby sexuality is stated to be experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviour, practices, roles and relationships. Not all of the above dimensions have to be experienced and included, furthermore, sexuality is seen to be influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.

Legally, the South African constitution does not allow unfair discrimination of anyone, including on the grounds of gender and sex and calls for realisation of rights within available resources. The country outlawed the discrimination on sexual orientation, and legalised same sex relationships (Rispel & Metcalf, 2009:137).

On a social level, societies are faced with stereotypes that shapes people’s worlds, something that people all learn unintentionally, for example, blacks having stereotypes about coloured people and vice-versa, women having stereotypes about men and vice-versa. So, the case will be similar with homosexuals and heterosexuals. Be as it may, the stereotypes can either be positive or negative. Further examples of the stereotypes about lesbian and gays are as follows: gays and lesbians regarded as mentally ill; gay men seen as promiscuous; lesbians seen as not feminine; the LGBTs can be spotted

by the way they act and dress. Holmes and Meyerhoff (2003:336) state that the language that people speak, through talk, promotion, marketing or any other mode of communications expresses certain viewpoints, propose certain plans or query certain ideas. Through language people convey attitude. Sexist stereotype attitude gender based and is not based on individual merits. Again, through sexist language, stereotype attitudes to women and men are communicated. The sexist language stereotypes are also communicated to the LGBTs.

Marketing communication should consider how the target audience behave and process information (Fill, 2006:18-19). In this case, communication ought to take cognisance of how target markets interpret information, and focus on reminding clientele to respond to the messages given and/or to use the service provided.

The organisation that was lobbying for the gay and lesbian population was the Gay and Lesbian Umbrella, in the North West province and the initiatives covered lobbying for better health service delivery. Inevitably embracing the health promotion service delivery. Health promotion and communication in practice, has to be tailor made for most target markets in a given situation. There is evidence that media exposure on HIV and AIDS fosters knowledge and acceptance on what is shared. HIV infections are attributed to low knowledge (Babalola *et al.*, 2009:1517). There is also evidence that communication campaigns can eventually lead to behaviour change amongst individuals (Bessinger *et al.*, 2004:1). Then again, there is a probability that, advertisements, articles, educational material and theatrical plays are mostly targeting and depicting heterosexual communities.

The role of Lesbians, Gays, Bisexual and Transgender (LGBTs) in the eradication of HIV may be undermined, yet HIV and AIDS is a communicable disease and the LGBTs sometimes move from one sexual orientation to the other. The infection of one person is the infection of many and yet the extend of infections by such liaison remains unknown as disclosure is still stigmatised (Rispel & Metcalf, 2009:135).

1.3 Statement of the Problem

An investigation into the gaps that are apparent in health promotion and communication on HIV and AIDS amongst the LGBTs; resulting from the ineffective managerial guidelines and service delivery processes.

1.4 Objectives of the Study

The objectives of the study were:

To highlight the probable service delivery gaps in health promotion and communication of HIV and AIDS prevention services provided for by the health sector to LGBTs.

Depending on the outcome of results and identification of such gaps, to further bring awareness and solicit action by the health sector to address those gaps, through the development of concept plans and interventions which continually strives to complete the comprehensive management of HIV and AIDS.

To also comply with the principles of the public health system, which is to give rise to the relevant and targeted interventions that alleviates the burden of diseases, making health services more accessible and providing "Health for All" as it was enshrined in the mission of the National Department of Health.

To promote sexuality sensitive health promotion and communication at the centre of policy making and guidelines to ensure that LGBTs movements are acknowledged and involved in decision making that underpin their HIV and AIDS health promotion and communication issues.

1.5 Research Design

The research paradigm used in this study was qualitative. The study investigated the psychosocial perspective of the LGBTs, on the topic of interest. The researcher moved from the assumption of probability of the existence of a problem that need to be highlighted, and by so doing, that can be regarded as diagnostic evaluation, at the

same time, the study could be seen as an exploratory journey, as not much was known about the perceptions or behaviour of the community that was studied.

Diagnostic evaluation are meant to inform the researchers and project managers about the present situation within the communities, highlighting current problems, trends, forces and resources, as well as the possible consequences of various types of intervention (Bless & Higson-Smith, 2006:58). In essence, the facts that were highlighted by the participants, were of intrinsic value to the outcome of the study, and were facts valued by the community that was studied.

1.6 Context of the Study

The study was a requirement of the Masters Degree of the researcher and also as an employee of the Department of Health in the North West Province of South Africa, and at that time, the head of the Health Promotion Section, the researcher played a role in the development of the health promotion strategies in the provincial health sector.

The study was conducted with the assistance of the Gay Umbrella, a Non-Governmental Organisation that advocated for the rights of the LGBTs. A dissertation was written, to show that the researcher mastered her promotion and communication discipline, and was able to convey information and new ideas to those whose work and lives will benefit from the dissertation (Beth, 2010: 34-35). The results of the study were to be tabled before the NWDoH and a number of private partners in the HIV and AIDS sector; and the promotion and communication sector for programme decision making.

1.7 Study Layout

This chapter basically, gives the reader a sense of the researcher's perception and rationale for the study. Following that is Chapter 2 on literature review on the concepts, keywords and terminologies, with the intention of discovering detailed information unknown to the researcher. Literature review structures the focus area of the research,

and distinguishes the current focus from the previous studies. In conclusion of the literature review, research questions were developed.

Chapter 3 focuses on the planned study design, and Chapter 4 on the research findings and measures of correlation of questions asked. The final chapter, which is Chapter 5, analyses and explains the results of each research question. Based on the analysis of the outcome of the study, the chapter also makes recommendations.

1.8 Conclusion

Prevention of HIV transmission in all groupings is a necessity as it is a communicable disease that cuts across all groupings, prejudiced and unprejudiced. HIV transmission is a threat to life, as well as the economy and as a result, prevention thereof ought to target all groups in the society. Promotion and communication on HIV and AIDS should elicit positive behavioural change, but can only be achieved if specific markets are targeted, for example, the youth, the elderly, the LGBTs.

The state of comprehensive management of HIV and AIDS can only be attained by recognising and responding to all elements that negatively impacts on or exacerbates the condition, may it be cultural, psychosocial and economic. These elements are scrutinised in the next chapter and the factors that may negatively affect promotions and communications within the societies. As already mentioned, the next chapter will provide focus area of the research, and distinguish the current research from the previous ones.

Chapter 2

Literature Review

2.1 Introduction

Based on the previous chapter, the researcher has acknowledged that there are factors that negatively impacts on the HIV and AIDS management which may be cultural, psychosocial and economic. The very same factors need to be considered upon comprehensive management of HIV and AIDS. The Lesbians, Gays, Bisexual and Transgenders (LGBTs) are a segment of the market population affected by HIV and AIDS, also affected by the abovementioned factors. Furthermore, promotion and communications forms part of the interventions adopted in the comprehensive management of HIV and AIDS, and it is isolated as an area of interest in this study. There are apparent needs or gaps in the service delivery to the LGBTs on the health promotion and communications on HIV and AIDS, which may be having a potential to exacerbate the scourge of HIV and AIDS in the North West Province of South Africa.

In this study, for the purpose of maintaining focus, the main keywords that puts the study into context are: LGBTs, HIV and AIDS, North West Province, South Africa, health service delivery, social risk factors, psychological impact and the health programmes. The literature review focuses on the historical, social and psychological patterns of HIV and AIDS service provision to the LGBT population, by the general health systems.

In this chapter, the historical review focuses on the mainstreaming of the general health sector services into homosexual and LGBTs, and into the pro and anti-homosexuality groups, the main interest being on the preventive and promotive aspects. The social review focuses on the perceptions and relations of the society to the LGBTs as well as the risk factors that the LGBTs face, a practical approach to the psychological issues that may have negative and positive impact on the LGBTs as a group of interest in this service area is also reviewed.

2.2 Health Service Delivery to the LGBTs

Heterosexual practice is insisted upon as the predominant view as opposed to homosexual practice, based on a summary of some key findings of previous studies into lesbian and gay health conducted in the United States and Britain, Wilton (2000:15) highlight several issues raised which are: ill-information by professional health and social workers on LGBT health issues and holding of prejudicial beliefs about LGBTs; coming out of the closet to a health worker putting an LGBT at risk of either experiencing poor treatment, hostility or abuse; limited empowerment to health care workers on LGBTs health issues; health care literature having a tendency of communicating homophobia and heterosexism; statutory powers of health services not favouring LGBTs and social services tending to discriminate the LGBTs; and lastly the LGBTs not comfortable to access the health service delivery system based on the mentioned facts, but will rather opt to delay going for treatment.

A study conducted by Rich (2006:51), with some focus areas similar to that of Wilton (2000:15) was conducted in the Western Cape Province in South Africa, and the results shows existence of overt homophobia when LGBTs are consulting some of the health care practitioners. The results indicate that, 15 participants (2%) indicated that they were refused treatment by the health care practitioners because of their sexual orientation. A further 23 (3%) were unsure which may suggest that these individuals received covert messages that were not openly verbalised. A portion of 72 participants (8%) delayed seeking health-related treatment as they were afraid of possible discrimination and a further 73 participants (8%) did not seek medical help (Rich, 2006:51).

Benson and Hergenroeder (2005:183) state that teen LGBTs will not access the health service delivery if they feel perceived negatively, based on their sexual orientation.

Another study by Saewyc *et al.* (2006:1) report that nurses did not feel competent to address the needs of LGBT youth. The studies above, shows the psychological homophobia and heterosexism that are brought to light cannot be defended either morally or professionally. Some of these homophobic prejudices are not easy to deal

with, but at times, in the professional world, it may be worth it to accept the people for the sexual orientation they choose (Wilton, 2000:10). Even if it is difficult to understand or accept the sexual orientation of the LGBTs (Wilton, 2000:10) calls for people not to be clouded by their beliefs, but to put service delivery first and not prejudice.

Two separate, but similar studies conducted by Rich (2006:50), Wells and Polders (2004:16) and Wells (2005: 22) state the following results on the satisfaction of LGBTs with health care providers in the 3 different provinces of South Africa, the following results were found: In the Western Cape Province, it was found out that not all health care practitioners provide a safe and accepting environment for LGBT people, the majority do appear to be supportive and uphold confidentiality. Overall 78% participants states that they are satisfied with the health service and 17% remain neutral (Rich, 2006: 50).

In Gauteng Province, although 76% of the sample was satisfied with services, a quarter of clients serviced were Whites, who consulted more with private doctors, appeared to be more satisfied with services received than Blacks (Wells & Polders, 2004:16). In Kwa-Zulu Natal, although 78% of respondents were satisfied with the services they had received from health care practitioners in the last 24 months, almost a quarter of the sample were not. The majority of White respondents (90%), who consulted more with private doctors than Black and Indian participants, appear to be more satisfied with the health care practitioners that they consulted, in comparison to Black (75%) and Indian respondents (70%), who consulted more with government doctors and clinics (Wells, 2005:22). Upon analysis of the results, it is clear that the public health sector is predominantly used by Black LGBTs as already alluded to. White LGBTs are mostly satisfied to consult private health sector.

2.3 HIV and AIDS Health Promotion and Communication

Message development, promotion and communication are of intrinsic value to LGBTs in HIV and AIDS, giving rise to a continuous need to develop and evaluate safer sex education for the LGBTs and to ensure the education that will bring about positive behaviour of adopting safer sex practices. The term Behaviour Change Communication (BCC) with regard to the topic of the research refers to carrying out activities aimed at educating communities to prevent further spread of HIV infections. BCC is considered as one appropriate strategy to increase knowledge and modify behaviour (Bessinger *et al.*, 2004: 397-398). The very same study by Bessinger *et al.* (2004:397-398) show that women exposed to BCC activities on the usage of condoms, were reported to have used the condoms.

Men were reported to be more likely to respond positively when compared to women. At the same time it is important to note that positive response can be influenced by aspects such as level of education and urbanisation, whereas negative response to condom usage may be influenced by aspects such as marriage, whereby condom usage is not likely to be used. The fact that men respond better than women may be attributed to societal or cultural norms which puts women in a position of being disadvantage in decision making. The reality is that such gender patterns do change over time since the environment is dynamic (Bessinger *et al.*, 2004:402-406). A deduction can then be made that the messages delivered should be ever-changing due to the ever-changing epidemics, medical advancement and environmental changes.

A study conducted on the relationship between media saturation, communication and exposure to HIV was conducted in Nigeria by Bababalola *et al.*, (2009:1513) confirms that communication exposure brings about accepting attitudes or BCC, on the contrary, there was no relationship between media saturation of communities on a health issue and acceptance in both men and women. Put in simple terms, communication does foster change in behaviour, but it does not mean that if communication reached everybody within the community, everybody will change.

The LGBT target market is comprised of those who are affected, not affected, infected and not infected by the virus. Some of the LGBTs may have to deal with two different stigmas, the HIV and AIDS and the coming out of the closet of homosexuality stigma (Keiswetter & Brotemarkle, 2010:273). Health promotion and communications initiatives should therefore, take into consideration such dynamics. The market that is targeted has different segments requiring special attention. Market segmentation process, define Strydom *et al.* (2000:102-103), is to achieve maximum clientele satisfaction, marketers, promoters or communicators divide the heterogeneous markets into fairly homogeneous subsets, a process known as market targeting.

Eckert and McGonnell-Ginnet (2003:271), allude to the fact that in linguistics what matters in what we utter is the response that the utterance can lead to, meaning it can solicit either a positive or a negative response. A deduction can be made that, the health system has the potential to use its messages for positive transformation of the society. As the principle applies in linguistics, the same will apply in marketing or promotions. The language that is spoken in marketing, should not just be the language that speaks about identifying LGBTs as a category, but should be a language that enables them to relate to what is being said about sexuality.

Language constantly evokes meaning, and that can result in misunderstanding, disruptions or contradictions. Hence in the promotions and communications becomes an important aspect. Coming back to LGBTs, HIV and AIDS and sexuality, misinterpretations are easy to come by, which may lead to attitudes (Holmes & Meyerhoff, 2003:123).

In carrying out the health promotion and communications activities, the communities served are assisted to achieve sexual health, which Shapiro and Ray (2007:1) view as a state of physical, emotional, mental and social wellbeing in relation to sexuality. The authors do not view sexual health as just the absence of disease, dysfunction or infirmity. To achieve sexual health, positive and respectful approach to sexuality is required, and the possibility of enjoyment, safe sexual experiences, no coercion and discrimination. Romeo and Kelley (2009:1003) are of the opinion that prevention

models on sexuality should enhance positive social identities, including sexual orientation and should bring about social norms of respecting each other.

Curbing of further spread of HIV and AIDS is a goal of health promotion and communications activities. All other programmes forming part of the comprehensive management of HIV and AIDS aiming at curbing HIV spread should then take into consideration the sexuality, socio-economic conditions, and information needed by the target market (Shapiro & Ray 2007:1). The results of a qualitative evaluation of HIV/AIDS IEC activities in Madagascar by Rakotananahary *et al.* (2002: 343) reveal that IEC activities fail to take into consideration the contextual differences of the target market into account, for instance, different practices, cultural opinions and levels of education. The issue of anatomy, behaviour and identity differences was also raised by (Keiswetter & Brotemarkle, 2010: 274).

As already indicated in Chapter 1, that most people surf the net to obtain information, Kunaga and Rosenfeld (2004:117) state that sexual health is amongst the topics that adolescents like to discuss. The study stated that frequent topics of discussion by the youth on the internet were found to be drugs (65%), sexually transmitted diseases (61%), smoking (59%), and nutrition (57%). There were some topics which the adolescents preferred to discuss with the health care providers such as nutrition (49%), weight (43%), exercise (41%) (Kunaga & Rosenfeld, 2004: 122).

The reason for people to favour the internet as opposed to consulting health care workers when it comes to obtaining information on health issues is the fact that there is confidentiality, room to ask questions, getting different sides of the issue of interest, convenience, interaction with others and face to face communication (Kunaga & Rosenfeld, 2004:118). One can also observe that the topics that are surfed on the internet require some level of confidentiality. For the LGBTs, the internet is a place of refuge as there is a creation of a sub-culture, that assist each other with information, identity, acceptance and social networks. The down side of it is that LGBTs networking on the internet, are sometimes rejected by the communities, though they are more willing to take risks with the partners they find on the internet (Doring, 2009: 1097). In

addition, internet produces a youth culture of interaction and identity expression leading to marginalisation of those involved (Romeo & Kelley, 2009:1003).

The South African National Department of Health, in collaboration with a communications and marketing company, Khomanani produced several television advertisements that upon analysis speaks to the heterosexual population, inevitably, seeking behaviour modification from the heterosexuals with the potential of discriminating the LGBTs. Contemporary communication tends to, most of the time, use images, which challenges the basic principles of marketing as the analysis of the message basically rests on what is seen. The same applies to HIV and AIDS television adverts in South Africa. Such images are serving as stimuli, signs, or representations that drive cognition, interpretation, and preference, the very same images influence what people know and believe (Kimmel, 2005: 256).

The mainstream sex education does not cover issues such as anal sex being more abrasive than vaginal sex which can cause the condom to break easily, or condoms and usage of lubricants (Hart, 1998: 14). Rispel and Metcalf (2009: 139), conducted a study in South Africa focusing on the need for public services to respond to men having sexual relations with other men (MSM). The recommendations of the study, included amongst other strategies, targeted and specific information, education, communication, condom promotion and social marketing.

In addition to all the mentioned strategies in health promotion and communications, the North West province is using the Promoter's Model found in Elder *et al.*, (2009:137), where Health Promoters are involved to enable communities to positively change their lifestyles. The health promoters are lay officials that are bridging the gap of impersonal communication by reaching out and interacting with communities in health matters. The communities consult them in cases whereby clarity on health issues, accessibility of services and knowledge are needed. Empowerment of health workers should therefore include empowerment of the health promoter, and not only clinicians. The other strategy used is the use of peer educators in health education, who prefer to relate to peers who are most similar to themselves (Mitchell *et al.*, 2007: 373). In their study, the

peer educators emerged as role models to others and were comfortable to receive information shared from reputable authorities. Peer education promotes regular contact with those receiving education.

2.4 Societal Risk Factors

Societal risk factors reviewed in this chapter, are those that put the LGBTs at higher risk of HIV infection, by virtue of belonging to a different social grouping. Several research studies that looked into the risks that LGBTs face during consultation, the risks that the LGBTs are likely to be exposed to in their everyday life that may worsen chances of contracting HIV, derail them from seeking help or become barriers to receiving help.

The higher the level of education, the better the health, state Langlois-Klassen *et al.* (2008: 173) in their study. Knowledge is the first factor of importance. According to an evaluation of national HIV responses from the United Nations General Assembly, special session on HIV/AIDS country reports, its survey data from 64 countries indicated that: 40% of men and 38% of women aged 15–24 years had accurate and comprehensive knowledge about HIV and information about preventing HIV transmission. Data show some level of improvement, especially for women, over 2005 knowledge levels (where 37% of young men and 28% of young women were found to have a basic knowledge of HIV). In 2007, knowledge levels were still below a target of 95% of young people knowledgeable by 2010. (Carael *et al.*, 2009:114).

Transference of STI and HIV may take place during sexual intercourse of LGBTs as it is with heterosexuals. There is a tendency to think that HIV transmission amongst gay men is of high risk, as semen is likely to be deposited in the mouth or anus during sex, exposing both partners to the risk, a practice that is similar to the women in heterosexual relations (Wilton, 2000:86). Bisexual men were reported to be engaging in riskier sexual intercourse in comparison to men sleeping with men (MSM), state (Benson & Hergenroeder, 2005:182).

Straight lesbians are less vulnerable since there is no transference of semen, but again, it should be considered that lesbianism does not mean one does not have heterosexual tendencies. Gay men are more likely to be vulnerable, as there may be transference of semen by the partners during anal penetration which is also abrasive, yet in heterosexual relations women are also more vulnerable given their reproductive nature to receive semen. In reality, both heterosexuals and homosexual are vulnerable if healthy lifestyles or safe behavioural patterns are not observed (Wilton, 2000:86).

It should also be noted that apart from the sexual orientation of the LGBTs, especially those that practice abrasive anal penetration, there are other social factors that contributes to putting some at risk, that requires attention during promotions. An example will be, LGBTs that are using drugs by injecting them, are at risk of contracting HIV, Hepatitis B (HBV), Hepatitis C (HCV) and syphilis. This fact is highlighted in the study by Johnston *et al.* (2010:486) on MSM injection Drug Use (MSM- IDU).

A study focusing on women in general, not specific to the LGBTs, by Pinkham and Malinowska-Sempruch (2008: 169) reveal that women that are using injected drugs in European countries have an HIV prevalence that is 50% higher than that of men in the same category. In Yunnan, China and in Mombasa, Kenya it was found out that the HIV prevalence of HIV among women using IUD was 85%, whereas it was 50% among all IDUs. The results may be suggesting the vulnerability of women in drug usage. In the very same study, Pinkham and Malinowska-Sempruch (2008:171) indicate that the women who have sex with women (WSM), over 50% of women engaging in sex with other women are also having sexual intercourse with men, and are not necessarily adhering to condoms. It is reported that 70% did not use condoms for vaginal penetration and 74% did not use condoms for anal penetration. Drug usage in women may also cause bleeding, and when pregnancy occurs, a woman might not even realise it (Pinkham & Malinowska-Sempruch, 2008:171). There is therefore a link between drug usage and reproductive health, and HIV transmission.

Benson and Hergenroeder (2005:189) are of the opinion that the social risk factors are exacerbating the STI and medical conditions, for example HIV transmission, but sexual orientation does not necessarily do so. He also alludes to the reality of using inappropriate health awareness strategies.

Findings from the two studies that are almost similar conducted by Rich (2006: 59 - 60) and Wells and Polders (2004:20) in two provinces of South Africa, amongst other things probe into LGBT's HIV and AIDS risks, and the following results were found: In the Western Cape Province, 262 participants (28%) of the total sample have not tested for HIV and many state that the reason is they are either too scared or they are not at risk for contracting HIV, 111 (59%) participants who have never been tested for HIV do not inform new partners. In this study, participants had the option to give multiple reasons for not testing for HIV (Rich, 2006: 59-60).

Out of the 262 participants, 57% who have never tested for HIV felt they are not at risk to contract HIV and 55% state they have never been in a situation to contract the disease. The 41% state they were too scared to get tested, and 26% state that they were not sexually active. In terms of testing procedure, 8% stated that they do not know how to get tested (Rich, 2006:59-60). On that note, It may be important to note the effective messaging and communication on HIV and AIDS can improve the low responses on HIV testing (Bessinger *et al.*, 2004: 397-398).

Table 2.1: Reasons for not testing for HIV in Gauteng

	Female (%)		Male (%)	
	Black	White	Black	White
Never been in a risky situation	58	67	46	36
Don't think I am at risk	50	67	41	64
Don't know how	23	14	16	23
Too scared	61	14	57	23
Not sexually active	37	56	42	33

Source (Wells & Polders, 2004: 20 -21)

A large number of respondents indicated that they did not know how to test or were too scared to test for HIV. Those that did not know how to test included both Blacks and Whites. There were more Blacks that were too scared to test (Wells & Polders, 2004:20). Mahalik *et al.* (2007: 2202) come up with the fact that sexual and racial minorities tend to engage more in sex. A fact that is of concern since the North West (NW) Province is predominantly Black.

The following differences along racial lines were found by Wells (2005: 23) as reasons for not testing for HIV: Double the number of Black than Indian and White respondents were too scared to get tested. Double the number of Black than Indian and White respondents did not know how to get tested. Double the number of White than Indian and Black respondents felt that they were not at risk and had never been in a risky situation in which they could have contracted HIV. For the purpose of this study, it is important to note that Blacks show a tendency of not to testing in the provinces where the studies were conducted and the number of respondents who are too scared to test is significantly high.

In KwaZulu-Natal, the HIV positive prevalence rate for lesbian or bisexual women is high, challenging the belief that this group is at low risk with regard to HIV. The

following factors could account for the high prevalence amongst lesbian or bisexual women: they could be having bisexual partners, experiencing high incidence of rape and in some cases engaging in transactional sex with men. On the same note, higher HIV positive rates were reported amongst Black respondents (13%), reported to be more than the Indian (8%) and White (5%) respondents (Wells, 2005: 23 -24).

Risks faced by the general population are: minimal community resources, time demand and sometimes the group that is receiving a service is not motivated, especially adolescents (Saewyc *et al.*, 2006:307). Risks faced that the LGBTs faces by virtue of their sexual orientation are: suicide, violence victimisation, harassment at school, forced sexual intercourse, physical or sexual abuse and STI and HIV infection (Benson & Hergenroeder, 2005:182; Saewyc *et al.*, 2004: 345). High rate of sex work was reported amongst transgenders in the study conducted by Bith-Melander *et al.* (2010: 213-218). Participation in sex work is part of survival to meet the daily demands of life or to affirm their gender.

Kunaga and Rosenfeld (2004:121) raise a concern about internet sites offering prescriptive medication over the counter making adolescents to be more vulnerable to such medication. The risks discussed above will differ from one developmental stage to the other, for example, the risks that the adolescent is exposed to will differ slightly from adulthood risks.

2.5 Discrimination Against LGBTs by the Health Sector

The HIV infected persons are generally discriminated against by the society, the situation becomes worse if one is LGBT. Then again, sometimes these discriminatory practices unfold unintentionally. Health care workers are in most cases not trained to provide services to LGBTs, which can lead to inappropriate service, misunderstanding and misdiagnosis (Keiswetter & Brotemarkle, 2010: 273).

Statistical records and reports do not single out on LGBTs that are affected at the Centres for Disease Control and Prevention (CDC). Gender categorisation is done by

male or female (Keiswetter & Brotemarkle, 2010: 271-273). The same categorisation applies to the National Department of Health (NDoH) in South Africa. It is only estimated that infections on HIV amongst LGBTs is high (Keiswetter & Brotemarkle, 2010: 272). Considering that the homosexuals are the unaccounted for minority statistically. The HIV and AIDS Strategic (2003: 64) states that 85% of the South African HIV epidemic is caused by heterosexual spread. In its situational analysis, it is silent on the LGBT category in its statistical analysis of prevalence.

Upon medical consultation or admission, health care workers are still relating to LGBTs using their birth genders simply because the recording and consulting rooms are structured in that way (Keiswetter & Brotemarkle, 2010:276). Benson and Hergenroeder (2005:188) state that, in general, discussions around sexuality are difficult topics for some health workers to deal with. Anxiety may attack the health care provider in such cases, the situation becoming worse when dealing with LGBTs, yet it is important for the health workers to show professionalism on the matter, stay unbiased and show respect.

Acceptance of LGBTs differs from one religion to the other, for example, Moslems do not tolerate People Living with HIV (PLHIV) as much as Christians do (Babalola *et al.*, 2009: 1519). Taking cognisance of the above discussions, health promotion and communications therefore ought to be able to create one voice to the LGBTs across the multiple or diverse groupings with them, to avoid unintentional discrimination.

2.6 Effects on the LGBTs

It will be of interest to understand what the LGBTs go through on a rational and emotional level in an environment of societal risks and apparent discrimination in the health service delivery. In their study conducted in the United States and Canada, whereby the LGBT youth were questioned on health care preferences on health providers, health settings and issues; it came out that the respondents were more interested in the characteristics of the service providers, and not the settings or services as Hoffman *et al.*(2009: 222) indicate that, the youth needed respect, to be listened to and for service providers not to be judgemental. Kreiss and Patterson

(1997: 270) realise the need for gender neutral language by service providers to avoid feeling of prejudice by LBGTs.

The psychosocial problems experienced by LBGTs are: school problems or peer rejection, family conflict and rejection, homelessness, which may lead to depression and suicidal tendencies and finally resorting to substance abuse (Kreiss & Patterson, 1997: 268-269; Romeo & Kelley, 2009:1002, Nerdahl *et al.*, 1997:184). The currently prevailing homophobia contributes to the psychological problems that LBGTs are facing as challenges faced are not being met (Santelli *et al.*, 2006: 78; Satterfield & Crabb, 2009:48). The fact that there is limited information on LBGTs, implies that chances of them suffering from psychosocial problems on HIV, poverty, discrimination, racism, unemployment and abuse are high (Bith-Melander *et al.*, 2010: 208).

Ageing in itself may necessitate psychological or mental health needs, but the burden may be more for LBGTs who are marginalised by the society. They may have more medical or financial responsibilities, for example, they may not qualify for certain benefits or grants that heterosexual spouses qualify for (Satterfield & Crabb, 2010: 48; Romeo & Kelley, 2009; 1003). Again, the National Survey of Middle Development indicates that sexual orientation came out as a significant stressor (Satterfield & Crabb, 2010:48). Homosexuality is slowly being destigmatised and there is improvement in recognising their psychological needs (Satterfield & Crabb, 2010: 49).

Several documents highlights stigmatisation of HIV people as one of the main stressor leading to psychological problems such as, shame, guilt, fear, anger, mental ill health and depression (Babalola *et al.*, 2008: 1513; Saewyc *et al.*, 2004: 345). In the 3 studies already alluded to conducted in South Africa in 3 of the 9 provinces by Rich (2006: 24), and almost similar, amongst other topics, the studies investigate levels of outness or disclosure of being LBGT and the health aspects of the LBGTs with particular interest to HIV and AIDS.

Studies conducted in the Western Cape Province by Rich (2006:24), Gauteng Province by Wells and Ponders (2004:7) and in KwaZulu-Natal Province by Wells (2005:12) indicate that, the average age for males to come out of the stigma closet was 19 years as compared to females at 21 years. In the Western Cape Province, the result indicates that females tend to 'come out' at a later stage than males, and were was statistically significant (Rich, 2006:24). It is important to realise that not only are the LGBTs dealing with the stigma of coming out if they are HIV infected. HIV disclosure is also a stigma leading to further marginalisation (Keiswetter & Brotemarkle, 2010: 273).

Table 2.2: Average age of coming out by gender and race groups in the Western Cape Province

	Sex		Race Groups		
Age in years	Male (n=456)	Female (n=448)	Black (n=196)	Coloured (n=233)	White (n=465)
Mean	19	21	17	19	21
*Mode measure)	19	18	15	18	19

Source (Rich, 2006:24)

Although the mean age of 'coming out' for this sample was 20 years, most Black participants 'came out' at 15 years (Rich, 2006:24).

Table 2.3: Levels of 'outness in KwaZulu-Natal Province (%)

	None	Some	Most	All
Family (n=391)	28	32	17	23
Friends (n=392)	11	29	22	38
Work (n=154)	24	21	22	33
Community (n=378)	26	37	23	15

Source (Wells, 2005:12)

A study conducted in Gauteng Province, states that the levels of outness are higher amongst Whites than Blacks on all levels of outness measured, that is, family, friends, work and community (Wells & Ponders, 2004:7). In KwaZulu-Natal Province, the mean age at which participants came 'out' was 20 years (SD=4). A positive correlation exists between age and level of outness. Older individuals are free to come out in comparison with younger ones (Wells, 2005:12). Kreiss and Patterson (1997:267) state that most LGBTs came out of the closet around the age of 20.

Kreiss and Patterson (1997:274) also look into the psychological issues in primary health care of LGBT youths deduced that in order to have a healthy future and taking cognisance of the increased visibility of the LGBTs, the stigma is decreasing and provision has to be made for appropriate service delivery by increasing awareness for health workers on LGBTs needs. It is also important to see healthy lifestyle awareness compatible to sexuality. The similar perception of empowering health workers is shared by Benson and Hergenroeder (2005:181) in his study of STI infection. The health workers may feel uncomfortable to relate to the LGBTs and miss their medical and psychological needs. Both studies also identified HIV infection as one of the risk factors among LGBTs.

Saewyc *et al.* (2006:307) look at nurses' feelings on being offered to work with adolescents, the results show that 68% of the nurses indicated that they could not deal with youth LGBTs. The percentage is the highest among all health issues considered in the study, but still the highest percentage (39.3%) of nurses showed lack of interest in the subject matter when asked if they require to be trained on the subject.

The notion that wisdom comes with age is true, thus implying that for an LGBTs that still has not come out of the closet and not obtaining the right education on HIV and AIDS runs at a risk of being infected or infecting others. The fact is, with age, he or she will disclose his or her sexual orientation but then it might be too late. Bith-Melander *et al.* (2010:208) state that the adolescents, suffer from serious rejection from their loved ones and their communities. The discrimination can cause them not to feel free or delay to disclose their sexual orientation. In summary, the trends in age of coming out

differ from one geographical area to the other, but the point is that LGBTs start to engage in sexual activities at an early age, like other youth, hence needing HIV and AIDS education earlier.

2.7 Programmes for the LGBTs

In the study that focused on social health for youth living with HIV, Shapiro and Ray (2007:71) allude to recommendations found in the USA research work and some of the suggested interventions are flexible hour service delivery, walk-in appointments and involvement of the clientele. To promote safer sex, Shapiro and Ray (2007:71) also suggest non-penetrative sex, mutual monogamy or polygamy with no infection prior to the inception of the relationship and usage of either female or male condom alone.

Perceptions that service providers create to the societies they serve are important. It is important not to be seen as anti-LGBT, and to be seen as fostering working towards the same goal (Saxe *et al.*, 2004:1). The programmes are supported by the very same societies in which they are implemented, hence perceptions are important (Saxe *et al.*, 2004:179).

Thornhill and Klein (2010:239) advocate for partnerships between LGBTs and other structures within the community in order to create conducive environments of health care for LGBTs. Kreiss and Patterson (1997:274) suggests ongoing societal dialogues with the LGBT's by health care providers.

School based programmes have also been identified as the interventions that can reduce sexual risk behaviour, and can reduce the stigma especially among adolescents, for example, School Health Education Programme initiated by United Nations Children's Fund (UNICEF) and the Ministry of Education, using stage drama for health education (Shapiro & Ray, 2007:69; Low: 2010:114). Theatre give people time to get into their audience or target market's perception and needs, even prior to coming up with scripts, but requires a lot of time to do the groundwork, as well as practice on how the issue will be communicated (Low, 2010:123). In some instances,

Benson and Hergenroeder (2005:189) reveal that school based programmes may overlook the important messages specific to the LGBTs.

Santelli *et al.* (2006: 2201) suggest another intervention of abstinence-only education, although the limitation is its undermining of the comprehensive approach to HIV and AIDS management. A point that needs consideration because in the study by Cohen and Tate (2006:178), abstinence promotion until marriage seem not to have been an effective intervention, especially for the youth and as a result, a combination of other strategies is encouraged. The reality is that abstinence is not adopted by many, as an option of change in behaviour. One of the reasons being that the abstinence-only programmes do not acknowledge that sex can be used as a form of trade especially in poverty-stricken areas, or where oppression of children and women is still prevalent (Cohen & Tate, 2005:176).

In addition, Santelli *et al.* (2006: 76) state that the information that is of value to the youth is contraception, legal rights and reproductive health services, and abstinence is not. Furthermore, even if abstinence can be promoted as curbing STI and HIV infections, it is misleading because it does not even take place in practice. Such programmes can also impact negatively on other programmes, for example, family planning.

In their study, Aggleton *et al.* (2005:527) highlight the importance of using Information, Education and Communication (IEC) material as of importance in HIV advocacy, but should not be regarded as the single strategy. Cohen and Tate (2005: 178) suggests that HIV prevention material should be accurate and appropriate for the target age. Topics on communication and the understanding of the patients' point of view are seen as risk reduction strategies and can be introduced into the nursing curricula (Haidet *et al.*, 2002:27). In the study by Rakotananahary *et al.* (2002:343) recommendations made for improving IEC campaigns covered amongst others, understanding of the target market, focus on demystifying illness and respecting the rights of those targeted, improvement of monitoring and evaluation, retention of attention and commitment and continuous feedback to communities. Thornhill and Klein (2009:230), emphasise that

relationships between LGBTs and the health sector ought to be strengthened, and issues be dealt with openly.

The integration of HIV services and drug use services is necessary as the latter worsens the former (Johnston *et al.*, 2010:485). There may be still risk involved to practice safe sex and engage in unsafe needle injection at the same time. Incorporation of reproductive health services with drug use and HIV services (Pinkham & Malinowska-Sempruch, 2008:173). Bith-Melander *et al.* (2010:219) advocate for integration of mental health issues. On the same note, specific clinics for the HIV infected were stigmatised and not an good option (Gilliam *et al.*, 2010:8).

The core standards adopted by health facilities have a public health domain, which also focuses on health promotion and prevention programmes, yet the standards are silent on promotions geared at inclusion of the marginalised groups. On a positive note, the standards advocate for health facilities to consider sound public advice to inform their plans, policies and practices. Depending on the final study results, the study might be opening for such opportunity of involving the LGBTs (Core Standards for, 2008:29). Peer education for children out of school, is suggested, but should focus on putting the youth first, gender equity, meaningful participation and right based approach (Mitchel, *et al.*, 2007:365).

Based on the literature review, the matrix hereunder by Smith (2003:8) give direction in terms of assessing if the health sector is meeting the needs of the LGBTs. The highlighted parts of the matrix are points of concern that the researcher has picked, based on the literature reviewed. The matrix is putting a spotlight on the service providers in the health sector to introspect the effectiveness of the service they provided. The matrix indicates probable problem areas, and is used to give direction to research questions, and could only be verified as true or untrue post the study findings in the final chapter of the research, and enhance meaningful recommendations on the health care for LGBTs.

Table 2.4: The Organisation Performance Assessment Matrix: Common Barriers Between You and Your (External) Customers

YOU (Health Workers)					
Believe you are doing enough for customers	Lack contact with customers	Not aware of own attitude to customers	Not fully aware of own role or position		
YOUR ORGANISATION (Health Sector)					
Departmental ring-fencing	Reluctance to change	Poor communications	Poor or no Information	Poor or no research	
SITUATIONAL FACTORS					
Distance from customers	Ignorance of customers	Poor knowledge of customer needs or attitudes	Non-customer view of products or service		
CUSTOMER BARRIERS					
Customers ignorance of products or service	Market noise	Competitor activity	Low-level importance to customers	Historical factors	Personal preferences
THE CUSTOMER (LGBTs)					

Source (Smith, 2003:8)

2.8 Critical Analysis

Bith-Melander *et al.* (2010: 219) advocate for health workers to pay special attention to transgender specific problems when offering them a service, so does (Johnston *et al.*, 2010:491; Cohen & Tate, 2006:178).

It has also come to light that there is a chance that physicians at times offer incomplete advice to their clients on HIV, although the validity of this finding was questionable (Haidet *et al.*, 2002:7). More research work is necessary and health workers ought to be conscientised on gender and sexual orientation sensitivity (Hoffman *et al.*, 2009: 228). More sentinel surveillance to determine HIV prevalence is also necessary (Rispel & Metcalf, 2009:133). Upon evaluation of IEC programmes, process and outcome should be looked at (Aggleton *et al.*, 2005: 21).

Issues such as stigma, homophobia and discrimination ought to be addressed holistically in developing supportive programmes to the LGBTs. The LGBTs should be part of the design of those programmes and the evaluation of policies and programmes. The LGBT groupings should not be responsible for their own catering or funding. The health sector also need to fund their programmes and work towards the same goal ensuring that there are no further spread of HIV and AIDS (Rispel & Metcalf, 2009:136-139).

de Wit *et al.* (2010:67) state that the complexity of HIV and AIDS prevention in LGBTs is exacerbated by the diverse needs or sub-groupings they belong to. To be able to can effectively prevent, promote or communicate messages that are likely to be effective, the starting point would be to understand the risk that the LGBTs face. Only through continuous research will the service providers be able to understand the needs of the LGBTs in terms of prevention. Programmes should therefore evolve as needs evolve and should be tailored to smaller target markets, using a variety of media to reach communities that are not likely to be reached. Planning is of intrinsic value in this regard. The literature review depicts that there is failure to segment the markets in HIV and AIDS promotion and communication, inevitably leading to possible discrimination and the strategies used may not be appropriate.

2.9 Research Questions

Based on the literature reviewed, the following research questions were developed for the intended study:

What are the service delivery gaps in health promotion and communication of HIV and AIDS prevention services provided for by the health sector to LGBTs, and how can the identified gaps be managed?

Does the mainstream health promotion and communication activities discriminate the LGBTs? If so, does it elicit any negative or risk behaviour in HIV transmission?

Is partnership between the health sector and LGBTs on health promotion and communication activities existent?

What are the needs of the LGBTs in health promotion and communication activities?

What programmes are the LGBTs recommending for change management?

Does the health sector understand the health promotion and communication of LGBTs? *See Appendix 1: Table of Construction.*

2.10 Conclusion

Homosexuality has been differently perceived and judged at different times in different cultures, yet despite the difference in perception, the reality of the need to mainstream homosexuality into health promotion and communications still remains, in observation of the fact that mainstreaming is taking place in other fields as well. The fact that HIV and AIDS is a communicable disease, needs no justification as to why the minority group of LGBTs should be a concern of the health service delivery, more so that some LGBTs are not sticking to one sexual orientation, and can cross over to the majority group of homosexuals. The study is dealing with a life threatening issue that affects all. The material consulted also proves that the LGBTs are in actual fact just a sub-group that shares sexual practices with heterosexuals.

The social stigma may be impacting negatively on the LGBTs to shout out for professional service or to source resources for support. Disclosure of being LGBT ought not to deliver them into the hands or systems of the oppressors, yet the literature reviewed proves that it is the case. Promotion and communications ought to take the challenges that the LGBTs face in the HIV and AIDS and to respond with specific or a targeted service delivery strategy that completes the comprehensive approach to the management of HIV and AIDS. There are definitely gaps elsewhere geographically, but the reality is that the results of the studies undertaken do not necessarily give answers

to the needs of the North West Province LGBTs, but an insinuation of the possibility of similar needs identified elsewhere.

The next chapter guides the reader on the research methodologies to be used in the study in an attempt to answer the research sub-questions. The chapter mainly focuses on planning and not the actual implementation of the study.

Chapter 3

Research Methodology

3.1 Introduction

In this chapter, a conceptual framework and the design of the research is discussed. The chapter highlights the academic paradigms adhered to, the data collection methods, sampling techniques, and depicts the planning phase of the study and the environment in which the study was undertaken.

The previous chapter, which reviewed the literature highlights the sensitivity of the community of interest as they were still stigmatised by the society. The stigma attached to being LGBT, demanded that care be taken throughout the research, by employing data collection and sampling strategies that limited the risks of jeopardising the study. Themes of the research emanated from the evidence of theory posed in the previous chapter.

The scope of and the limitations to the study are discussed in this chapter to give the reader an opportunity to identify the gaps of the planning phase and those experienced in the implementation phase. The researcher played attention to the psychosocial nature of the research and adopted the qualitative research model, since it is appropriate in eliciting factual and adequate information from the participants.

The research was conducted with the assistance of the Gay Umbrella, a Non-Profit making Organisation (NPO) that advocated for the rights of the Lesbian, Gay, Bi-sexual and Transgenders (LGBTs), in the North West Province of South Africa at that time. The role thereof, being to connect the researcher to the targeted respondents, and ultimately use the research as an opportunity to advocate on behalf of the LGBTs.

3.2 Research Type

3.2.1 Research Method

The research, which is a systematic process of collecting, analysing, and interpreting data, so as to understand the HIV and AIDS health promotion and communications more (Leedy & Omrod 2005:05; Bloomberg & Volpe, 2008:135). The research is qualitative as it follows a process of methodological inquiry, by exploring a probable social problem concerning the LGBTs in their natural setting (Walliman, 2005: 249; Lunenburg & Irby, 2008: 89). The study builds a complex and holistic picture of the service delivery status of the health sector towards the LGBTs, and moves towards an inquiry process of the status and needs of LGBTs on HIV & AIDS health promotion and communication (Glatthorn & Joyner, 2006: 207).

Walliman (2005:271) regards the qualitative nature of the study as anti-positivist, as it adopted usage of soft data. Welman *et al.* (2005:212) acknowledge that new data can possibly emerge during the course of the study, which is not a norm in positivist or quantitative studies. On the contrary, questionnaire design can limit overloaded emergence of new data (Gray, 2009: 338). It should also be noted, that, the subjectivity of the researcher cannot be ruled out in the outcome of a qualitative research, as recording of new information may take place all the way (Maree, 2007: 79).

The grounded theory research design, as Maree (2007:77) explains, it means that theory is grounded on the observations of the everyday life of the health service delivery to the LGBTs, at the same time trying to create meaning of what the LGBTs on the ground, were saying. The grounded theory uncovers practical understanding of what the people are saying or experiencing as the perceived problem. The intention of adopting the theory was meant for assistance in the development of practical interventions on HIV and AIDS (Denscombe, 2003:112). It should be noted that, the success in grounded theory lies in how data is finally analysed (Denscombe, 2003:114).

The researcher, in the capacity of an individual, partnered with the Gay Umbrella, a Non-Profit Making organisation that advocated for the rights of the LGBTs. The role of Gay Umbrella was to link the researcher with the LGBTs, as coming out of the closet was still a sensitive issue.

3.2.2 Data Required

The data required was primary data as it was collected from the primary or firsthand source experiencing the probable problem, the LGBTs. Data collected was soft data and provision was made to translate it into quantifiable analysis. The data themes and questions were regarded to be reliable as they could be used in other geographic areas under similar circumstances. The fact that the researcher derived theory from studies on the LGBTs, it was adequate to deem data as internally valid. The external validity or possibility of generalising the data were not immediately confirmed at the beginning of the study, more so that Rudestem and Newton (2007:113) see it as the opinion of the reader, and not the author as to whether the study could be generalised or not. Secondly, biasness on pre-emption of data analysis was avoided, by not confirming generalisation, especially in a qualitative study (Rudestem & Newton, 2007: 111).

Data was adequately collected as per specifications in questionnaires. Questionnaires with unreadable data were considered as invalid. The data collected was regarded as appropriate as it derived themes from the theory of literature review and the models of responding to needs of LGBTs as suggested by previous studies (Rudestem & Newton, 2007:114).

3.3 Data Collection Method

3.3.1 Methods for Collecting Primary Data

A control and confidential consent form was designed, of which cited an explanation to the respondents that under confidential consent: they were giving permission that their responses may be used for research purposes, provided their identity was not to be

revealed in the published records of the research, furthermore, the respondents could only be contacted by the Graduate School, University of the North West, in collaboration and with permission from the Gay Umbrella Organisation. The arrangement was undertaken in order to observe the moral principle guiding research (Gray, 2009: 69).

The instruction part of the questionnaire had a grid, which made provision for respondents to give permission that their responses may be used for research purposes, on the condition that their identity was not revealed in the published records of the research. Under this consent, the participants only signed and wrote in the date on which the questionnaire was filled. The very same grid provided for inclusion of a serial number for the questionnaire. In terms of control, the independent form already alluded to in the first paragraph made provision for the full names of the respondents, and communicated to the respondents that after they have signed the form, it was to be kept safe and confidential by Gay Umbrella, to assist in case proof is needed that the research took place or its truthfulness is checked (Gray, 2009: 69-70).

In essence, Gay Umbrella kept contact information of all research participants, and was not included in the questionnaire. Serial numbers were used to enable tracking of participants when the need arises. The rationale for the arrangement was that, the Gay Umbrella Organisation was the link between the researcher and the participants. The organisation was working from a data base of the LGBTs that it had, and it could not be given to the researcher as it would have bridged confidentiality. Being on the database did not imply that the person has come out of the social stigma closet. At the same time, some system of control was necessary in the research project

3.3.2 Data Collection Tool

A standardised questionnaire, with closed-ended questions was designed as it offered both fidelity and structure, state Rudestem and Newton (2007:111), in a sense that it reduced words and ideas, inevitably assisting to avoid data overload and secondly enabling numeric or statistical encoding of qualitative data (Rudestem & Newton,

2007:111). Thirdly, to enable content analysis, or quantitative analysis of qualitative data as indicated by Welman *et al.* (2005: 221). Lastly, standardised questionnaires were cost and production effective (Gray, 2009:338).

Theme or topic coding was done by dividing the questionnaire into the different parts, that is, out of a total of 7 parts, 5 parts categorised information into topics which were in line with the research questions asked in the previous chapter. Part 3 asked general personal details which is descriptive data, part 4 asked about the gaps in services delivery, part 5 asked about discriminatory practices, part 6 asked about the partnership between LGBTs and the health sector and part 7 asked about the needs of LGBTs. Topic coding was geared at enabling sorting and refining of data, especially upon statistical analysis, but simultaneously assisting the researcher in data administration (Rudestem & Newton, 2007:182; Gray, 2009:338). The other parts that are not alluded to, were a guide to the questionnaire. *See Appendix 2: Research Questionnaire.*

Since the research featured qualitative data collection, room was made for emerging categories of topics upon data analysis, but in this case the standardisation and usage of close-ended questions limited that, as such new ones were categorised as other in order to avoid jeopardising the perceptions of the respondents. Then again, the category stating other, could not be overused as it had potential to be a deterrent (Gray, 2009:338; Denscombe, 2003:160).

In order to achieve validity, care was taken to ensure that the face or the outside cover of the questionnaire looked professional and trustworthy and can be traced back to an institution. The different sections of the questionnaire were also aligned to the research questions to ensure that all that needs to be measured was contained in the questionnaire and that the themes were well explored (Maree, 2007:217). The themes emerged as the research was unfolding (Neale, 2009:262). After all that has been stated, it should be realised that qualitative data analysis or its outcomes are pure, but

may just be a description of the researcher's interpretation (Gray, 2009:338). See *Appendix 4: Research Themes Matrix*.

3.4 Sampling Methods

The LGBTs who participated in this study may be referred to as the interest community, as they were sharing identity, but not the geographic location. The participants were sampled through snowballing in the North West (NW) Province, Ngaka Modiri Molema (NMM) District, and were from the different towns which are Mahikeng, Itsoseng and Bodibe. Keller (2006:67) views sampling as a statistical way of responding to limited resources. The sampling frame used, which according to Gray (2009:148) and Denscombe (2003:12) refer to the selection criteria, in this case, the database of 450 LGBTs province-wide registered by Gay Umbrella's, states Baird (2010:18) in the year 2010, upon review in January 2011, the data-base enlisted 632 participants. Out of the 632, a population or the number of people who can possibly participate in the research were 270 from NMM District, explains Gray (2009:148) and a sample of 169 was targeted for research as per model on Educational and Psychological Measurement of Sampling (Lunenburg & Irby, 2008:180). Provision was also made for the possibility of spoiled questionnaires, as a result, the 169 targeted was inflated by 11 with a new target sample of 180.

Probability sampling was used, which gave all in the sampling frame equal probability of participating in the research (Vogt, 2005: 262; Welman, 2005: 59; Denscombe, 2003:12). Snowball sampling was used, meaning that LGBTs on the database could further refer the researcher to other LGBTs who are good participants for the study, irrespective of being registered in the database or not (Lunenburg & Irby, 2008: 89; Maree, 2007: 217). Random sampling which Denscombe (2003:12) describes as having to take a representative cross section of a sampling frame, would have not been appropriate as it may have limited the participants that could have been reached. It meant that the LGBTs that recorded in the database, may have not participated due to having not disclosed their sexual orientation to their families or in their societies, that is, due to the social climate not being favourable (Denscombe, 2003:20). Snowballing

gave the researcher the opportunity to reach those not in the database and to stay cautious on exercising confidentiality.

The initial plan was to use the opportunity of selecting the LGBTs who will be gathering at the Gay Umbrella's annual provincial festival usually held towards the end of March annually, and working on a population of 632 and provincial scope as opposed to the district scope. The district scope was a contingency measure to the unfavourable time frames of the research study, as the data collection methods were negatively impacted upon. The time frame of the research study was reduced in order to comply with the academic time frames. LGBTs could no longer be found in one setting and questionnaires be administered by the researcher at once. The new strategy required taking Gay Umbrella staff from their routine duties, to travel with the researcher to the field and as a result escalated the research data gathering costs and time. Time and cost efficiency were a challenge.

3.5 Types of Variables

The rank order scale or ordinal scale gives a relative position of a score in a series of score, explains Vogt (2005: 263) and was mostly used, for instance, an analysis of LGBTs, in ranking order and feelings of being discriminated against. Thomas and Brubaker (2008: 227) and Eysenk (2004:1) refer to such categories quantities, arranged sequensetially, from high to low as distribution statistics. The easy to understand, summarised information in quantitative form is descriptive statistics. Furthermore, in cases whereby the association of measure was made between two variables, the chi square was used to test the independence or goodness-of-fit, indicates Vogt (2005: 43), for example, finding out if the younger or older LGBTs think that they are being discriminated against in HIV and AIDS promotion and communications.

Ordinal variables best suited the structuring of the questionnaire which already categorised information, that was ranked per different categories. Vogt (2005: 303-305) also suggests the Spearman Correlation Coefficient (Rho) for correlation of rank

difference or association between 2 sets of ranks. A statistic that shows the degree of monotonic relationship between the two variables. Keller (2006:11) believes that anything that can be perceived is measurable. The most important thing is to stay close to the data (Lunenburg & Irby, 2008:240).

3.6 Ethical Considerations

The following research ethics or moral principles guiding the research were observed: participants were informed on the names of institutions involved in carrying out the research; provided with information on the purpose of research, methods and benefits to all participants; offered the LGBTs the opportunity to seek clarification on study processes and requirements; designed the questionnaire in such a way that the identity of participants was not revealed, and still developed a control tool that enabled tracing back the truthfulness of the study and granting of consent; made provision for participants to have the freedom to skip questions that made them uncomfortable; received authorisation to conduct the study from the Gay Umbrella organisation as research partners and the advocacy institution for LGBTs; engaged the Gay Umbrella in screening the appropriateness of the language used in the questionnaire. See *Appendix 3: Research Control Tool*.

The study took into consideration not to subject the participants to mental suffering, for example, maintaining privacy since some have not come out through snowballing; provided with information that the results may be fruitful in the advocacy processes of the LGBTs in the health sector; and participants were given an option not to participate (Walliman, 2005: 342; Gray, 2009: 69-70; Driscoll & Brizee, 2010:1).

3.7 Limitations of the Study

The following factors were limitations to the study: standardisation of questionnaire may have limited perceptions of respondents (Gray, 2009:338), and the sampling frame was biased as it only registered the LGBTs that have come out or that were reachable; and the strategy used to access data required more time and resources (Denscombe, 2003:18).

3.8 Conclusion

The chapter gave in-depth information on the research design, data collection methods, sampling techniques and limitations to the study. Care was taken in the research design to ensure that the sensitivity of the interest group under study is observed at all times, but at the same time guarding against jeopardising the study findings. The information provided highlighted how the theories merge with the practical approach to the exploration of the needs of LGBTs on HIV and AIDS health promotion and communications.

The next chapter will focus on analysing data post collection. The focus will be on the answers obtained to questions in questionnaires, all answers to a specific question will be depicted using statistical methods, and will be discussed in relation to what came out of the literature that was reviewed. The relevant measures of association will also be explained.

Chapter 4

Data Discussion

4.1 Introduction

Data were collected with the intention of indicating if there are gaps in the health promotion and communication of HIV and AIDS amongst the Lesbian, Gays, Bisexuals and Transgenders (LGBTs). The gaps being referred to may be a result of discriminatory practices in service delivery as found out in the literature review. In other geographical locations, studies showed that the LGBTs are marginalised in the health promotion and communication of HIV and AIDS, but there was no information with regard to the community under study.

Other than obtaining personal details of the respondents, the research questions focused on the following: identification of gaps in the service delivery of the health sector on HIV and AIDS health promotion and communication; the discriminatory practices and the risks that discrimination can bring with such practices if prevalent; furthermore, the study uncovered the status of partnerships of the health sector and the LGBTs; and lastly, the study investigated the health needs of the LGBTs.

This chapter outlines the discussions on the questions, by following the same sequence of the above stated focus areas, followed by the Measures of Association on the different questions, that is correlation of the relation between two or more variables, and concluding remarks.

4.2 Response Rate

The data base of the Gay Umbrella; the sampling frame, at the beginning of the study only recorded 632 Lesbian, Gays, Bisexuals and Transgenders (LGBTs) in the district studied. Disclosure of the LGBTs sexual orientation status was still a sensitive issue in the community under study due to stigmatisation, thus a possibility that the sampling frame could have been bigger.

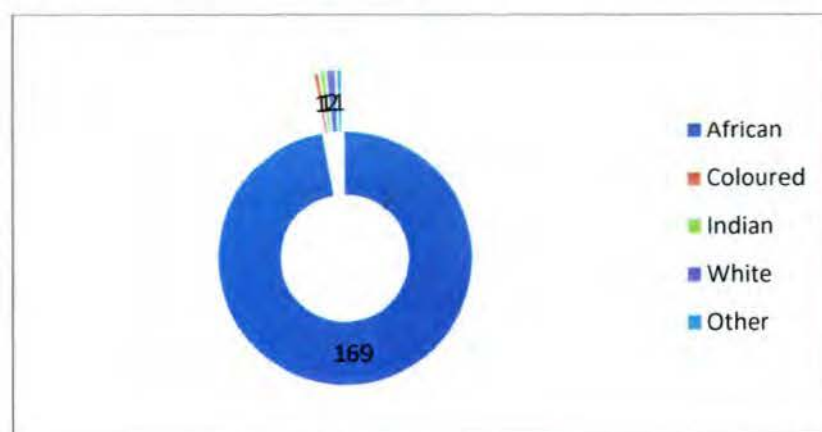
The required sample was 169 and a total of 180 LGBTs responded, giving a total of 174 valid questionnaires, thus enabling a higher response rate of 103%. A higher number in the distribution of questionnaires was deliberately carried out, in an attempt to accommodate the possibility of some of the questionnaires being invalid. Data in questionnaires were summarised on a spreadsheet and the statistics were calculated using Statistical Package for the Social Sciences (SPSS).

4.3 Demographics

The sampling frame of Ngaka Modiri Molema District was 270. Initially, the researcher's intention was to conduct the study in the whole of the North West Province, which had 4 districts. A slight deviation was made, by limiting the scope of research to a district, due to new research time frames set by the academic management.

Snowballing sampling was used, where respondents referred the researcher to others state Lunenburg and Irby (2003:12), thus making it not feasible to obtain a geographically wider sample of the whole North West Province, given the shorter time frames. Some respondents originated from other districts not included in the study, and temporarily stayed in the Ngaka Modiri Molema District for either work or study purposes. The majority were traced at the North West University, Mahikeng campus, and others at parties or entertainment forums.

Figure 4.1 Races of the respondents



The pie chart above shows that out of the 174 respondents the majority were Black. The community under study was predominantly Black. One of the reasons why the study was conducted in this community is that one of the South African studies conducted in Gauteng Province reviewed, indicates by percentage that more Blacks are too scared to test for HIV states Wells and Polders (2004:20), another reason being that the study adopted voluntary snowballing sampling, as a result, few respondents belonging to the other races were approached at entertainment gatherings, where the researcher was invited.

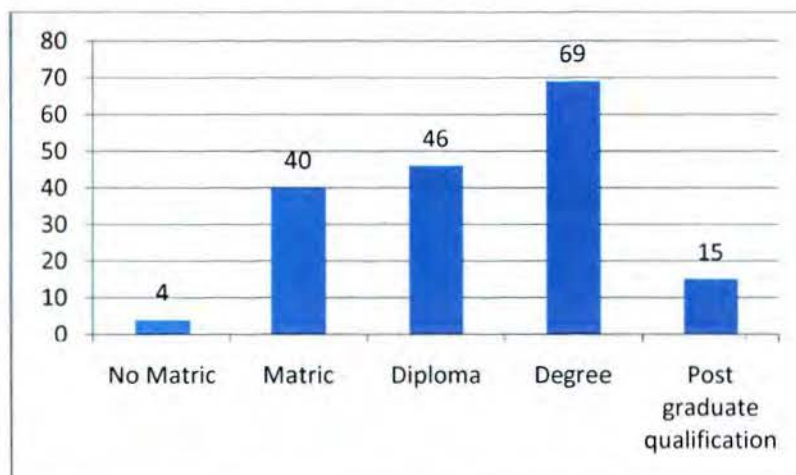
The race category: other, referred to any other category of race that was not classified in the questionnaire and was not part of the mainstream races found in the North West Province.

Table 4.1 Ages of the Respondents

18-21	69
21-35	57
35-40	22
41-50	15
55	11

The above nominal data on the ages of the respondents shows that most respondents were youth. Literature reviewed indicates that adolescents or young LGBTs are the most vulnerable, as they are at the age of coming out of the closet, and require more support from others; unlike the older ones (Wells, 2005:12; Wells & Ponders, 2004:7). As peers, they were likely to identify each other for participation in the study, unlike the older LGBTs who were already grounded in their sexual orientation.

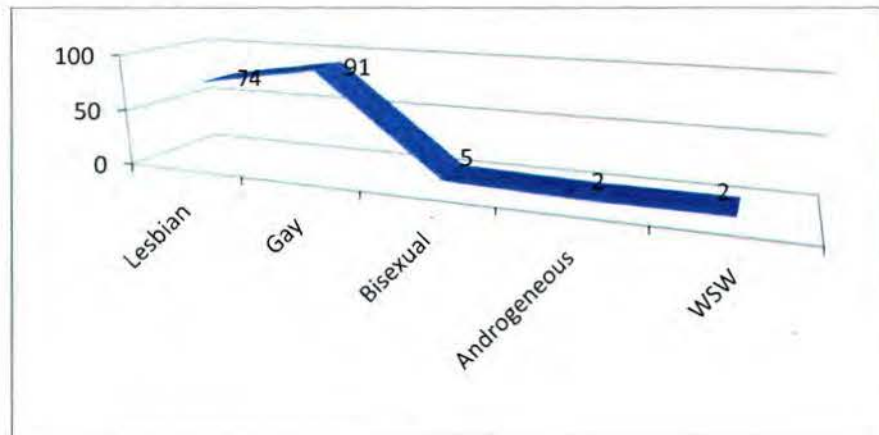
Figure 4.2 Qualifications of the Respondents



The majority of the respondents were traced at the university as already indicated under demographics. The fact that most respondents were highly qualified, holding a degree, indicates reasons for obtaining a higher response rate or high questionnaire validity (Rudestem & Newton, 2007:111). It may also indicate that the respondents likely understood the rationale and value of the research, and the impact that the results may have on them (LGBTs) as a group of interest. The results of the research could be used for advocacy on LGBTs health issues.

Usage of the questionnaire as a tool was also appropriate for the learned as they were likely to give appropriate responses. The learned were likely to search for information on their own, for example, do more fact finding on the HIV and AIDS promotion and communications issues, without waiting to be approached; the common media being to surf the net (Kunaga & Rosenfeld, 2004:12). In addition, the respondents were younger, still sexually active and may have been practicing more than one sexual orientation; also needing to know more about safe sex across the different sexual practices. The research did not focus on the LGBTs self-acquisition of information, but on whether they are favoured during promotion and communications.

Figure 4.3 Sexual Preferences of the Respondent



The questionnaire only focused on the predominant behaviour practiced by each respondent, though literature cited that one individual might practice more sexual orientation, for example, a lesbian may sometimes engage in sexual activity with men. The different categories of sexual orientation that respondents could choose from also included categories such as, transsexual, transgender, intersexual and lastly, men sleeping with men, which the respondents did not identify themselves with.

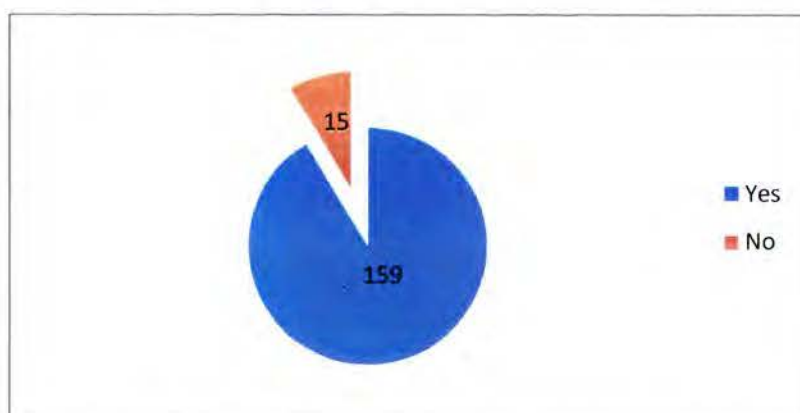
The sexual orientation chosen meant the following: Lesbian: A woman whose primary sexual and romantic attraction is to other women. Gay: A man whose primary sexual and romantic attraction is to other men. Bisexual: A person who has sexual and romantic attraction to both men and women. Androgeneous: Exhibiting approximately equal proportions of masculine and feminine characteristics simultaneously; and MSM: Men having Sexual relations with other Men.

Data showed that, in the North West, Ngaka Modiri Molema District, there were more Gay Men, followed by Lesbian Women. This finding concurred with the latest study conducted in the province by Baird (2010:30), where 78% of men, and 75% of women indicated that they had sex with someone of the same sex. It should be noted that MSM and Gay may be meaning the same thing, though the popular term was Gay.

4.4 Results of Investigation

Figure 4.4 - 4.5 hereunder outlines responses to questions that focused on the gaps in service delivery, pertaining to HIV and AIDS health promotion and communications by the health sector to LGBTs. Figure 4.6 – 4.13 and Table 4.1 - 4.2 elicits information on what LGBTs see as service delivery gaps and discriminatory practices in promotion and communication. Figure 4.14 - 4.17 reveals findings on the status of partnership between the health sector and the LGBTs; Figure 4.1 - 4.24 uncovers the needs of LGBTs with regard to promotion and communications.

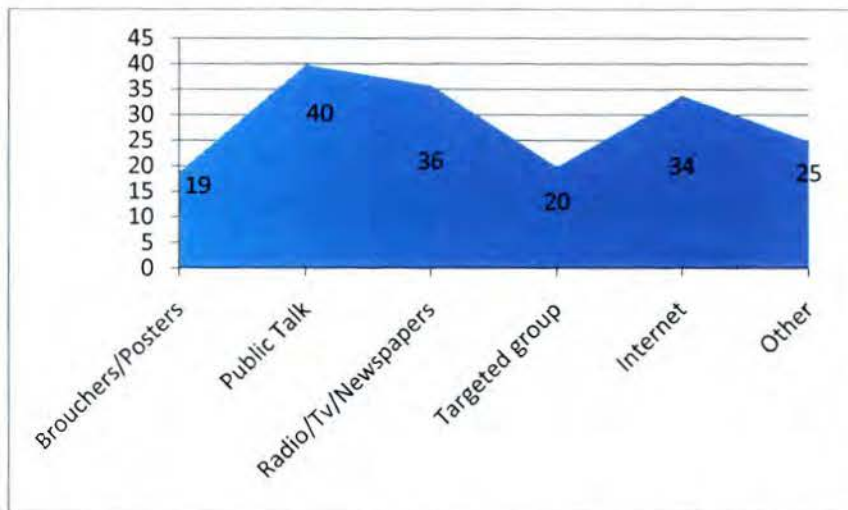
Figure 4.4 Exposed to or received any health promotion and communication material or talks on HIV and AIDS by the health sector



The question sought to find out if the respondents were ever exposed to any health promotion and communication material or talks on HIV and AIDS by the health sector; and not if they knew anything about HIV and AIDS. The respondents may have been informed about HIV and AIDS, but the issue is, does information ever come from the health sector.

Out of the total respondents, 15 of the respondents did not receive health promotion and communication material or talks on HIV and AIDS offered by the health sector. One hundred and fifty nine did get the opportunity of exposure to health promotion and communication material or talks on HIV and AIDS, the source being the health sector. The fact that many were exposed, it meant that questions that followed on discriminatory practices and needs analysis were likely to be answered honestly.

Figure 4.5 What type were you exposed to



Different types of media were generally used to impart information; with public talks, print, electronic media and the internet mainly used to reach the LGBTs. It should be borne in mind that public talks can range from academic and non-academic sessions, whereas print, electronic media and the internet require certain levels of literacy. On that note, literature review revealed that most young LGBTs would surf the net or try other avenues to obtain information on health issues (Doring, 2009:1094; Kunaga, 2004:1). On the other hand, the very same popular media were used by the health sector to reach out to the public.

Figure 4.6 Do you think that the lgbs needs on HIV and AIDS health promotion and communications are met

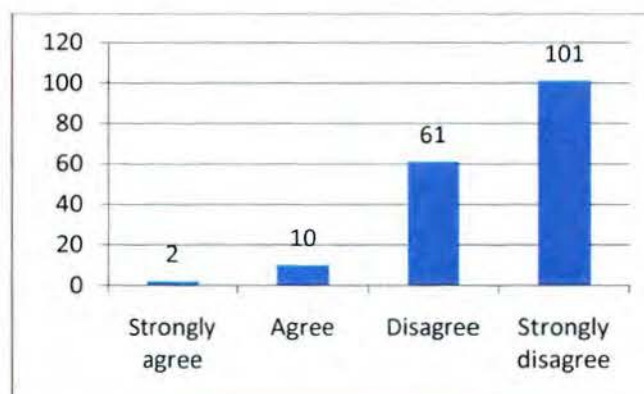
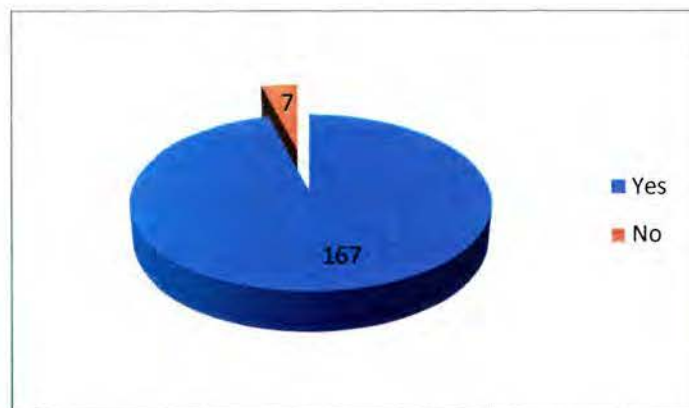


Figure 4.4 confirmed that the majority of LGBTs were exposed to some form of HIV and AIDS health promotion and communication; Figure 4.5 shows that the majority did receive public talks, used print and electronic media, and the internet; and Figure 4.6 is

showing that the LGBTs exposed to some form of promotion and communication strongly disagreed that it met their needs.

Meeting of needs meant, the kind of information imparted, irrespective of it being mainstream or targeted, met what the LGBTs needed to know about HIV and AIDS.

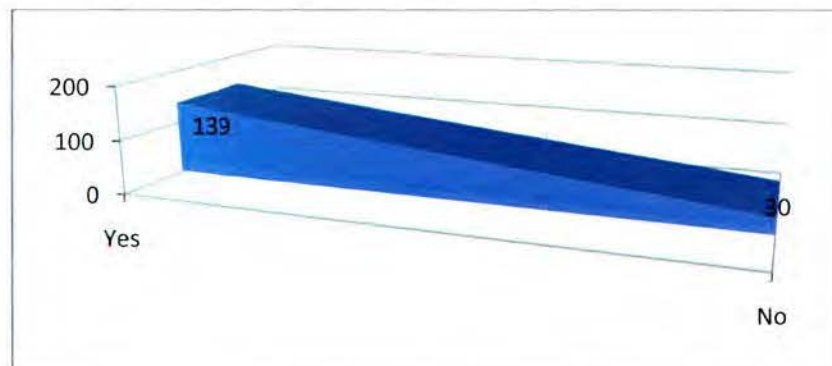
Figure 4.7 Do you know what is to discriminate



Discrimination, with reference to gender discrimination - it is preference of one gender over the other. An act of prejudice or unfairness. Health workers may discriminate clients intentionally or unintentionally, but theory tend to prove that discrimination may be a result of health workers not trained or knowledgeable on such issues (Keiswetter & Brotemarkle, 2010: 273).

A significant number of LGBTs showed that they knew what discrimination meant. The questionnaire also explained discrimination prior to answering of questions, meaning, the 7 that did not know what discrimination was, were brought on board, and the rest given an opportunity of common understanding of the term.

Figure 4.8 Do you think that promotional material / talks on HIV and AIDS discriminates against the lgbt



Having solicited common understanding on gender discrimination in Figure 4.7; the above Figure 4.8, indicates that most LGBTs regarded the material used as discriminating. The question that arises is: if Figure 4.6 shows that the LGBTs exposed to some form of promotions and communication strongly agreed that it met their needs; how can meeting of needs be differentiated from being discriminated against.

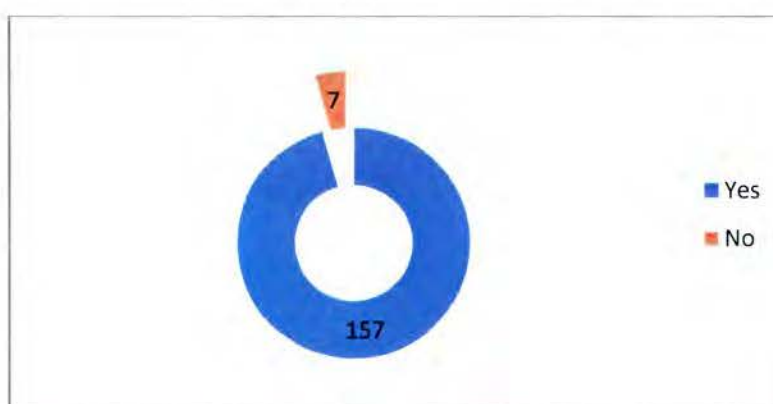
The difference may be, despite receiving information that meet the needs, discrimination still existed. Linking it with Figure 4.5, the LGBTs did explore other avenues to find HIV and AIDS information. What came out of the literature review was that, health care literature has a tendency of communicating homophobia and heterosexism (Wilton, 2000:15).

Table 4.2 Which medium is mostly used as a discriminatory tool

Type	Frequency
Vouchers/Posters	21
Public Talk	46
Radio	20
Newspapers	20
TV	20
Mass event	10
Theatre Group	1
Targeted group	21
Internet	10
Other	5

The very same media that the LGBTs were mostly exposed to, is the one that they regarded as mostly discriminating them. The types of media were derived from the literature consulted; it was therefore necessary to create the category 'other', to make room for any other type of media that the researcher may have not conceived mentally. The district under study only had one theatrical theatre.

Figure 4.9 Is discrimination likely to increase the hiv transmission risk



In his recommendations, Rokotananahary *et al.* (2002:343) state that, in promotions and communications, the understanding of the target market is important to enable addressing of issues relevant to them. Double discrimination of being LGBT and HIV was likely to increase HIV infection risk as they are marginalised (Keiswetter & Brotemarkle, 2010: 273).

Figure 4.10 If you think discrimination exists, do you try to use the messages that are not targeted to you for your own benefit

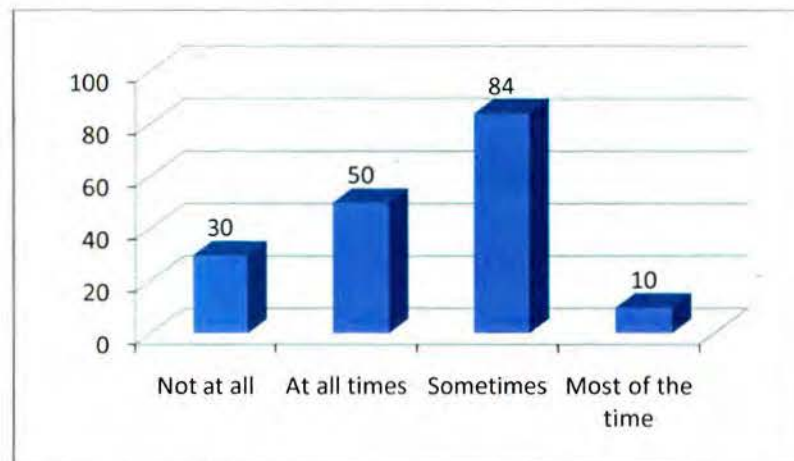
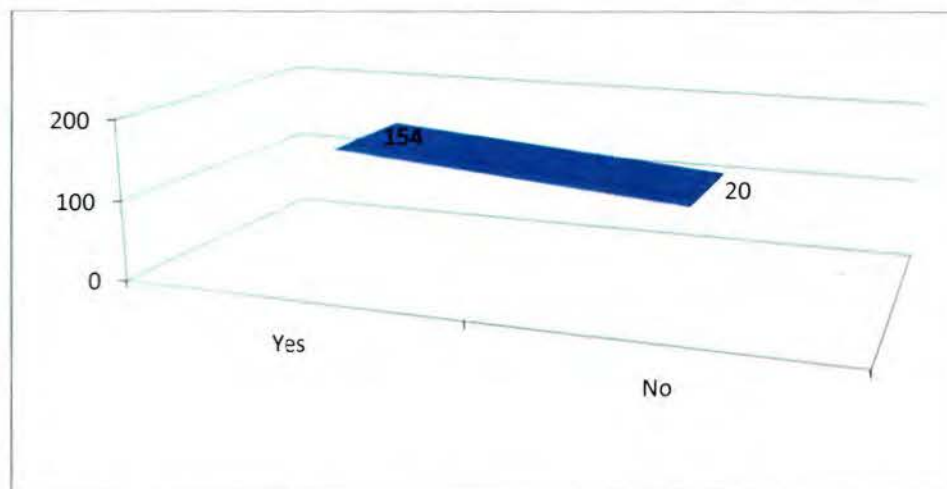


Figure 4.10 shows that the majority of the LGBTs sometimes use the messages that are not targeted to them for their own benefit. Only a few would most of the time do that. This issue warrants pondering on the rationale for promotion and communication. The processes are geared at changing behaviour positively, simply to reduce new HIV infections (Shapiro & Ray, 2007:1). Figure 4.9 tallies with Figure 4.10. It is quite obvious that if LGBTs do not always try to use general information for their own benefit, they will be at risk.

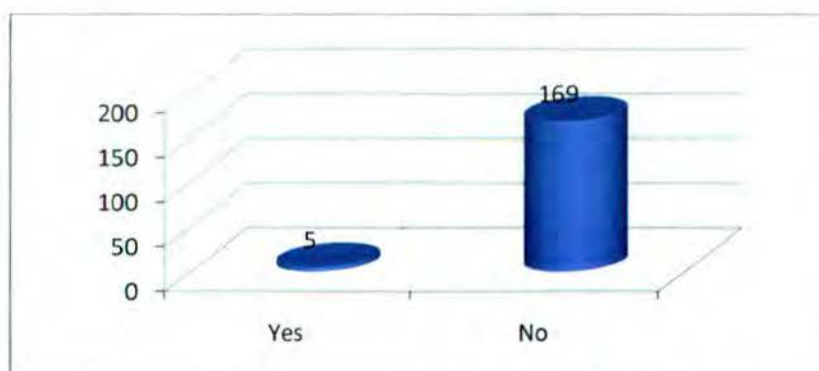
On the contrary, theory indicates that by not offering the LGBTs targeted promotion and communication, the health sector was missing them and failed the integrated approach to HIV and AIDS interventions. It is a risk reduction measure to understand the clients' point of view (Haidet *et al.*, 2001:27).

Figure 4.11 Do you know any of the LGBTs who get infected with HIV due to them having not received any information on HIV



The respondents were making a statement about someone they know to have been infected due to having not received information on HIV, and not necessarily a participant in this research. Figure 4.2 indicates that it is important to note that the participants in the study were literate. The same scenario could not be assumed for the people that the respondents knew. The assumption may be true as literature pointed out that the literate and urbanised were more likely to respond to promotion and communications (Bessinger *et al.*, 2004: 402- 406). Then again, there are social issues that may lead to unsafe sex such as marriage, or a woman who is in a disadvantaged position in a relationship.

Figure 4.12 Have you been at risk of getting HIV due to having not receiving information on it



The above Figure 4.12 states that the respondents, were not at risk of being infected with HIV in the past due to having not received information. The group being referred to

is a literate group. Previous studies prove that the literate would use services such as the internet to obtain information on sexuality or HIV, states Doring (2009:1094). Figure 4.5 confirms that the use of internet is also one of the preferred methods of obtaining information, hence the respondents would have not been at risk in the past, despite the health sector having not reached out to them.

Figure 4.13 Do you currently consider yourself to be at risk of HIV infection as a result having not received information on it

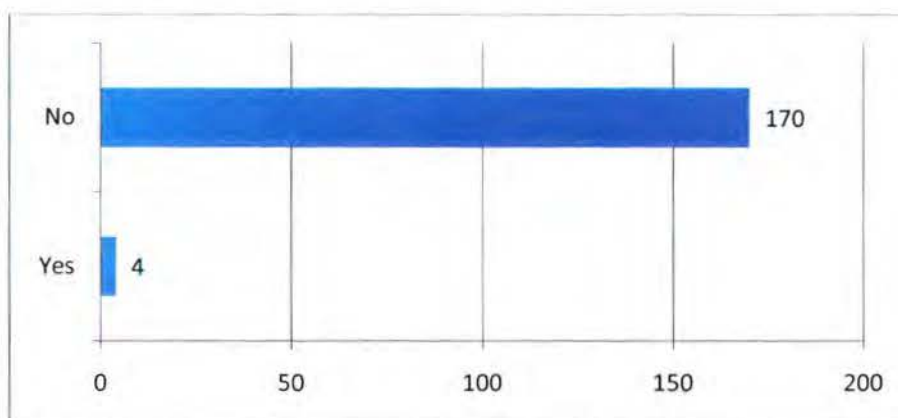


Figure 4.12 and 4.13 are almost similar, the difference is that the above Figure 4.13 is focusing on the current, whereas the previous focused on the past. The arguments under the two will therefore be the same.

The group being referred to is a literate group. Previous studies prove that the literate would use services such as the internet to obtain information on sexuality or HIV (Doring, 2009:1094). The use of internet also is confirmed by Figure 4.5 as one of the preferred methods of obtaining information, hence the respondents would have not been at risk in the past, despite the health sector having not reached out to them.

Figure 4.14 Are you aware of any forums where the health sector meets the LGBTs

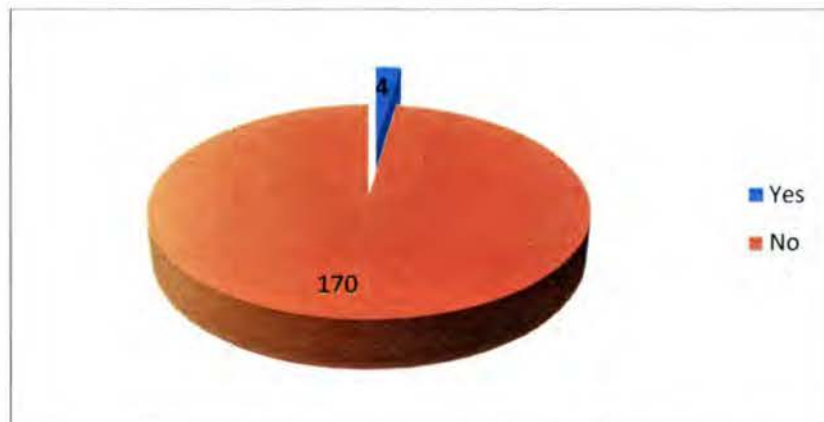
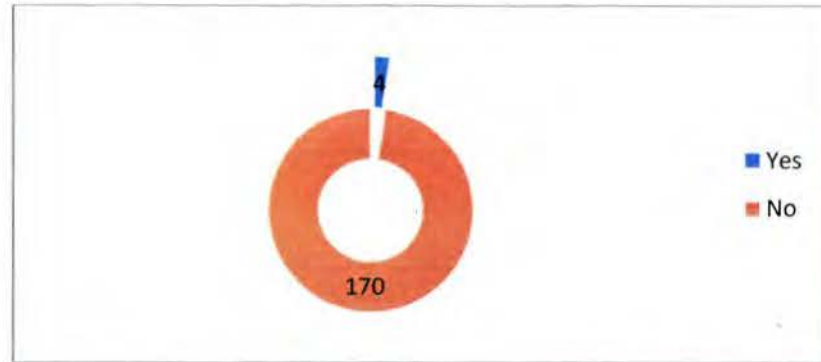


Figure 4.14 reveals that the respondents were not aware of forums where health and LGBTs meet to discuss the health issues. It could be there were no such forums in existence, hence the respondents were not aware of them, more so that arguments stated under Figure 4.5; 4.12 and 4.13 shows that the respondents do search for information that benefits them. Secondly, the Gay Umbrella Organisation, may have not at the time established sound working relations with the health sector; hence no forums that the LGBTs were aware of. Gay Umbrella is the organisation that provided the sampling frame for this research, and it was advocating for LGBTs rights.

Through these forums, development of programmes will evolve. The programmes should be tailor made to reach smaller markets such as LGBTs. The LGBTs ought to be part of the design and evaluation of those programmes (Rispel & Metcalf, 2009:136-139; de Wit *et al.*, 2010:67).

Figure 4.15 If yes, are you participating in such forums



Based on the arguments of Figure 4.14, the findings above in Figure 4.14 were sensible as the respondents could have not participated in forums they do not know or forums that were not existent. According to Hoffman *et al.* (2009:228), it could be that more research work is still necessary, which includes the conscientisation of health workers on such issues.

Figure 4.16 Do you participate in the planning and running of health sector promotional and communication activities to LGBTs

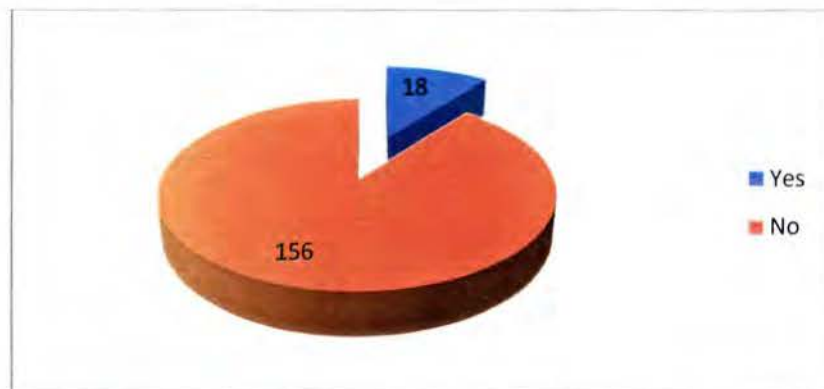
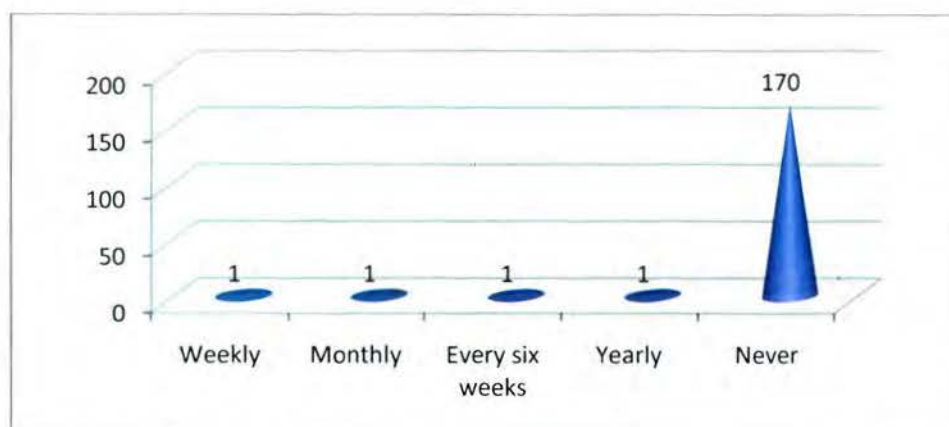


Figure 4.16 shows that only a few LGBTs were participating in the planning and running of health sector promotional and communication activities to LGBT's. As opposed to participation on the issue of forums depicted by Figure 4.14, there was a slight increase in the number participating in the planning and running of health sector promotional and communication activities to LGBTs in Figure 4.15. This may mean that, as individuals, some of the LGBTs may have been working with the health sector, whereas as organised forums it was not taking place.

Figure 4.17 How regularly do you participate in health sector, HIV and AIDS activities



In relating Figure 4.17 to 4.16, there is an apparent inconsistency of information, though not a wide gap statistically. Figure 4.16 states that 156 LGBTs were not participating in the health sector, yet Figure 4.17 states that 170 LGBTs never participated, a difference of 14 LGBTs. Participation was considered to be very minimal, and arguments cited under Figure 4.14 and 4.15, which raised the importance of setting up programmes for the LGBTs and the need for more research would apply.

Figure 4.18 Rating on the relationship between the health sector and LGBTs

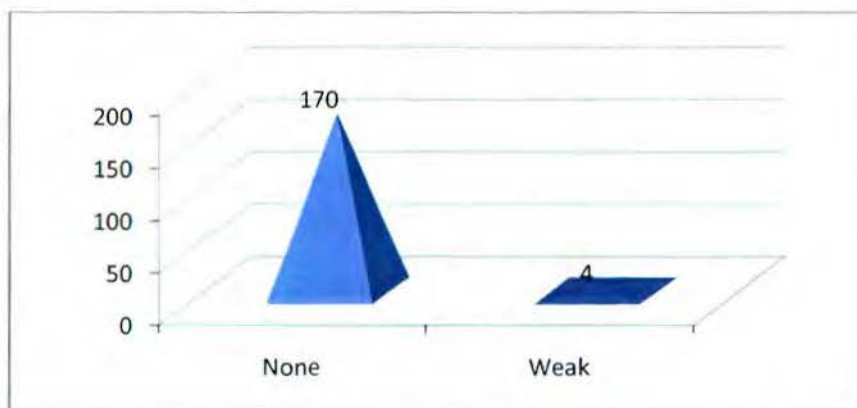
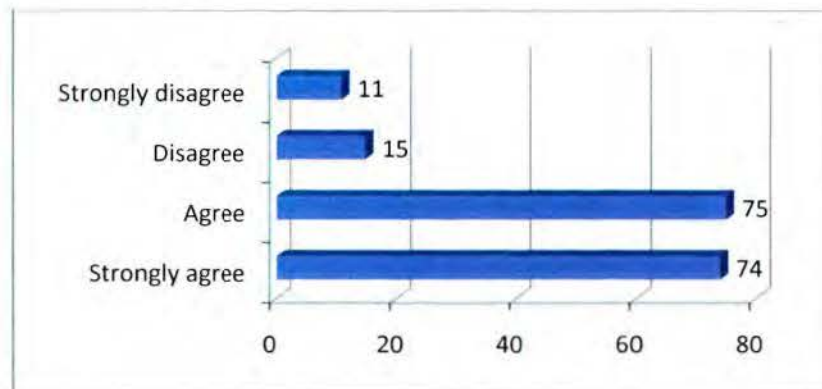


Figure 4.18 results were consistent with the previous 4 consecutive Figures: 4.14 - 4.17. Unawareness of forums and minimal participation in health and LGBT forums or health programmes in general was already established

It is important to recognise that the lack of the apparent gaps in collaboration between the health sector and the LGBTs may be as a result of health workers not knowledgeable on LGBT health issues, as stated in Figure 4.14.

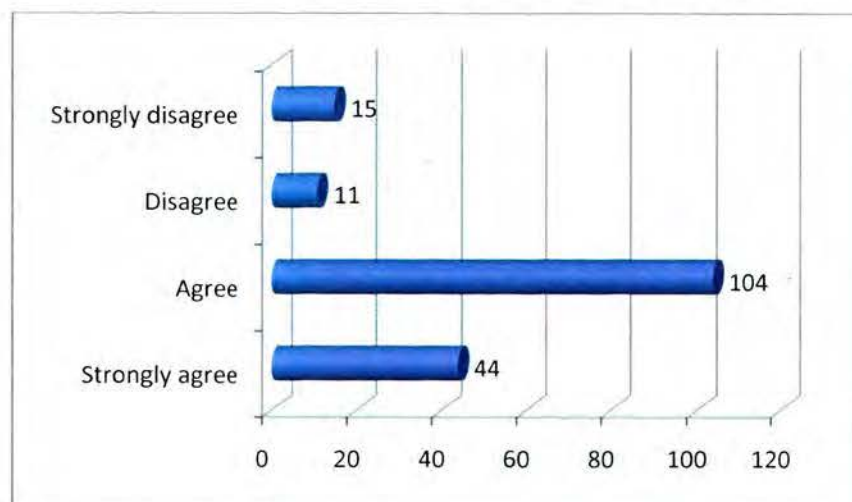
Figure 4.19 The relevance of messages on HIV and AIDS promotion communication to the LGBTs



Taking into consideration Figure 4.8, which indicates that the material used is discriminating the LGBTs, and Figure 4.10, which indicates that despite being discriminated against, the LGBTs would sometimes use provided information for their own benefit; may be suggesting that messages are relevant for the public, indicates Figure 4.19. The majority agrees and strongly agrees that the messages are relevant.

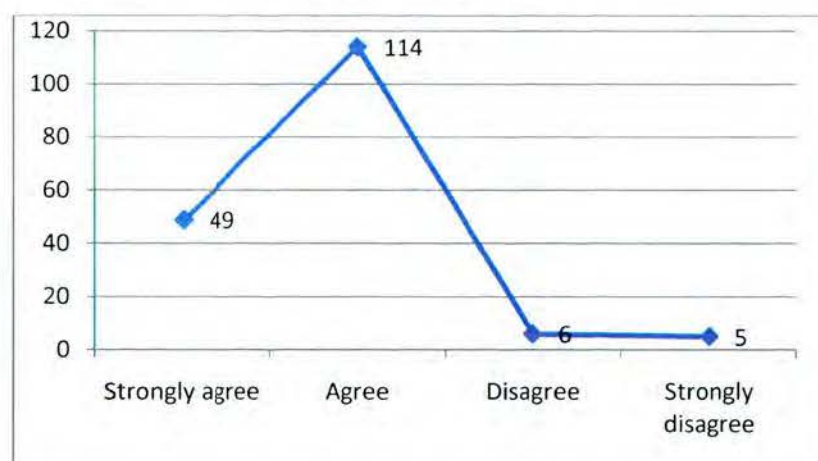
Deductions can therefore be made that the messages are relevant for all, or advice can be applied to all, irrespective of one's sexual orientation, but theory has proved that communications tend to focus mainly on heterosexual inferences. Such subtle discrimination, may cause negative attitudes and cannot be defended morally. Target marketing is suggested in this case (Keiswetter & Brotemarkle, 2010: 273). The appropriateness of messages can only be achieved if the LGBTs are involved.

Figure 4.20 Do you think that the media used to spread messages on HIV and AIDS promotion communication are relevant to the LGBTs



In Figure 4.20, respondents show that they agree that media used to spread the messages are relevant. The fact that the respondents are not agreeing strongly means that there is still room for improvement in the health sector in terms of the media used to reach out to different target markets. The used media, may not be interesting to or reaching the LGBTs. For instance, creativity may be explored in theatrical message dissemination whereby the health sector gets to understand the target market's needs, develop relevant scripts and dwell on how the message should be delivered (Low, 2010:123).

Figure 4.21 Do you think that the language / lingo on HIV and AIDS promotion communication are relevant to the LGBTs



Arguments under Figure 4.21 are similar to those under Figure 4.20. Most respondents agree to the relevancy of the language used during message development, a response of strongly agreeing may be proving that the health sector was providing the service appropriately. The already alluded to idea of setting up forums where the health sector will meet the LGBTs is likely to alleviate such concerns.

Figure 4.22 What are your most preferred programme to reach out to LGBTs on HIV and AIDS

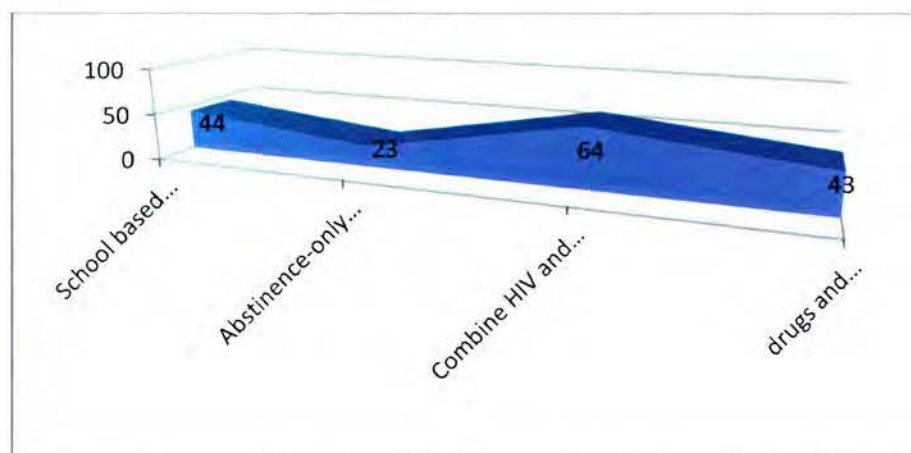


Figure 4.22 highlights that combined HIV and AIDS programmes were preferred, that is, integration of the HIV and AIDS programmes with others may it be mental, reproductive and drug programmes. Comprehensive programmes alluded to here were not investigated in relation to market segmentation. LGBTs chose school health programmes as the second best, meaning more health education may be necessary at a lower level. This fact also came about in theory, confirming that young people in general are vulnerable to HIV and AIDS infection, hence needing more information for guidance.

Figure 4.23 Do LGBTs need targeted HIV and AIDS promotion and communication, other than being part of activities targeting all

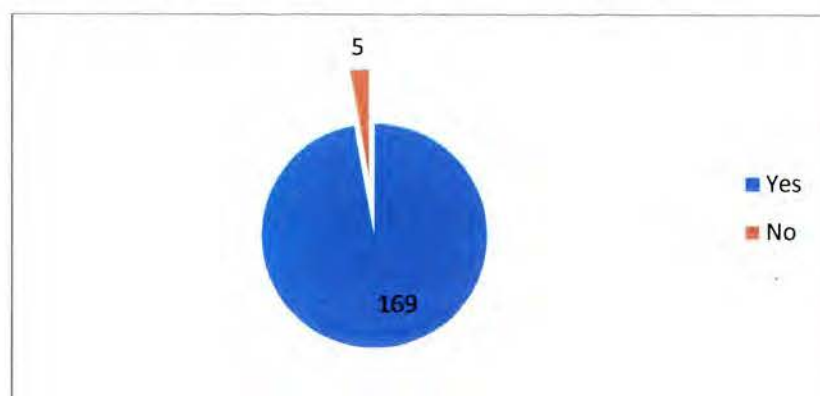
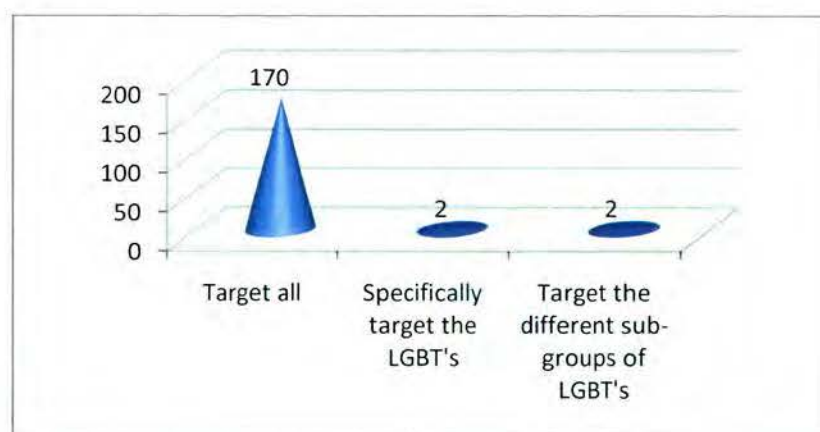


Figure 4.23 focuses on promotion and communication that targets specific groups, in this case, the LGBTs; by so doing, the issues that are specific to the LGBTs will be addressed. For example, an HIV positive LGBT may suffer double stigma in the society, the HIV and the sexual orientation status (Keiswetter & Brotemarkle, 2010: 273). The bigger market activities may not cater for such specifics. It is important to realise that all messages should not discriminate anyone in homogeneous markets, yet in this research, such discrimination was noted in Figure 4.8.

Figure 4.24 Who do you prefer Information, Education and Communication material to target



The LGBTs opted for non-segmented health promotion and communication Information, Education and Communication (IEC) material to target all. Figure 4.23 focuses on general promotional activities, whereas Figure 4.24 focuses on IEC material. To sum it up, material can be developed for the homogeneous market, but activities or programmes for the segmented market.

Literature reviewed made general statements for target specific interventions, whereas this research reveals something new, which is targeting required in specific interventions, but not all. The need to make some improvements were noticeable, that is, in the language and media used for spreading messages in Figure 4.20 and 4.21.

The remaining questions were: do the LGBTs want to see themselves in the bigger group and breaking homophobia; do the LGBTs need an opportunity to use mainstream information but still be able to relate to it given their sexual orientation; and are there more areas where distinction between targeting and non-targeting still has to be made?

4.5 Measures of Association

In the section that follows hereunder, measures of correlation are applied to the question themes. To be specific, the spearman's rho was used to measure correlation which is a measure of the relation between two or more variables (Thomas and Brubaker 2008: 232). The measurement scales used were interval scales, but other correlation coefficients are available to handle other types of data. Correlation coefficients can range from -1.00 to +1.00. The value of -1.00 represents a perfect negative correlation while a value of +1.00 represents a perfect positive correlation. A value of 0.00 represents a lack of correlation. Correlation coefficients above 0.600 will be discussed further.

Table 4.3 Correlation

			Ethnicity	Age	Qualification	Area	Sexual Pref	Qu 1	Qu2	Qu3	Qu4	Qu5	Qu6
Spearman's rho	Ethnic	Correlation Coefficient	1.000	-.190	-.289		.312	.560	.270	-.175	.840	.407	.293
		Sig. (2-tailed)		.012	.000		.000	.000	.000	.021	.000	.000	.000
		N	174	174	174	174	174	174	174	174	174	174	174
	Age	Correlation Coefficient	-.190	1.000	.880		.607	.339	-.936	.837	-.226	.571	.829
		Sig. (2-tailed)	.012		.000		.000	.000	.000	.000	.003	.000	.000
		N	174	174	174	174	174	174	174	174	174	174	174
	Qualification	Correlation Coefficient	-.289	.880	1.000		.576	.439	.929	.781	-.322	.707	.907
		Sig. (2-tailed)	.000	.000			.000	.000	.000	.000	.000	.000	.000
		N	174	174	174	174	174	174	174	174	174	174	174
	Sexual preference	Correlation Coefficient	.312	.607	.576		1.000	.205	.547	.644	.376	-.170	.555
		Sig. (2-tailed)	.000	.000	.000			.007	.000	.000	.000	.025	.000
		N	174	174	174	174	174	174	174	174	174	174	174
	Qu 1	Correlation Coefficient	-.560	.339	.439		.205	1.000	-.483	.312	.667	.621	.492
		Sig. (2-tailed)	.000	.000	.000		.007		.000	.000	.000	.000	.000
		N	174	174	174	174	174	174	174	174	174	174	174
	Qu2	Correlation Coefficient	.270	-.936	-.929		.547	-.483	1.000	-.819	.322	.680	.916
		Sig. (2-tailed)	.000	.000	.000		.000	.000		.000	.000	.000	.000
		N	174	174	174	174	174	174	174	174	174	174	174
	Qu3	Correlation Coefficient	-.175	.837	.781		.644	.312	.819	1.000	-.208	.526	.804
		Sig. (2-tailed)	.021	.000	.000		.000	.000	.000		.006	.000	.000
		N	174	174	174	174	174	174	174	174	174	174	174
	Qu4	Correlation Coefficient	.840	-.226	-.322		.376	.667	.322	-.208	1.000	.454	.340
		Sig. (2-tailed)	.000	.003	.000		.000	.000	.000	.006		.000	.000
		N	174	174	174	174	174	174	174	174	174	174	174
	Qu5	Correlation Coefficient	.407	.571	.707		-.170	.621	.680	.526	.454	1.000	.719
		Sig. (2-tailed)	.000	.000	.000		.025	.000	.000	.000	.000		.000
		N	174	174	174	174	174	174	174	174	174	174	174

Qu6	Correlation Coefficient	.293	-	-.907**		.555	.492	.916	-	.340	.719	1.000
	Sig. (2-tailed)	.000	.000	.000		.000	.000	.000	.000	.000	.000	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu7	Correlation Coefficient	.840	-	-.322**		.376	.667	.322	-	1.000	.454	.340
	Sig. (2-tailed)	.000	.003	.000		.000	.000	.000	.006	.000	.000	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu8	Correlation Coefficient	.141	.727	.723		.911	.013	.705	.763	.167	-	-
	Sig. (2-tailed)	.064	.000	.000		.000	.867	.000	.000	.027	.000	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu9	Correlation Coefficient	.115	-	-.699**		.499	.206	.782	.559	.137	.347	.664
	Sig. (2-tailed)	.130	.000	.000		.000	.006	.000	.000	.071	.000	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu10	Correlation Coefficient	-	.169	.272		.278	.499	-	.156	-	-	-
	Sig. (2-tailed)	.886	.026	.000		.000	.000	.001	.040	.000	.000	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu11	Correlation Coefficient	-	.169	.272		.278	.499	-	.156	-	-	-
	Sig. (2-tailed)	.886	.026	.000		.000	.000	.001	.040	.000	.000	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu12	Correlation Coefficient	-	.169	.272		.278	.499	-	.156	-	-	-
	Sig. (2-tailed)	.886	.026	.000		.000	.000	.001	.040	.000	.000	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu13	Correlation Coefficient	-	.169	.272		.278	.499	-	.156	-	-	-
	Sig. (2-tailed)	.886	.026	.000		.000	.000	.001	.040	.000	.000	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu14	Correlation Coefficient	-	.374	.479		-.126	.904	.534	.345	.603	.677	.525
	Sig. (2-tailed)	.506	.000	.000		.097	.000	.000	.000	.000	.000	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu15	Correlation Coefficient	-	.169	.272		.278	.499	-	.156	-	-	-
	Sig. (2-tailed)	.886	.026	.000		.000	.000	.001	.040	.000	.000	.000
	N	174	174	174	174	174	174	174	174	174	174	174

Qu16	Correlation Coefficient	.886	-.169	-.272		.278	-.499	.241	-.156	.749	.363	.261
	Sig. (2-tailed)	.000	.026	.000		.000	.000	.001	.040	.000	.000	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu17	Correlation Coefficient	.303	.817	-.883		.483	.517	.899	.721	.361	.676	.919
	Sig. (2-tailed)	.000	.000	.000		.000	.000	.000	.000	.000	.000	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu18	Correlation Coefficient	.031	-.468	-.269		-.135	-.056	.339	-.151	.037	.094	.049
	Sig. (2-tailed)	.683	.000	.000		.076	.465	.000	.047	.626	.217	.518
	N	174	174	174	174	174	174	174	174	174	174	174
Qu19	Correlation Coefficient	.347	.500	.421		.736	.316	-.424	.460	.405	-.206	-.407
	Sig. (2-tailed)	.000	.000	.000		.000	.000	.000	.000	.000	.006	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu20	Correlation Coefficient	.234	-.228	-.366		-.013	.418	.265	.321	.278	.704	.334
	Sig. (2-tailed)	.002	.002	.000		.869	.000	.000	.000	.000	.000	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu21	Correlation Coefficient	1.000	-.190	-.289		.312	.560	.270	.175	.840	.407	.293
	Sig. (2-tailed)	.000	.012	.000		.000	.000	.000	.021	.000	.000	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu22	Correlation Coefficient	.886	-.169	-.272		.278	-.499	.241	-.156	.749	.363	.261
	Sig. (2-tailed)	.000	.026	.000		.000	.000	.001	.040	.000	.000	.000
	N	174	174	174	174	174	174	174	174	174	174	174
		Qu7	Qu8	Qu9	Qu10	Qu11	Qu12	Qu13	Qu14	Qu15	Qu16	Qu17
Ethnic	Correlation Coefficient	.840	.141	.115	.886	.886	.886	.886	.506	.886	.886	.303
	Sig. (2-tailed)	.000	.064	.130	.000	.000	.000	.000	.000	.000	.000	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Age	Correlation Coefficient	-.226	.727	.805	.169	.169	.169	.169	.374	.169	-.169	-.817
	Sig. (2-tailed)	.003	.000	.000	.026	.026	.026	.026	.000	.026	.026	.000
	N	174	174	174	174	174	174	174	174	174	174	174

Qualification	Correlation Coefficient	-.322	.723	.699	.272	.272	.272	.272	.479	.272	.272	.883
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Sexual Preference	Correlation Coefficient	.376	.911	.499	.278	.278	.278	.278	.126	.278	.278	.483
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000	.000	.097	.000	.000	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu 1	Correlation Coefficient	-.667	.013	.206	.499	.499	.499	.499	.904	.499	.499	.517
	Sig. (2-tailed)	.000	.867	.006	.000	.000	.000	.000	.000	.000	.000	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu2	Correlation Coefficient	.322	.705	.782	.241	.241	.241	.241	.534	.241	.241	.899
	Sig. (2-tailed)	.000	.000	.000	.001	.001	.001	.001	.000	.001	.001	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu3	Correlation Coefficient	-.208	.763	.559	.156	.156	.156	.156	.345	.156	.156	.721
	Sig. (2-tailed)	.006	.000	.000	.040	.040	.040	.040	.000	.040	.040	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu4	Correlation Coefficient	1.000	.167	.137	.749	.749	.749	.749	.603	.749	.749	.361
	Sig. (2-tailed)	.000	.027	.071	.000	.000	.000	.000	.000	.000	.000	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu5	Correlation Coefficient	.454	.434	.347	.363	.363	.363	.363	.677	.363	.363	.676
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu6	Correlation Coefficient	.340	.714	.664	.261	.261	.261	.261	.525	.261	.261	.919
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu7	Correlation Coefficient	1.000	.167	.137	.749	.749	.749	.749	.603	.749	.749	.361
	Sig. (2-tailed)	.000	.027	.071	.000	.000	.000	.000	.000	.000	.000	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu8	Correlation Coefficient	.167	1.000	.548	.125	.125	.125	.125	.111	.125	.125	.650
	Sig. (2-tailed)	.027	.000	.000	.099	.099	.099	.099	.143	.099	.099	.000
	N	174	174	174	174	174	174	174	174	174	174	174

Qu9	Correlation Coefficient	.137	-.548	1.000	-.103	-.103	-.103	-.103	.228	-.103	-.103	.740
	Sig. (2-tailed)	.071	.000		.177	.177	.177	.177	.002	.177	.177	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu10	Correlation Coefficient	-.749	.125	-.103	1.000	1.000	1.000	1.000	.452	1.000	1.000	-.270
	Sig. (2-tailed)	.000	.099	.177					.000			.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu11	Correlation Coefficient	-.749	.125	-.103	1.000	1.000	1.000	1.000	.452	1.000	1.000	-.270
	Sig. (2-tailed)	.000	.099	.177					.000			.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu12	Correlation Coefficient	-.749	.125	-.103	1.000	1.000	1.000	1.000	.452	1.000	1.000	-.270
	Sig. (2-tailed)	.000	.099	.177					.000			.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu13	Correlation Coefficient	-.749	.125	-.103	1.000	1.000	1.000	1.000	.452	1.000	1.000	-.270
	Sig. (2-tailed)	.000	.099	.177					.000			.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu14	Correlation Coefficient	-.603	.111	.228	.452	.452	.452	.452	1.000	.452	.452	-.560
	Sig. (2-tailed)	.000	.143	.002	.000	.000	.000	.000		.000	.000	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu15	Correlation Coefficient	-.749	.125	-.103	1.000	1.000	1.000	1.000	.452	1.000	1.000	-.270
	Sig. (2-tailed)	.000	.099	.177					.000			.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu16	Correlation Coefficient	.749	.125	.103	1.000	1.000	1.000	1.000	.452	1.000	1.000	-.270
	Sig. (2-tailed)	.000	.099	.177					.000			.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu17	Correlation Coefficient	.361	-.650	.740	.270	.270	.270	.270	.560	.270	.270	1.000
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000	.000	.000	.000	.000	
	N	174	174	174	174	174	174	174	174	174	174	174
Qu18	Correlation Coefficient	.037	-.148	.549	-.028	-.028	-.028	-.028	.062	.028	.028	.200
	Sig. (2-tailed)	.626	.051	.000	.715	.715	.715	.715	.419	.715	.715	.008
	N	174	174	174	174	174	174	174	174	174	174	174

Qu19	Correlation Coefficient	.405	.736	.304	.309	.309	.309	.309	.207	.309	.309	.276
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000	.000	.006	.000	.000	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu20	Correlation Coefficient	.278	.221	-.181	.209	.209	.209	.209	.462	.209	.209	.202
	Sig. (2-tailed)	.000	.003	.017	.006	.006	.006	.006	.000	.006	.006	.007
	N	174	174	174	174	174	174	174	174	174	174	174
Qu21	Correlation Coefficient	.840	.141	.115	.892	.892	.892	.892	.506	.892	.892	.303
	Sig. (2-tailed)	.000	.064	.129	.000	.000	.000	.000	.000	.000	.000	.000
	N	174	174	174	174	174	174	174	174	174	174	174
Qu22	Correlation Coefficient	.749	.125	.103	1.000	1.000	1.000	1.000	.452	1.000	1.000	.270
	Sig. (2-tailed)	.000	.099	.177	.000	.000	.000	.000	.000	.000	.000	.000
	N	174	174	174	174	174	174	174	174	174	174	174
					Qu18	Qu19	Qu20	Qu21	Qu22			
Spearman's rho	Ethnic	Correlation Coefficient			.031	.347	.234	1.000	.886			
		Sig. (2-tailed)			.683	.000	.002	.000	.000			
		N			174	174	174	174	174			
	Sexual Preference	Correlation Coefficient			-.468	.500	-.228	-.190	-.169			
		Sig. (2-tailed)			.000	.000	.002	.012	.026			
		N			174	174	174	174	174			
	Qualification	Correlation Coefficient			-.269	.421	-.366	-.289	-.272			
		Sig. (2-tailed)			.000	.000	.000	.000	.000			
		N			174	174	174	174	174			
	Gender Classification	Correlation Coefficient			-.135	.736	-.013	.312	.278			
		Sig. (2-tailed)			.076	.000	.869	.000	.000			
		N			174	174	174	174	174			
Qu 1	Correlation Coefficient			-.056	-.316	-.418	-.560	-.499				
	Sig. (2-tailed)			.465	.000	.000	.000	.000				
	N			174	174	174	174	174				
Qu2	Correlation Coefficient			.339	-.424	.265	.270	.241				
	Sig. (2-tailed)			.000	.000	.000	.000	.001				
	N			174	174	174	174	174				
Qu3	Correlation Coefficient			-.151	.460	-.321	-.175	-.156				
	Sig. (2-tailed)			.047	.000	.000	.021	.040				
	N			174	174	174	174	174				
Qu4	Correlation Coefficient			.037	.405	.278	.840	.749				
	Sig. (2-tailed)			.626	.000	.000	.000	.000				
	N			174	174	174	174	174				

Qu5	Correlation	.094	-.206**	.704**	.407**	.363**
	Coefficient					
	Sig. (2-tailed)	.217	.006	.000	.000	.000
Qu6	N	174	174	174	174	174
	Correlation	.049	-.407**	.334**	.293**	.261**
	Coefficient					
Qu7	Sig. (2-tailed)	.518	.000	.000	.000	.000
	N	174	174	174	174	174
	Correlation	.037	.405**	.278**	.840**	.749**
Qu8	Coefficient					
	Sig. (2-tailed)	.626	.000	.000	.000	.000
	N	174	174	174	174	174
Qu9	Correlation	-.148	.736**	-.221**	.141	.125
	Coefficient					
	Sig. (2-tailed)	.051	.000	.003	.064	.099
Qu10	N	174	174	174	174	174
	Correlation	.549**	-.304**	-.181*	.115	.103
	Coefficient					
Qu11	Sig. (2-tailed)	.000	.000	.017	.129	.177
	N	174	174	174	174	174
	Correlation	-.028	-.309**	-.209**	-.892**	-1.000**
Qu12	Coefficient					
	Sig. (2-tailed)	.715	.000	.006	.000	.000
	N	174	174	174	174	174
Qu13	Correlation	-.028	-.309**	-.209**	-.892**	-1.000**
	Coefficient					
	Sig. (2-tailed)	.715	.000	.006	.000	.000
Qu14	N	174	174	174	174	174
	Correlation	-.062	-.207**	-.462**	-.506**	-.452**
	Coefficient					
Qu15	Sig. (2-tailed)	.419	.006	.000	.000	.000
	N	174	174	174	174	174
	Correlation	-.028	-.309**	-.209**	-.892**	-1.000**
Qu16	Coefficient					
	Sig. (2-tailed)	.715	.000	.006	.000	.000
	N	174	174	174	174	174
Qu17	Correlation	.028	.309**	.209**	.892**	1.000**
	Coefficient					
	Sig. (2-tailed)	.715	.000	.006	.000	.000
Qu18	N	174	174	174	174	174
	Correlation	.200**	-.276**	.202**	.303**	.270**
	Coefficient					
Qu18	Sig. (2-tailed)	.008	.000	.007	.000	.000
	N	174	174	174	174	174
	Correlation	1.000	-.082	-.145	.031	.028
	Coefficient					
	Sig. (2-tailed)	.	.281	.056	.683	.715
	N	174	174	174	174	174

Qu19	Correlation Coefficient	-.082	1.000	-.240**	.347**	.309**
	Sig. (2-tailed)	.281		.001	.000	.000
	N	174	174	174	174	174
Qu20	Correlation Coefficient	-.145	-.240**	1.000	.234**	.209**
	Sig. (2-tailed)	.056	.001		.002	.006
	N	174	174	174	174	174
Qu21	Correlation Coefficient	.031	.347**	.234**	1.000	.892**
	Sig. (2-tailed)	.683	.000	.002		.000
	N	174	174	174	174	174
Qu22	Correlation Coefficient	.028	.309**	.209**	.892**	1.000
	Sig. (2-tailed)	.715	.000	.006	.000	
	N	174	174	174	174	174

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

African LGBTs, the majority in the study (Figure 4.1), are likely to have knowledge on discrimination (Figure 4.7); with a positive correlation of 0.840, and significance of 0.000. Africans are likely to view discrimination as increasing risk to HIV infection; with a positive correlation of 0.840, and significance of 0.000. African LGBT respondents, are less likely, not to be at risk of being infected by HIV in the past, due to lack of information from the health sector, with a negative correlation of 0.886, and significance of 0.000 (Figure 4.13).

African LGBT respondents, are less likely, not to be at risk of being infected by HIV currently, due to lack of information from the health sector (Figure 4.13); with a negative correlation of 0.886, and a significance of 0.00. African LGBTs, are less likely not to be aware of forums where health sector meets LGBTs (Figure 4.13); with a negative correlation of 0.886, and a significance of 0.000. African LGBTs, are less likely not to participate in forums where health sector meets LGBTs is not determined (Figure 4.13); with a negative correlation of 0.886, and a significance of 0.000.

African LGBTs, are less likely not to regularly participate in health sector, HIV and AIDS promotional activities; with a negative correlation of 0.886, and a significance of 0.000. African LGBTs, are likely to see the relationship between the health sector and

the LGBTs as non-existent (Figure 4.18); with a positive correlation of 0.886, and a significance of 0.000. African LGBTs, are likely to rate media used as relevant. In this case (Figure 4.20); with a perfect positive correlation of 1.000. African LGBTs, are likely to be older; with a positive correlation of 0.886, and a significance of 0.000

Older LGBTs, are likely to be qualified; with a positive correlation of 0.880, and a significance of 0.000. Older LGBTs, are likely to have identified their sexual preference; with a positive correlation of 0.607, and a significance of 0.000. Older LGBTs, are less likely to be exposed to the mostly used media; with a negative correlation of 0.936, and a significance of 0.000. Older LGBTs, are likely not to see the health sector as meeting their needs (Figure 4.6); with a positive correlation of 0.837, and a significance of 0.000. Older the LGBTs are less likely to feel that public talks are discriminatory, which are regarded as the mostly used discriminatory tool (Figure 4.2); with a negative correlation of 0.829, and a significance of 0.000.

Older LGBTs are likely to sometimes use general material for their own benefit; with a positive correlation of 0.727, and a significance of 0.000. Older LGBTs, are less likely to know a LGBT infected due to no information on HIV and AIDS; with a negative correlation of 0.805, and a significance of 0.000. Older LGBTs, are less likely to rate the messages used as relevant (Figure 4.19); with a negative correlation of 0.817, and a significance of 0.000.

The better qualified LGBTs, are less likely to be exposed to the mostly used media; with a negative correlation of 0.929, and a significance of 0.000. The better qualified LGBTs, are likely not to see the health sector as meeting their needs (Figure 4.6); with a positive correlation of 0.781, and a significance of 0.000. The better qualified LGBTs, are less likely to feel that the promotional and communication material is discriminating against them (Figure 4.8); with a negative correlation of 0.707, significance of 0.000. The better qualified LGBTs are less likely to see public talks as discriminatory, which are regarded as the mostly used discriminatory tool (Figure 4.2); with a negative correlation of 0.907, and a significance of 0.000.

The better qualified LGBTs are likely to sometimes use general material for their own benefit; with a positive correlation of 0.723, and a significance of 0.000. The better qualified LGBTs, are less likely to know a LGBT infected due to having no information on HIV and AIDS (Figure 4.11); with a negative correlation of 0.699, and a significance of 0.000. The better qualified LGBTs, are less likely to rate the language used as relevant (Figure 4.20); and a negative correlation of 0.883, and a significance of 0.000.

LGBTs with identified sexual preference, are likely not to see the health sector as meeting their needs (Figure 4.6) with positive correlation of 0.644, and a significance of 0.000. LGBTs with identified sexual preference, are likely to sometimes use general material for their own benefit; with a positive correlation of 0.911, and a significance of 0.000.

LGBTs exposed to health sector HIV and AIDS promotion and communication, are less likely to have increased knowledge on discrimination on HIV and AIDS promotion and communication (Figure 4.7); with a negative correlation of 0.667, and a significance of 0.000. LGBTs exposed to health sector HIV and AIDS promotion and communication, are less likely to increase the view of health promotion and communication material or talks as discriminating (Figure 4.7); with a negative correlation of 0.621, significance of 0.000. LGBTs exposed to health sector HIV and AIDS promotion and communication, are less likely to have a view that discrimination increases the risk to HIV transmission; with a negative correlation of 0.667, and a significance of 0.000. LGBTs exposed to health sector HIV and AIDS promotion and communication, are likely not to participate in the planning and running of services; with a positive correlation of 0.904, and a significance of 0.000.

LGBTs who are more exposed the mostly used medium, public talks, are less likely to agree that their needs are met (Figure 4.6); with a negative correlation of 0.819, and a significance of 0.000. LGBTs who are more exposed to the mostly used medium, public talks, are likely to increase the view of health promotion and communication material or talks as discriminating; with a positive correlation of 0.680, and a significance of 0.000. LGBTs who are more exposed to the mostly used medium,

public talks, are likely to see public talks as discriminatory, which are regarded as the mostly used discriminatory tool (Figure 4.2); with a positive correlation of 0.916, and a significance of 0.000.

LGBTs who are more exposed to the mostly used medium, public talks, are less likely to sometimes use general material for their own benefit (Figure 4.10); with a negative correlation of 0.705, and a significance of 0.000. LGBTs who are more exposed to the mostly used media, public talks, are likely to know a LGBT infected due to no information on HIV and AIDS; with a positive correlation of 0.782, and a significance of 0.000. LGBTs who are more exposed to the mostly used media, public talks, are likely rate the language used as relevant (Figure 4.20); with a positive correlation of 0.899, significance of 0.000.

LGBTs who feel that their needs on HIV and AIDS promotion and communication are being met, are less likely to see public talks as discriminatory, which are regarded as the mostly used discriminatory tool (Figure 4.2); with a negative correlation of 0.804, and a significance of 0.000. LGBTs who sometimes use general material for their own benefit, are likely to see the health sector as meeting their needs on HIV and AIDS promotion and communication (Figure 4.6); with a positive correlation of 0.763, significance of 0.000. LGBTs who feel that their needs on HIV and AIDS promotion and communication are being met, they are less likely to see the messages as relevant; with a negative correlation of 0.721, and a significance of 0.000.

LGBTs with increased knowledge on discrimination on HIV and AIDS promotion and communication, are less likely not to be at risk of being infected by HIV in the past, due to lack of information from the health sector (Figure 4.12); with a negative correlation of 0.749, and a significance of 0.000. LGBTs with increased knowledge on discrimination on HIV and AIDS promotion and communication, are less likely not to be at risk of being infected by HIV currently, due to lack of information from the health sector (Figure 4.13); with a negative correlation of 0.749, and a significance of 0.000.

LGBTs with increased knowledge on discrimination on HIV and AIDS promotion and communication, are less likely not to be aware of forums where health sector meets LGBTs (Figure 4.13); with a negative correlation of 0.749, significance of 0.000. LGBTs with increased knowledge on discrimination on HIV and AIDS promotion and communication, are less likely not to participate in forums where health sector meets LGBTs is not determined (Figure 4.13); with a negative correlation of 0.749, and a significance of 0.000.

LGBTs with increased knowledge on discrimination on HIV and AIDS promotion and communication, are less likely not to participate in planning and running of services (Figure 4.17); with a negative correlation of 0.603, and a significance of 0.000. LGBTs with increased knowledge on discrimination on HIV and AIDS promotion and communication, are less likely not to regularly participate in health sector, HIV and AIDS promotional activities; with a negative correlation of 0.749, and a significance of 0.000. LGBTs with increased knowledge on discrimination on HIV and AIDS promotion and communication, are likely to see the relationship between the health sector and the LGBTs as non-existent (Figure 4.18); with a positive correlation of 0.749, and a significance of 0.000.

LGBTs with increased knowledge on discrimination on HIV and AIDS promotion and communication, are likely to see the need for targeted promotion and communication activities; with a positive correlation of 0.840, and a significance of 0.000. LGBTs with increased knowledge on discrimination on HIV and AIDS promotion and communication, are likely to agree to targeting all, with information material; with a positive correlation of 0.749, and a significance of 0.000.

LGBTs who are more exposed to the mostly used media, public talks, are likely to increase the view of health promotion and communication material or talks as discriminating, with a positive correlation of 0.680, and a significance of 0.000. LGBTs who feel discriminated by the HIV and AIDS promotion and communication material, are likely to see public talks as discriminatory, which are regarded as the mostly used discriminatory tool (Figure 4.2); with a positive correlation of 0.719, and a significance

of 0.000. LGBTs who feel discriminated by the HIV and AIDS promotion and communication material, are less likely not to participate in planning and running of services (Figure 4.17); with a negative correlation of 0.677, and a significance of 0.000.

LGBTs who feel discriminated by the HIV and AIDS promotion and communication material, are likely to rate the messages as relevant; with a positive correlation of 0.676, and a significance of 0.000. LGBTs who feel discriminated by the HIV and AIDS promotion and communication material, are likely to prefer combined HIV and AIDS programmes, that is, integrated with other; with a positive correlation of 0.704, and a significance of 0.000.

The LGBTs who see public talks as discriminatory, which are regarded as the mostly used discriminatory tool, are less likely to sometimes use general material for their own benefit; with a negative correlation of 0.714; and a significance of 0.000. The LGBTs who see public talks as discriminatory, which are regarded as the mostly used discriminatory tool, are likely to know if a LGBT was infected due to no information on HIV and AIDS; with a positive correlation of 0.664, and a significance of 0.000.

LGBTs of view that discrimination increases the risk to HIV infection, are less likely not to be at risk of being infected by HIV in the past, due to lack of information from the health sector (Figure 4.12); with a negative correlation of 0.749, and a significance of 0.000. LGBTs of view that, discrimination increases the risk to HIV infection, are less likely not to be at risk of being infected by HIV currently, due to lack of information from the health sector (Figure 4.13); with a negative correlation of 0.749, and a significance of 0.000. LGBTs of view that, discrimination increases the risk to HIV infection, are less likely not to be aware of forums where health sector meets LGBTs (Figure 4.13); with a negative correlation of 0.749, and a significance of 0.000.

LGBTs of view that, discrimination increases the risk to HIV infection, are less likely not to participate in forums where health sector meets LGBTs is not determined (Figure 4.13); with a negative correlation of 0.749, and a significance of 0.000. LGBTs of view

that, discrimination increases the risk to HIV infection, are less likely to not participate in planning and running of services (Figure 4.17); with a negative correlation of 0.603, and a significance of 0.000.

LGBTs of view that, discrimination increases the risk to HIV infection, are less likely not to regularly participate in health sector, HIV and AIDS promotional activities; with a negative correlation of 0.749, and a significance of 0.000. LGBTs of view that, discrimination increases the risk to HIV infection, are likely to see the relationship between the health sector and the LGBTs as non-existent (Figure 4.18); with a positive correlation of 0.749, and a significance of 0.000. LGBTs of view that, discrimination increases the risk to HIV infection, are likely to see the need for targeted promotion and communication activities; with a positive correlation of 0.840; and a significance of 0.000. LGBTs of view that, discrimination increases the risk to HIV infection, are likely to agree to targeting all, with information material; with a positive correlation of 0.749, and a significance of 0.000.

LGBTs who sometimes use general material for their own benefit, are less likely to see messages as relevant; with a negative correlation of 0.650, and a significance of 0.000. LGBTs who sometimes use general material for their own benefit, are likely to see language as relevant (Figure 4.20); with a positive correlation of 0.736, and a significance of 0.000.

LGBTs who know a LGBT infected due to no information on HIV and AIDS, are likely to see messages as relevant; with a positive correlation of 0.740, and a significance of 0.000. LGBTs who know a LGBT infected due to no information on HIV and AIDS, are likely to see media as relevant; with a positive correlation of 0.549, and a significance of 0.000.

LGBTs not at risk of being infected by HIV in the past, due to lack of information from the health sector (Figure 4.12), are likely not to be at risk of being infected by HIV currently, due to lack of information from the health sector, with a perfect positive

correlation of 1.000. LGBTs not at risk of being infected by HIV in the past, due to lack of information from the health sector are likely not to be aware of forums where health sector meet the LGBT; with a perfect positive correlation of 1.000. LGBTs not at risk of being infected by HIV in the past, due to lack of information from the health sector are likely not to participate in forums; with a perfect positive correlation of 1.000.

LGBTs not at risk of being infected by HIV in the past, due to lack of information from the health sector are likely not to regularly participate in the health sector, HIV and AIDS promotional activities; with a perfect positive correlation of 1.000. LGBTs not at risk of being infected by HIV in the past, due to lack of information from the health sector, are likely to see the relationship between the health sector and the LGBTs as non-existent (Figure 4.18); with a perfect negative correlation of 1.000.

LGBTs not at risk of being infected by HIV in the past, due to lack of information from the health sector, are less likely to see the need for targeted promotion and communication activities; with a negative correlation of 0.892; and a significance of 0.000. LGBTs not at risk of being infected by HIV in the past, due to lack of information from the health sector, are likely to agree to targeting all, with information material; with a perfect negative correlation of 1.000.

LGBTs not at risk of being infected by HIV currently, due to lack of information from the health sector, are likely not to be aware of forums where health sector meet the LGBT; with a perfect positive correlation of 1.000. LGBTs not at risk of being infected by HIV currently, due to lack of information from the health sector, are likely, not to participate in forums; with a perfect positive correlation of 1.000. LGBTs not at risk of being infected by HIV currently, due to lack of information from the health sector, are likely not to regularly participate in health sector, HIV and AIDS promotional activities; with a perfect positive correlation of 1.000.

LGBTs not at risk of being infected by HIV currently, due to lack of information from the health sector, are less likely to see the relationship between the health sector and the

LGBTs as non-existent (Figure 4.18); with a perfect negative correlation of 1.000. LGBTs not at risk of being infected by HIV currently, due to lack of information from the health sector, are less likely to see the need for targeted promotion and communication activities; with a negative correlation of 0.892, and a significance of 0.000. LGBTs not at risk of being infected by HIV currently, due to lack of information from the health sector, are less likely to agree to targeting all, with information material; with a perfect negative correlation of 1.000.

LGBTs not aware of forums were health sector meet the LGBT are likely, not to participate in forums; with a perfect positive correlation of 1.000. LGBTs not aware of forums were health sector meet the LGBT are likely, not to regularly participate in health sector, HIV and AIDS promotional activities; with a perfect positive correlation of 1.000. LGBTs not aware of forums were health sector meet the LGBTs are less likely, to see the relationship between the health sector and the LGBTs as non-existent (Figure 4.18); with a perfect negative correlation of 1.000. LGBTs not aware of forums were health sector meet the LGBTs, are less likely to see the need for targeted promotion and communication activities; with a negative correlation of 0.892, and a significance of 0.000. LGBTs not aware of forums were health sector meet the LGBTs, are less likely to agree to targeting all, with information material; with a perfect negative correlation of 1.000.

LGBTs who do not participate in forums, are likely, not to regularly participate in health sector, HIV and AIDS promotional activities; with a perfect positive correlation of 1.000. LGBTs who do not participate in forums, are less likely to see the relationship between the health sector and the LGBTs as non-existent (Figure 4.18); with a perfect negative correlation of 1.000. LGBTs who do not participate in forums, are less likely to see the need for targeted promotion and communication activities; with a negative correlation of 0.892; and a significance of 0.000. LGBTs who do not participate in forums, less likely to agree to targeting all, with information material; with a perfect negative correlation of 1.000.

LGBTs not regularly participating in health sector, HIV and AIDS promotional activities, are less likely to see the relationship between the health sector and the LGBTs as non-existent (Figure 4.18); with a perfect negative correlation of 1.000. LGBTs not regularly participating in health sector, HIV and AIDS promotional activities, are less likely to see the need for targeted promotion and communication activities; with a negative correlation of 0.892; and a significance of 0.000. LGBTs not regularly participating in health sector, HIV and AIDS promotional activities, are less likely to agree to targeting all, with information material; with a perfect negative correlation of 1.000.

LGBTs who see the relationship between the health sector and the LGBTs as non-existent (Figure 4.18), are less likely not to participate in forums; with a perfect negative correlation of 1.000. LGBTs who see the relationship between the health sector and the LGBTs as non-existent (Figure 4.18), are less likely not to regularly participate in health sector, HIV and AIDS promotional activities; with a perfect negative correlation of 1.000. LGBTs who see the relationship between the health sector and the LGBTs as non-existent (Figure 4.18), are likely to see the need for targeted promotion and communication activities; with a positive correlation of 0.892; and a significance of 0.000.

LGBTs who see a need for targeted promotion and communication activities, are likely to agree to targeting all, with information material; with a positive correlation of 0.892; and a significance of 0.000

4.6 Conclusion

Data analysis brought about issues of interest in this research. In terms of the demographic information, most participants were Black and in the age group 18–35, mostly with a sexual preference of either gay or lesbian. The majority were literate, holding a degree, second to that some held a diploma. The gaps identified in service delivery were failure to meet needs, discriminating promotional material and the view that discrimination is likely to increase the transmission of HIV. The participants themselves were never and not at risk of HIV transmission.

Most LGBTs were not aware of the health sector - LGBT forums, and planning or running thereof. Thus, minimal participation and a predominant view of no relationship between the health sector and LGBTs. Most agree that the language, messages and media used are relevant. There was a need for targeting or market segmentation in Information, Education and Communication (IEC) material, whereas for other general promotional and communication activities it was not required. Combining HIV and AIDS programmes with others was also preferred as opposed to abstinence only programmes.

The fact that the participants were not at risk of HIV transmission could be attributed to the majority being literate, sometimes using information that was not meant for them for their own benefit and the apparent tendency to search for information. The relevance found in language, messages and media was a contradiction to the need for targeted IEC material. Such contradictions and correlations are to be discussed further in the next chapter. Recommendations on what the health sector can do to manage the gaps will be provided.

Chapter 5

Results

5.1 Introduction

The discussion in this final chapter of the dissertation, mainly focus on the analysis and discussion on the results of each question, in relation to variables, measures of correlation and themes. The analysis established if the research questions were answered, taking cognisance of the many factors that could have impacted on the results. During the discussions of the above, the theory of the literature review is referred to, with the main intention of grounding it to the collected data.

Secondly, the researcher indicates how the results of the study impacted on the initial objectives as set in Chapter 1. An evaluation of what the results meant was conducted and finally the recommendations that management need to consider in the study were made. The recommendations were for the health sector to consider upon programme implementation and management for the LGBTs province-wide.

5.2 Summary of the Study

The study investigated the apparent gaps in health promotion and communication on HIV and AIDS, amongst the LGBTs. The aim being to enable programme decision making in efforts that minimise the scourge of HIV and AIDS.

The conceptual framework and the design of the research were qualitative and explorative. The grounded theory was adhered to based on the on the observations of the everyday life of the health service delivery to the LGBTs, at the same time trying to create meaning of what the LGBTs on the ground were saying. The North West Province LGBTs, in the Ngaka Modiri Molema Dictrict were snowballed, and the data collection method was standardised questionnaire.

Literature reviewed focused on the historical, social and psychological patterns of HIV and AIDS service provision to the Lesbians, Gays, Bisexual and Transgender (LGBTs)

population, by the general health systems. It highlighted the sensitivity of the community of interest, as they were still stigmatised by the society. The stigma attached to being LGBT, and in some cases being HIV positive, demanded that care be taken throughout the research, by employing data collection and sampling strategies that limited the risks of jeopardising the study. The main keywords that put the study into context were: LGBTs, HIV and AIDS, North West Province, South Africa, health service delivery, social risk factors, psychological impact and the health programmes.

The sampling frame was 632 LGBTs, and 169 respondents required as per research guidelines. A total of 180 LGBTs responded; giving a total of 174 valid questionnaires, thus enabling a higher response rate of 103%. Data in questionnaires were summarised on a spreadsheet and the statistics were calculated using SPSS. The Spearmans Rho measures of correlation was adopted to check the relationship between the different variables.

5.3 Response to Research Questions

Hereunder, is a summary on the demographic details, and following that, is an analysis of each research question in relation to the findings of the study.

Most respondents were aged between 18-21 years, educated, and most held a degree qualification, and second to that a diploma. The majority of respondents were predominantly gays or lesbian Blacks, as the study was undertaken in a predominantly Black society, and in terms of the measures of correlation findings, the participating Blacks in the study, had knowledge on discrimination, and viewed it as having potential to increase risk of being infected with HIV.

On the contrary, correlation proves that having not received information on HIV and AIDS did not put the Blacks at risk in the past and at the time when the research was undertaken. The fact that they were not at risk could be attributed to, high literacy levels, and the age group, as literate and young people do search for information on

their own (Kunaga & Rosenfeld, 2004: 117). The higher the level of education, the better the health status, state Langlois-Klassen *et al.* (2008: 173). In addition, correlation proves that the better qualified, had less chances of being exposed to the mostly used health media, but with the younger ones, it was the opposite. The respondents comprised of young people, and better qualified meant post-graduate. The group of respondents was reasonably qualified, and correlation proved that they were exposed to the mostly used health media. The group was likely not to use general material for themselves as they were younger.

5.3.1 What are the service delivery gaps in health promotion and communication of HIV and AIDS prevention services provided for by the health sector to LGBTs, and how can the identified gaps be managed?

The majority of the respondents were exposed; 159 of 174. Correlation proves that exposed group was likely not to have knowledge on discrimination; not to find the material discriminating; not to view discrimination as increasing risk, not to participate in the planning and running of services. Interpretation of findings: despite the group having been reached, they were likely not to be involved in health sector services, meaning being reached had nothing to do with being involved, thus not participating. Rokotananahary *et al.* (2002: 343) and Haidet *et al.* (2007:27), see a need for the health sector to reach out to the LGBTs, but at the same time understanding their point of view or health issues. The missing point here was none-involvement in the development of health promotion and communication material as stated above. Findings proves that there was exposure.

The mostly used medium was public talks (40 respondents); followed by radio /TV/newspaper (36 respondents) and the third variable being the internet (34 respondents). The margins between the three variables are not wide. Correlation indicates that, the group exposed to public talks; were less likely to feel that their needs were met; likely to find public talks and Information, Education and Communication (IEC) material discriminatory; less likely to use general material for their own benefit; may be knowing someone infected due to having not received information and found language used to be relevant.

Interpretation of findings: the correlation measures also confirms that the findings of none involvement of LGBTs in the development of health promotion and communication material is related to the feelings of being discriminated against. The downfall to the point under discussion is that a communication does foster change in behaviour, but it does not mean that if communication has reached everybody within the community, they will all change (Bababalola *et al.*, 2009: 1513).

The majority of the respondents' needs were not met; 101 of 174. Correlation indicates that, the group did not view public talks as discriminatory; sometimes used the material for their own benefit; and thought the material was relevant. Interpreting the findings: Behaviour Change Communication (BCC) is a consideration as it is aimed at carrying out activities that educate communities to prevent further spread of HIV infections (Bessinger *et al.*, 2004: 397). In summary, the identified gaps were non-involvement of LGBTs, and the promotion and communication needs that were not met.

5.3.2 Does the mainstream health promotion and communication activities discriminate the LGBTs? If so, does it elicit any negative or risk behaviour in HIV transmission?

The majority of participants had knowledge on what is to discriminate; 169 of 174. Correlation indicates that, the group, predominantly Black, was likely to have knowledge on discrimination; not likely to be vulnerable to HIV transmission, even though they were not aware of and not participating in health sector forums; likely to want IEC material to target the general public. Interpretation of findings: in this case, it is preference of one gender over the other, referred to stigmatisation and discrimination against LGBTs, on the basis of HIV and AIDS, or on coming out of the closet of homosexuality (Keiswetter & Brotemarkle, 2010:273). Sometimes one individual suffers from the double stigma. The Blacks knew what discrimination was; and race did not put them at risk of HIV transmission, as stated in the introductory remarks under point 5.3. The discussions were linked to the qualification and age variables. Findings proves that there was adequate knowledge on discrimination.

The majority found the material to be discriminating, 139 of 169. The margin of outliers was not too big, and less likely not to jeopardise the results, as a result, the response was interpreted. Correlation indicates that, the LGBTs were more exposed to public talks and saw them as discriminatory; participated in the planning and running of services. Interpretation of findings: there was discrimination. It should be realised that South Africa outlawed the discrimination on sexual orientation, and that same sex relationships are legal (Rispel & Metcalf, 2009:137).

The medium that was mostly used as the discriminatory tool, was the very same one that LGBTs were mostly exposed to, that is, the public talks. The other finding coming to light is that, public talks are more frequently used than radio, newspapers, TV with internet receiving less frequency. The frequencies were on public talks were 46, radio/newspapers/TV were 20 and posters 21. The internet's frequencies were very low, yet it was a third variable the LGBTs were exposed to.

Correlation indicates that, the group was likely to be more exposed to the mostly used media, public talks; see public talks as discriminatory; rate material as relevant; prefer combined HIV and AIDS programmes; to know if a LGBT was infected due to no information; participated in planning and running of services; and less likely to sometimes use general material for their own benefit.

Interpretation of findings: Internet was not as frequently used by the group, and may have been a result of limited accessibility. Kunaga and Rosenfeld (2004:118) observe that the topics that were mostly surfed on the internet required some level of confidentiality. Findings prove that, the traditional media were viewed as discriminatory, and seemed to be the relevant media of that time.

The majority of the respondents agree that the discrimination was likely to increase the risk; 157 of 174. Correlation indicates that, they were not at risk of getting HIV in the past and currently due to lack of information; likely to be aware of forums; likely to

regularly participate in health sector activities, though they did not see LGBT and health sector partnership as existent. The group preferred LGBT targeting in IEC material. Interpretation of findings: the response that discrimination was likely to increase the risk did not match the correlation as discrimination did not put the LGBTs at risk of being infected. This may be attributed to a noticeable sense of independency in terms of obtaining information, or and a possibility of being involved in the health sector activities. Shapiro and Ray (2007:1) state that, to achieve sexual health, positive and respectful approach to sexuality is required, and the possibility of enjoyment, safe sexual experiences, no coercion and discrimination. At the same time, the health care workers who are in most cases not trained to provide services to LGBTs, also need training (Keiswetter & Brotemarkle, 2010: 273).

The majority sometimes used the material for their own benefit; 84 of 174, which is just above half of $n = 174$. Correlation indicate that, the group found the material not to be relevant, whereas the language used was regarded as relevant. Interpreting the findings: there was consistency with regard to the response and the correlation measures. Findings proved that messages are used for own benefit, despite material being irrelevant. It should be noted that, the LGBT groupings should not be responsible for their own catering of resources or funding. The health sector also need to assist with this regard (Rispel & Metcalf, 2009:136- 139).

The majority knew an LGBT who got infected with HIV due to them having not received any information on HIV; 154 of 174. Correlation indicated that, the group found the material and the media to be relevant; and opted for general public targeting in all health sector activities. Interpretation of findings: most knew someone infected, due to them having not received information. Findings proved that most LGBTs knew someone infected, but that could not be attributed to them having not received information.

Findings proves that the majority were not put at risk of being infected in the past; 169 of 174. Correlation indicates that, the LGBTs were not likely to be currently at risk; to

be aware of forums; to participate in forums; viewed partnership as non-existent; likely not to prefer targeting for all in promotional and communication activities; agreed to IEC material that targeted LGBTs. Interpretation of findings; there was correlation to the previous findings, especially in relation to LGBTs searching for information, as stated under introduction.

The majority were not put at risk of being infected currently; 170 of 174. Correlation indicates that, the LGBTs were not likely to be aware of forums, and to participate in them; viewed partnership as non-existent; likely not to prefer targeting for all in promotional and communication activities; and did not agree to IEC material that targeted LGBTs. Interpretation of findings: the current scenario was similar to the past scenario. The difference was that, the past need of the IEC material that targeted LGBTs was no longer required. It may be a marked improvement in the inclusion of LGBTs issues in general material.

In summary, findings proves that there was discrimination, despite the response that discrimination increased the risk of infection, contrary to the finding that discrimination did not put the LGBTs at risk of being infected. The traditional media was viewed as discriminatory. Knowing someone infected could not be attributed to them having not received information. Messages are used for own benefit, despite material being irrelevant.

5.3.3 Is partnership between the health sector and LGBTs on health promotion and communication activities existent?

Most respondents were not aware of LGBT-health sector forums; 170 of 174. Correlation indicates that, the LGBTs were not participating in forums; viewed partnership as non-existent; likely not to prefer targeting for all in promotional and communication activities; did not agree to IEC material that targeted LGBTs. Interpretation of findings: correlation concurs with the response. Findings proved that most LGBTs were not aware of forums.

Most respondents were not participating in forums; 170 of 174. Correlation indicates that, the LGBTs were not participating in planning and running of health sector initiatives; viewed partnership as non-existent; likely not to prefer targeting for all in promotional and communication activities; did not agree to IEC material that targeted LGBTs. Interpretation of findings: correlation concurs with the previous three responses. The LGBTs were not aware of forums, as a result could not participate. Findings proved that most LGBTs were not aware of forums. The health sector also need to fund their programmes and work towards the same goal ensuring that there are no further spread of HIV and AIDS (Rispel & Metcalf, 2009:136- 139).

Most of the respondents did not participate in the planning and running of the health sector activities; 156 of 174. The significance of correlation was mostly below 0.600, and upon introducing 5.3, it was stated that they would not be discussed. Secondly, some correlations did not warrant serious attention since they were not significant. Interpretation of findings: based on the fact that the LGBTs were not aware of forums were the health sector and LGBTs met. Findings proved that, respondents were not participating. Programmes should therefore evolve as needs evolve and should be tailored to smaller target markets, using a variety of media to reach communities that are not likely to be reached. Planning is of intrinsic value in this regard (de Wit, *et al.*, 2010:67). Thornhill and Klein (2010:239) advocate for partnerships between LGBTs and other structures within the community in order to create conducive environments of health care for LGBTs.

Most respondents were never regular participants in health sector activities; 170 of 174. Correlation indicates that, the LGBTs viewed partnership as non-existent; likely not to prefer targeting for all in promotional and communication activities; did not agree to IEC material that targeted LGBTs. Interpretation of findings: based on the fact that most LGBTs were not participating in the planning and running of the health sector activities, regularity thereof could have not been relevant. Findings proved that, respondents were not regular participants in health sector activities. Kreiss and Patterson (1997:274) suggest ongoing societal dialogues with the LGBTs by health care providers.

Most respondents rated the relationship as non-existent; 170 of 174. Correlation indicates that, the LGBTs were not likely to participate in forums, likely to prefer targeting for all in promotional and communication activities. Interpretation of findings: there was correlation of facts, being not aware of and not participating in forums, not planning and running health sector initiatives. Findings proved that, the relationship was non-existent. Thornhill and Klein (2009:230), emphasise that relationships between LGBTs and the health sector ought to be strengthened, and issues be dealt with openly.

In summary, respondents were not aware of LGBT-health sector forums, as a result did not participate in the planning and running of the health sector activities, and were not regular participants in health sector activities. The LGBTs viewed the LGBT-health sector relationship as non-existent.

5.3.4 What are the needs of the LGBTs in health promotion and communication activities?

Most respondents agree that the messages were relevant; 149 of 174 agree or strongly agree. LGBTs exposed to different material, were likely to see messages as relevant. The variable is a perfect correlation to itself. Interpretation of findings: It came out that the LGBTs were exposed to public talks, newspaper, TV, radio and internet. Based on the above two facts, findings proved that, the messages were relevant. The literate and urbanised are more likely to respond to promotions and communications (Bessinger *et al.*, 2004: 402).

Most respondents agree that the media was relevant; 149 of 174 agree or strongly agree. The variable is a perfect correlation to itself. Interpretation of findings: the public talks, newspaper, TV, radio and internet prove to be relevant media. Communication campaigns can eventually lead to behaviour change amongst individuals (Bessinger *et al.*, 2004:1).

Most respondents agree that the language was relevant; 114 of 174 agree. The variable is a perfect correlation to itself. Interpretation of findings: findings prove that, the language was relevant. Holmes and Meyerhoff (2003:336), state that the language that people speak, through talk, promotion, marketing or any other mode of communications expresses certain viewpoints, propose certain plans or query certain ideas. Again, Eckert and McConnell-Ginet (2003: 271), allude to the fact that in linguistics what matters in what we utter is the response that the utterance can lead to, meaning it can solicit either a positive or a negative response.

In summary, the previous finding relating to gaps in service delivery was that discrimination existed, on the contrary, the messages, media and language used were viewed as relevant. There is discrimination, but the exact mode could not be singled out.

5.3.5 What programmes are the LGBTs recommending for change management?

Combined HIV and AIDS programme were mostly preferred; 64 of 174. Secondary to that choice was the school based programmes, followed by drugs and reproductive health programmes. The variable is a perfect correlation to itself. Interpretation of findings: findings proved that, the mentioned programmes were most preferred. It should be borne in mind that the LGBTs that are using drugs by injecting them, are at risk of contracting HIV, Hepatitis B (HBV), Hepatitis C (HCV) and syphilis. The fact is highlighted in the study by Johnston *et al.* (2010:486), hence the drug and reproductive health combination was suggested in the question. The integration of HIV services and drug use services is necessary as the latter worsens the former (Johnston *et al.* 2010: 485). School based programmes may use creativity such as stage drama for health education (Shapiro & Ray, 2007:69; Low : 2010: 114).

Strydom *et al.* (2000:102) define market segmentation process as, to achieve maximum clientele satisfaction, marketers, promoters or communicators divide the heterogeneous markets into fairly homogeneous subsets, a process known as market

targeting. Most respondents agree to market segmentation or targeting all in activities; 169 of 174 agree. Correlation indicated that, the LGBTs are likely to agree to targeting all, with information material. Interpretation of findings: language, messages and media are relevant. The need for targeting may indicate the need for involvement.

Most respondents agree to targeting all, with information material; 170 of 174. The variable is a perfect correlation to itself. Rakotonanahary *et al.* (2002: 343) reveal that IEC activities fail to take into consideration the contextual differences of the target market into account, for instance, different practices, cultural opinions and levels of education. Interpretation of findings: language, messages and media are relevant. Therefore, there is no change required; the response and previous findings do correlate. On the contrary, the need for targeting in promotional activities may indicate the need for involvement.

In summary, combined HIV and AIDS programme were mostly preferred and most respondents agree to market segmentation or targeting all in activities and IEC material.

5.3.6 Does the health sector understand the health promotion and communication needs of LGBTs?

The organisation performance matrix in Chapter 2 by Smith (2003:8), adopted post literature review, highlights the following probabilities in terms of the problem investigated: the health sector lacking contact with the LGBTs and not aware of own attitude; poor communication from the health sector to the LGBTs and poor or no research; situational factors highlighted were poor knowledge of customer needs or attitudes and non-customer view of service; and lastly the customer finding the service to be of low level. All above probabilities were found to be true as per study results, except for the latter.

5.4 Limitations

In considering the study findings, it is important to note that there were some limitations to the study. The promotion and communications discipline may be unknown to the respondents, and that may have limited their conceptual creativity in responding to questions, hence there were instances whereby responses to questions did not correlate, but reasonably qualified.

The study findings are limited to the North West, Ngaka Modiri Molema District in South Africa, and the recommendations made may be applied in management decision making in wider scope of the North West Province of South Africa. The rationale being that the LGBTs who responded to the questionnaire, were identified at district level, whereas their origins were province-wide. The respondents moved dynamically across the province due to either work or studies.

5.5 Managerial Recommendations

Based on the above probabilities and findings, the following recommendations are suggested for the health sector in the North West Province:

Involvement of the LGBTs in IEC material development.

Continuous promotion and communication, that strives for customer satisfaction, through regular customer satisfaction evaluation.

Avoid discrimination of LGBTs by creating a balance for all sexual orientations in the media, language and messages used in traditional promotion and communications.

Target the LGBTs in messaging, so as to ensure that they use messages for their own benefit.

Market all available services to LGBTs.

Establish regular forums where LGBTs can share their point of views, needs and be given an opportunity to fully participate in planning and implementation of their services.

Establishment or expansion of HIV and AIDS programmes for LGBTs, that are combined or that address other needs putting the LGBTs at risk.

5.6 Future Research

This study raised interest in further exploration of some of its findings. The following investigative research topics are suggested for further exploration at provincial scope:

Effective IEC materials for LGBTs.

Effective HIV and AIDS promotion and communications programmes for LGBTs.

Discriminatory practices used in media impacting on the LGBTs.

LGBTs needs on HIV and AIDS health promotion and communications - wider scope.

Improving health sector and LGBTs partnerships on HIV and AIDS health promotion and communication.

Applying market segmentation of LGBTs in HIV and AIDS health promotion and communications.

5.7 Conclusion

LGBTs are a minority, but that does not warrant ignorance on ensuring that promotion and communication on HIV reaches them in order to avoid all risk situations exposing them to HIV transmission. HIV spread is a threat to life, as well as the economy and as a result, prevention thereof ought to target all groups in the society. Most importantly, LGBTs do have the right to the health services, as indicated under the objectives of the research.

The findings confirmed weaknesses in areas discussed under the recommendations, but did not provide definite answers to the gaps identified, instead opened up the need for more research into this aspect or discipline. Based on the research methodologies applied, the research is reliable, but the results thereof cannot be generalised beyond

its scope. It is recommended that the research be repeated, and its scope be increased to enable wider generalisation of results.

It is imperative for the dissertation to be availed to the health and the related sectors integrating services on HIV and AIDS for the LGBTs, in order for them to know the lessons learnt and gather creative perspectives emanating from the study. This study will equip the readers in this field with knowledge necessary in dealing with the LGBTs. The suggested future research and recommendations, may be carried by any sector with interest in the wellbeing of LGBTs. The recommendations made, complements the national strategies of comprehensive management of HIV and AIDS.

List of References

- Aggleton P., Jenkins P. & Malcolm A. 2005. HIV/AIDS and Injecting Drug use: Information, Education and Communication. *Drug Policy*; 16S: S21-S30. [online]. Available at www.sciencedirect.com. Accessed January 3, 2011.
- Babalola S., Fatusi A. & Anyanti J. 2009. Media Saturation, Communication Exposure and HIV Stigma in Nigeria. *Social Science and Medicine*; 68: 1513 – 1520. Elsevier Ltd. [online]. Available at www.elsevier.com/locate/socscimed. Accessed January 3, 2011.
- Baird H. 2010. Same-sex Sexuality in the North West Province. Community Report on the Outcomes of a Research Project. Centre for Applied Psychology. Pretoria.
- Beth L. 2010. Handbook for Academic Authors. Cambridge University Press. 5th Ed. Cape Town.
- Benson P. A. S. & Hergenroeder A. C. 2005. Bacterial Sexually Transmitted Infections in Gay, Lesbian, and Bisexual Adolescents: Medical and Public Health Perspectives. *Seminars in Pediatric Infectious Diseases*; 16: 181 -191. Houston. Elsevier Inc.
- Bessinger R., Katende C. & Gupta N. 2004. Multi-media Campaign exposure effects on Knowledge and Use of Condoms for STI and HIV/AIDS Prevention in Uganda. *Evaluation and Program Planning*; 27:397-407. Elsevier Ltd.[online]. Available at www.elsevier.com/locate/evalprogplan. Accessed January 3, 2011.
- Bith-Melander P., Sheoran B., Sheth L., Bermudez C., Drone J., Wood W. & Kurt S. 2010. Understanding Sociocultural and Psychological Factors Affecting Transgender People of Color. *Association of Nurses in AIDS Care*, 21(3): 207 - 220, May/June 2010. Accessed January 3, 2011.
- Bless C. & Higson-Smith C. 2006. Fundamentals of Social Research Methods: An African Perspective. 4th ed. Cape Town. Juta & Co. Ltd.
- Bloomberg L. D. & Volpe M. 2008. Completing Your Qualitative Dissertation: A Road Map From Beginning to End. 1st Ed. Sage Publication. California.

- Carael M., Marais H., Polsky J. & Mendoza A. 2009. Is there a Gender Gap in HIV Response: Evaluating National HIV Responses From the United General Assembly Special Session on HIV/AIDS Country Reports. *Acquired Immune Deficiency Syndrome*; 52(2): s111-118. December 2009. Lippinkott Williams & Wilkins.
- Cohen J. & Tate. T. 2006. The Less They Know the Better: Abstinence-Only HIV/AIDS Programs in Uganda. *Reproductive Health Matters*; 14(28): 174 -178. [online]. Available at www.rhmjournal.org.uk
- Core Standards for Health Facilities in South Africa. 2008. Government Printers: Pretoria. Available at [http:// www.doh.gov.za](http://www.doh.gov.za). Accessed December 3, 2010.
- Crompton L. 2003. Homosexuality and Civilization.1st Ed. Cambridge: The Belknap Press of Harvard University Press.
- Denscombe M. 2003. The Good Research Guide for Small-Scale Social Research Projects. 2nd Ed. Open University Press. Maidenhead. Philadelphia.
- de Wit J. B. F. , Prestage G. P. & Duffin I. R. 2010. Gay Men: Current Challenge and Emerging Approaches in HIV Prevention. *NSW Public Health Bulletin*; 21(3-4): 65 – 68.
- Doring N. M. 2009. The Internet's Impact on Sexuality: A Critical Review of 15 Years of Research. *Computers in Human Behaviour*; 25: 1089-1101.[online]. Available at www.elsevier.com/locate/comphumbeh. Accessed January 3, 2011.
- Driscoll L. D. & Brizee A. 2010. Ethical Considerations in Primary Research. Purdue University.
- Eckert P. & McConnell-Ginet, S. 2003. Language and Gender. 1st Ed. United Kingdom. Cambridge University Press.
- Elder J. P., Ayala G. X., Medina-Parra D. & Talavera G. A. 2009. Health Communicationin the Latino Community: Issues and Approaches. *Annual Review of Public Health.* 227 – 251.
- Eysenck M. W. 2004: Research Methods: Data Analysis. Psychology Press Ltd. Psychology: An International Perspective.

- Fill C. 2006. Marketing Communication: Engagement Strategies and Practices. 4th Ed. Prentice Hall. London.
- Friedman I. & Nokwedi J. 1998. Health promotion Advocacy Package. National Health Promotion Forum. Johannesburg.
- Gilliam P.P., Ellen J. M., Leornard L., Kinsman S., Jevitt C. M. & Straub D. M. 2010. Transition of Adolescents with HIV to Adult Care: Characteristics and Current Practices of the Adolescent Trials Network for HIV / AIDS. *Nurses in Health Care*. 1-12.
- Glatthorn A. A. & Joyner R. L. 2005. Writing a Winning Thesis or Dissertation: A Step-by-Step Guide. 2nd Ed. Corwin Press. A Sage Publication Company. Thousand Oaks, California.
- Gray D. E. 2009. Doing Research in the Real World. 2nd Ed. Sage Publications Ltd. London.
- Haidet P., Stone D.A., Taylor W. C. & Makadon H. J. 2002. When Risk is Low: Primary Care Physicians' Counseling About HIV Prevention. *Patient Education and Counseling*; 46:21-29. Elsevier Science Ireland Ltd.[online].Available at www.elsevier.com/locate/pateducou. Accessed January 3, 2011.
- Hart C. 1998. Doing a Literature review - Releasing the Social Science Research Imagination. 1st ed. London. Sage Publications.
- Hoffman N. D., Freeman K. & Swann S. 2009. Health Care Preferences of Lesbian, Gay, Bisexual, Transgender and Questioning Youth. *Society for Adolescent Medicine. Adolescent Health*; 45:222-229. Elsevier Inc.
- Holmes J. & Meyerhoff M. 2003. The Handbook of Language and Gender. 2nd Ed. Malden: Blackwell Publishing.
- Johnston L. G., Holman A., Dahoma M., Miller L. A., Kim E., Mussa M., Othman A. A., Kim A., Kendall C. & Sabin K. 2010. HIV Risk and the Overlap of Injecting drug Use and High-Risk Sexual Behaviors Among Men who Have sex with Men in Zanzibar (Unguja), Tanzania. *International Journal of Drug Policy*; 21: 485 – 492. Elsevier B. V. [online]. Available at www.elsevier.com/locate/drugpo. Accessed January 3, 2011.

- Keiswetter S. & Brotemarkle B. 2010. Culturally Competent Care for HIV-Infected Transgender Persons in the Inpatient Hospital Setting: the Role of the Clinical Nurse Leader. *Association of Nurses in AIDS Care*; Vol 21, No. 3. May/June 2010, 272 -277.
- Keller D. K. 2006. The Tao of Statistics: A Path to Understanding (With no Maths). California. Sage Publications, Inc.
- Kimmel, A. J. 2005. Marketing Communication - New Approaches, Technologies and Styles. 1st Ed. New York: Oxford University Press Inc.
- Kreiss J. L. & Patterson D. L. 1997. Psychological Issues in Primary Care of Lesbian, Gay, Bisexual and Transgender Youth. *Pediatric Health Care*;11: 266-274. National Association of Pediatric Nurse Associates and Practitioners.
- Kunaga M. & Rosenfeld W. D. 2004. Adolescent Sexuality and the Internet: The Good, the Bad and the URL. *Pediatric Adolescent Gynecology* 17:117-124. North American Society for Pediatric and Adolescent Gynecology. Elsevier Inc.
- Langlois-Klassen D., Kipp W. & Rubaale T. 2008. Who's Talking? Communication Between Health Providers and HIV-Infected Adults Related to Herbal Medicine for AIDS Treatment in Western Uganda. *Social Science and Medicine* 67 (165 – 176). Elsevier Ltd.
- Leedy P. D. & Omrod J.E. 2005. Practical Research: Planning and designs. 5th ed. New Jersey. Pearson Prentice Hall.
- Low K. 2010. Creating a Space for the Individual: Different Theatre and Performance - Based approaches to Sexual Health Communication in South Africa. *Applied Arts and Health*; 1(1); (111 -126). Intellect Ltd.
- Lunenburg F. C. & Irby B. J. 2008. Writing a Successful Thesis or Dissertation: Tips and Strategies in the Social and Behavioral Sciences. 1st Ed. Corwin Press, A Sage Co. California
- Mahalik J. R., Burns S. & Syzdek M. 2007. Musculinity and Perceived Normative Health Behaviors. *Social Science and Medicine*; 64 (2201 -2209). Elsevier Ltd.
- Maree K. 2007. First Steps in Research. 1st Ed. Van Schaik Publishers. Hatfield. Pretoria.

- Maticka-Tyndale E., Tiemoko, R. & Makinwa-Adeboseyo, P. 2007. Human Sexuality in Africa: Beyond Reproduction. 1st ed. Johannesburg: Action Health Incorporated.
- Medhurst A. & Munt, S. R. 1997. Lesbian and Gay Studies: A Critical Introduction. 1st Ed. Washington: Cassell.
- Mitchell K., Nyakake M. & Oling J. 2007. How Effective are Street Youth Peer Educators? Lessons Learned from an HIV/AIDS Prevention Programme in Urban Uganda. *Health Education*; 107(4); 364 – 376. Emerald Group Publishing Limited.
- Neale D. 2009. A Creative Writing Handbook: Developing Dramatic Technique, Individual Style and Voice. 1st Ed. A & C Black Publishers in association with The Open University.
- Nerdahl P., Berglund D., Bearinger L.H., Saewyc E., Ireland M. & Evans T. 1997. New Challenges, New Answers: Pediatric Nurse Practitioners and the Care of Adolescents. *Pediatric Health Care*; 13: 183 -190.
- Pinkham S. & Malinowska-Semprunch K. 2008. Women, Harm, Reduction and HIV. *Reproductive Health Matters*; 16(31):168-181. [online]. Available at www.rhmjournal.org.uk. Accessed January 3, 2011.
- Rakotananahary A., Rafranzoa Z. & Bensaid K. 2002. Qualitative Evaluation of HIV/AIDS IEC Activities in Madagascar. *Evaluation and Program Planning*; 25: 341 - 345. Elsevier Science Ltd.
- Rich E. 2006. Levels of Empowerment among Lesbian, Gay, Bisexual and Transgender (LGBT) People in the Western Cape South Africa. Cape Town. UNISA Centre for Applied Psychology & Out LGBT. Available at [http:// www.out.org.za](http://www.out.org.za). Accessed December 2, 2010.
- Rispel L. C. & Metcalf C. A. 2009. Breaking the Silence: South African HIV Policies and the Needs of Men who Have Sex with Men. *Reproductive Health Matters Journal*; 17(33):133 – 142).
- Romeo K. E. & Kelley M. A. 2009. Incorporating Human Sexuality Content into a Positive Youth Development Framework: Implications for Community Prevention. *Children and Youth Services Review*; 31: 1001 – 1009.

- Rudestem K. E. & Newton R. R. 2007. Surviving Your Dissertation: A Comprehensive Guide to Content and Process. 3rd Ed. Sage Publications Inc. California.
- Saewyc E. M, Bearinger L., McHamon G. & Evans T. 2006. A National Needs Assessment of Nurses Providing Health Care to Adolescents. *Professional Nursing*; Vol 22, No 5. (Sep – Oct.), 304-314. Elsevier Inc.
- Saewyc E. Bauer G. R., Skay C. L., Bearinger L. H., Resnick M. D., Reis E. & Murphy A. 2004. Measuring Sexual Orientation in Adolescent Health Surveys: Evaluation of Eight-School Based Surveys. *Adolescent Health*; 35: 344el. New York. Elsevier Inc.
- Santelli J., Ott M. A., Lyon M., Rogers J., Summers D. & Schleifer R. 2006. Abstinence and Abstinence-only Education: A Review of U.S. Policies and Programs. *Adolescent Health*; 38:72 – 81. Society for Adolescent Medicine.
- Satterfield J. M. & Crabb R. 2009. Cognitive-Behavioral Therapy for Depression in Older Gay Man: A Clinical Case Study. *Cognitive and Behavioral Practice Journal*; 17(2010), 44-45. Elsevier Ltd.
- Saxe J. M. Burgle B. J., Collins-Bride G. M., Stringari-Murray S., Dennehy R.N. & Holzemer R. N. 2004. Strategic Planning for UCSF's Community Health Nursing Faculty Practices. *Nursing Outlook*; Vol 52 (July – August), No. 4: 179-188. Elsevier Inc.
- Shapiro K. & Ray S. 2007. Sexual Health for People Living with HIV. *Reproductive Health Matters*; 17(29 Supplement);67 – 92. [online]. Available at www.rhmjournal.org.uk. Accessed January 3, 2011.
- Smith I. 2003. Meeting Customer Needs. 3rd Ed. Oxford: Elsevier Butterworth-Heinemann.
- Stott R. 2000. The Ecology of Health - Schumacher Briefing No. 3. 1st ed. Foxhole. Green Books for the Schumacher Society.
- Strydom J., Jooste C. & Cant M.C. 2000. Marketing Management. 4th Edition. Juta & Co. Ltd. Kenwyn.

The HIV & AIDS and STI National Strategic Plan 2007-2011. 2006. South African National AIDS Council Secretariat, Government Printers: Pretoria. Available at <http://www.doh.gov.za>. Accessed December 2, 2010.

Thomas M. R. & Brubaker D. L. 2008. Theses and Dissertations: A guide to Planning, Research and Writing. Corwin Press. 1st Ed. A sage Publications Co. Carlifornia

Thornhill L. & Klein P. 2010. Creating Environments of Care With Transgender Communities. *The Association of Nurses in AIDS Care; Vol 21, No. 3. May/June 2010*, 230 -239.

Vogt W. P. 2005. Dictionary of Statistics and Methodology: A Non-Technical Guide for Social Sciences. 3rd Ed. Sage Publications Inc. California

Walliman N. 2005. Your Research Project: A Step-by-Step Guide for First Time Researcher. 2nd Ed. Sage Publications Ltd.

Wells H. 2005. Levels of Empowerment among Lesbian, Gay, Bisexual and Transgender (LGBTs) People in KwaZulu-Natal South Africa. Durban. The Durban Lesbian and Gay Community and Health Centre & Out LGBT. Available at <http://www.out.org.za>. Accessed December 2, 2010.

Wells H. & Polders, I. 2004. Levels of Empowerment among Lesbian, Gay, Bisexual and Transgender (LGBT) People in Gauteng South Africa. Pretoria. UNISA Centre for Applied Psychology & Out LGBT. Available at <http://www.out.org.za>. Accessed December 2, 2010

Welman C., Kruger F. & Mitchell B. 2005 Research Methodology. 3rd Ed. Oxford University Press. SA (Pty)Ltd.

Wilton T. 2000. Sexualities in Health and Social Context: A Textbook. 1st Ed. Buckingham: Open University Press.

Appendix 1: Table of Construction

Research Question	Survey Question	Variable
Personal Details		
Provision of personal data	I am:	○ African ○ Coloured ○ Indian ○ White ○ Other ○ I do not want to answer this question
	I am:	○ 18 – 21yrs ○ 21 - 35yrs ○ 35 – 40yrs ○ 40 – 55yrs ○ 55yrs> ○ I do not want to answer this question
	I have:	○ No matric ○ Matric ○ Diploma ○ Degree ○ Post graduate qualification ○ I do not want to answer this question
	I reside in :	○ Bojanala ○ Ngaka Modiri Molema ○ Dr. Kenneth Kaunda ○ Dr. Ruth Segomotsi Mompati
	I am:	○ Lesbian ○ Gay ○ Transgender ○ Bisexual ○ Transsexual ○ Intersexual ○ Androgeneous ○ MSM ○ WSW ○ I do not want to answer this question (See list of definitions)
Service Delivery Gaps		

Does the mainstream health promotion and communication activities discriminate the LGBTs?	Have you ever been exposed to or received any health promotion and communication material or talks on HIV and AIDS by the health department?	☐ Yes ☐ No
	If yes, what type were you exposed to?	☐ Brochures/ Posters ☐ Public Talk ☐ Radio ☐ Newspapers ☐ TV ☐ Mass event ☐ Theatrical Play ☐ Targeted group ☐ Internet ☐ Other
	Do you think that the LGBT's needs on HIV and AIDS health promotion and communications are not met?	☐ I strongly agree ☐ I agree ☐ I disagree ☐ I strongly disagree
Discriminatory Practices and Risks		
Does the discrimination elicit any negative or risk behavior in HIV transmission?	Do you know what is to discriminate?	☐ Yes ☐ No
	Do you think the promotional and communication material / talks on HIV and AIDS discriminates the LGBTs	☐ Yes ☐ No ☐ I do not want to answer this question
	Which medium of promotion and communications do you think is mostly used as a discriminatory tool?	☐ Brochures/ Posters ☐ Public Talk ☐ Radio ☐ Newspapers ☐ TV ☐ Mass event ☐ Theatrical Play ☐ Targeted group ☐ Internet ☐ Other
	Is discrimination likely to cause HIV transmission risk?	☐ Yes ☐ No
	If you think discrimination exists, do you try to use the messages that are not targeted to you for your own benefit?	☐ Not at all ☐ At all times ☐ Sometimes ☐ Most of the time

	Do you know of any LGBT who got infected with HIV due to them having not received any information on HIV?	☐ Yes ☐ No
	Have you, in the past ever been at risk of getting HIV due to having not received information on it?	☐ Yes ☐ No ☐ I do not want to answer this question
	Do you currently consider yourself to be at risk of HIV infection as a result having not received information on it?	☐ Yes ☐ No ☐ I do not want to answer this question
Partnership status analysis		
Is partnership between the health sector and the community existent?	Are you aware of any forums where the health sector meets the LGBTs?	☐ Yes ☐ No
	If yes, are you participating in such forums	☐ Yes ☐ No ☐ I do not want to answer this question
	Do you participate in the planning and running of health sector promotional and communications activities to LGBTs?	☐ Yes ☐ No
	How regular do you participate in health sector, HIV and AIDS activities?	☐ Weekly ☐ Monthly ☐ Every six months ☐ Yearly ☐ Never ☐ I do not want to answer this question
	Rate the relationship between the health sector and LGBTs	☐ None ☐ Weak ☐ Moderate ☐ Strong ☐ I do not want to answer this question

Needs analysis		
What are the needs of the LGBTs in health promotion and communication activities?	Do you think that the messages on HIV and AIDS promotion communication are relevant to the LGBTs?	☐ I strongly agree ☐ I agree ☐ I disagree ☐ I strongly disagree
	Do you think that the media used to spread messages on HIV and AIDS promotion are relevant to the LGBTs?	☐ I strongly agree ☐ I agree ☐ I disagree ☐ I strongly disagree
	Do you think that the language / lingo on HIV and AIDS promotion and communication is relevant used is to the LGBTs?	☐ I strongly agree ☐ I agree ☐ I disagree ☐ I strongly disagree
	Do LGBTs need targeted HIV and AIDS promotion and communication, other than being part of activities targeting all?	☐ Yes ☐ No
	What is your most preferred programme to reach out to LGBTs on HIV and AIDS?	☐ School based programmes ☐ Abstinence – only programmes ☐ Combined HIV and AIDS, drugs and reproductive health programmes
	Do you prefer Information, Education and Communication material to :	☐ Target all ☐ Specifically target the LGBTs ☐ Target the different sub-groups of LGBTs ☐ None of the above

Appendix 2: Research Questionnaire

FOR OFFICE USE ONLY: Respondent Code: _____

VOLUNTARY QUESTIONNAIRE FOR LGBTs

"What are the Lesbians, Gays, Bisexual and Transgender (LGBT) needs on HIV and AIDS health promotion and communication in the North West Province of South Africa?"

Graduate School, University of the North West, Mahikeng Campus

Researcher: Lorato Mahura (Student). Study Leader: Prof. S Lubbe.

Part 1: Note to the respondent

Kindly assist the researcher to understand what LGBTs need in terms of HIV and AIDS health promotion and communication.

- The results of the survey will be used to advocate for LGBTs needs, through permission of Gay Umbrella, and can be obtained from them.
- Please note that you are allowed not to take part in this study.
- If you do not want to take part, kindly send the blank questionnaire before the due date.
- All answers you provided in this questionnaire will remain private and confidential. No one will be able to trace your opinions back to you as a person.

The questionnaire has 7 parts:

Part 1 guides you and asks permission from you to use your responses for academic research.

Part 2 a lists of the definitions or meaning of some words is attached.

Part 3 asks general personal details your race, age, gender, qualification and place of stay.

Part 4 asks about the gaps in services that you are aware of.

Part 5 asks about discriminatory practices and the risks that discrimination can bring with such practice.

Part 6 asks about the partnership of LGBTs and the health sector.

Part 7 asks about the needs of LGBTs.

How to complete the questionnaire

1. Please answer the questions as truthfully as you can. Also, please be sure to read and follow the directions for each part. If you do not follow the directions, it will be difficult to use the information you provided for the study.
2. In case you are not comfortable to answer some questions that might be sensitive, please note that the researcher is giving you the option not to answer. For those questions that you do answer, your responses will be kept confidential.
3. Kindly mark each response by making a tick or a cross, or encircling each appropriate response with a PEN (not a pencil).

Thank you very much for filling in this questionnaire. Permission to use my responses for academic research
I hereby give permission that my responses may be used for research purposes provided that my identity is not
in the published records of the research.

Your research code: _____

Signature: _____ Date: _____

Part 2: List of Definitions or Meaning of Words

Lesbian	A woman whose primary sexual and romantic attraction is to other women.
Gay	A man whose primary sexual and romantic attraction is to other men.
Bisexual	A person who has sexual and romantic attraction.
Transgender	Some people describe themselves as transgender when they experience a gender identity different from their birth sex. For example a person born into a male body, but who feels female may live as a woman and may describe herself as transgender. Some transgender individuals alter their physical appearance through attire and/or use of hormones and surgery to match their internal sense of gender, including male-to-female and female-to-male.
Gender identity	One's internal sense of male or female.
Transsexual	A male or female who has gone through surgical procedure to alter or change their birth sex.
Intersex	Some one born with male and female organs.
Androgynous	Exhibiting approximately equal proportions of masculine and feminine characteristics simultaneously.
MSM	Men having Sexual relations with other Men.
WSW	Women having Sexual relations with other Women.
HIV	Human Immunodeficiency Virus.
AIDS	Acquired Immuno-Deficiency Syndrome.
Health Promotion	A process of enabling people to increase control over, and improve their health
Communication	The exchange and flow of information and ideas from one person to another.
Discrimination	With reference to gender discrimination – it is preference of one gender over the other. An act of prejudice or unfairness.
LGBT	Lesbians, Gays, Bisexual and Transgender.

	PART 3: PERSONAL DETAILS <i>Please tell us a little about yourself</i> Please mark only ONE option per question (the most appropriate or regular) below.	6.	PART 4: SERVICE DELIVERY GAPS Please mark only ONE option per question (the most appropriate or regular) below. Have you ever been exposed to or received any health promotion and communication material or talks on HIV and AIDS by the health sector? ☐ Yes ☐ No
1.	I am: ☐ African ☐ Coloured ☐ Indian ☐ White ☐ Other	7.	If yes, what type where you exposed to? ☐ Brochures/ Posters ☐ Public Talk ☐ Radio/TV/ Newspapers ☐ Mass event ☐ Theatre Play ☐ Targeted group ☐ Internet ☐ Other
2.	I am: ☐ 18 – 21yrs ☐ 21 - 35yrs ☐ 35 – 40yrs ☐ 40 – 55yrs ☐ 55yrs> ☐ do not want to answer this question	8.	Do you think that the LGBTs needs on HIV and AIDS health promotion and communications are met? ☐ I strongly agree ☐ I agree ☐ I disagree ☐ I strongly disagree
3.	I have: ☐ No matric ☐ Matric ☐ Diploma ☐ Degree ☐ Post graduate qualification	9.	PART 5: DISCRIMINATORY PRACTICES AND RISKS Please mark only ONE option per question (the most appropriate or regular) below. Do you know what it is to discriminate? ☐ Yes ☐ No
4.	I reside in: ☐ Bojanala ☐ Ngaka Modiri Molema ☐ Dr. Kenneth Kaunda ☐ Dr. Ruth Segomotsi Mompati	10.	Do you think the promotional and communication material / talks on HIV and AIDS discriminates against the LGBTs? ☐ Yes ☐ No ☐ I do not want to answer this question
5.	I am: ☐ Lesbian ☐ Gay ☐ Transgender ☐ Bisexual ☐ Transsexual ☐ Intersexual ☐ Androgeneous ☐ MSM ☐ WSW (See list of definitions)	11.	Which medium of promotion and communications do you think is mostly used as a discriminatory tool? ☐ Brochures/ Posters ☐ Public Talk ☐ Radio ☐ Newspapers ☐ TV ☐ Mass event ☐ Theatre Play ☐ Targeted group ☐ Internet ☐ Other

12.	Is discrimination likely to increase the HIV transmission risk? ☐ Yes ☐ No	20.	How regularly do you participate in health sector, HIV and AIDS activities? ☐ Weekly ☐ Monthly ☐ Every six months ☐ Yearly ☐ Never
13.	If you think discrimination exists, do you try to use the messages that are not targeted to you for your own benefit? ☐ Not at all ☐ At all times ☐ Sometimes ☐ Most of the time	22.	Rate the relationship between the health sector and LGBTs: ☐ None ☐ Weak ☐ Moderate ☐ Strong
14.	Do you know of any LGBT who got infected with HIV due to them having not receiving any information on HIV? ☐ Yes ☐ No	21.	PART 7: NEEDS ANALYSIS Please mark only ONE option per question (the most appropriate or regular) below. Do you think that the messages on HIV and AIDS promotion communication are relevant to the LGBTs? ☐ I strongly agree ☐ I agree ☐ I disagree ☐ I strongly disagree
15.	Have you, in the past ever been at risk of getting HIV due to having not receiving information on it? ☐ Yes ☐ No	22.	Do you think that the media used to spread messages on HIV and AIDS promotion are relevant to the LGBTs? ☐ I strongly agree ☐ I agree ☐ I disagree ☐ I strongly disagree
16.	Do you currently consider yourself to be at risk of HIV infection as a result having not received information on it? ☐ Yes ☐ No	23.	Do you think that the language / lingo on HIV and AIDS promotion and communication is relevant to the LGBTs? ☐ I strongly agree ☐ I agree ☐ I disagree ☐ I strongly disagree
17.	PART 6: PARTNERSHIP STATUS ANALYSIS Please mark only ONE option per question (the most appropriate or regular) below. Are you aware of any forums where the health sector meets the LGBTs? ☐ Yes ☐ No	25.	What is your most preferred programme to reach out to LGBTs on HIV and AIDS? ☐ School based programmes ☐ Abstinence – only programmes ☐ Combined HIV and AIDS, ☐ drugs and reproductive health programmes
18.	If yes, are you participating in such forums? ☐ Yes ☐ No	24.	Do LGBTs need targeted HIV and AIDS promotion and communication, other than being part of activities targeting all? ☐ Yes ☐ No
19.	Do you participate in the planning and running of health sector promotional and communications activities to LGBTs? ☐ Yes ☐ No	26.	Do you prefer Information, Education and Communication material to: ☐ Target all ☐ Specifically target the LGBTs ☐ Target the different sub-groups of LGBTs ☐ None of the above END

Appendix 3: Research Control Tool

“What are the Lesbians, Gays, Bisexual and Transgender (LGBT) needs on HIV and AIDS health promotion and communication in Ngaka Modiri Molema District, North West Province of South Africa?”

Research Questionnaire Confidential Consent / Control Form

NB: You are requested to read the information below before you fill the questionnaire.

Confidential Consent

I hereby give permission that my responses may be used for research purposes provided that my identity is not revealed in the published records of the research. I can only be contacted by the Graduate School, University of the North West, if it is working with and obtained permission from the Gay Umbrella Organisation.

Control: After you have signed the form, it will be kept by Gay Umbrella to assist in case proof is needed that the research took place

Serial No.	Name	Surname	Signature	Contact No. / Address	Contact No./ Address

Appendix 4: Research Themes Matrix												
Most important theme 30												
Average important theme 20												
Least important theme 10		1	2	3	4	5	6	7	8	9	10	11
No.	ARTICLE USED: AUTHOR ONLY - SEE REF LIST	HIV and AIDS	Sexual Orientation	Health Service Delivery to LGBTs	Social Risk Factors & Discrimination	Needs and Programmes for LGBTs	Health promotion and communication	Research Approaches	Qualitative Research	Sampling	Data Collection	Data analysis
1	Aggleton J., Jenkins P. & Malcolm A. 2005.					1	1					
2	Babalola S., Fatusi A. & Anyanti J. 2009.				1	1	1					
3	Baird H. 2010.		1									
4	Beth L. 2010.							1				
5	Benson P. A. S. & Hergenroeder A. C. 2005.			1	1							
6	Bessinger R., Katende C. & Gupta N. 2004.						1					
7	Bith-Melander P. <i>et al.</i> 2010.			1	1	1						
8	Bless C. & Higson-Smith C. 2006.							1				
9	Bloomberg L. D. & Volpe M. 2008.							1				
10	Carael M., Marais H., Polsky J. & Mendoza A. 2009.						1					
11	Cohen J. & Tate. T. 2006.	1		1		1						
12	Core Standards for Health Facilities in South Africa. 2008.					1						
13	Crompton, L. 2003.							1				
14	Denscombe M. 2003.							1	1	1	1	1

No.	ARTICLE USED: AUTHOR ONLY - SEE REF LIST	HIV and AIDS	Sexual Orientation	Health Service Delivery to LGBTs	Social Risk Factors & Discrimination	Needs and Programmes for LGBTs	Health promotion and communication	Research Approaches	Qualitative Research	Sampling	Data Collection	Data analysis
15	de Wit J. B. F., Prestage G. P. & Duffin I. R. 2010	1				1						
16	Doring N.M. 2009.	1					1					
17	Driscoll L. D. & Brizee A. 2010.							1				
18	Eckert, P. & McConnell-Ginet, S. 2003.						1					
19	Elder J. P. <i>et al.</i> 2009.						1					
20	Eysenck M. W. 2004:											1
21	Fill C. 2006.						1					
22	Friedman I. & Nwokedi J. 1998.						1					
23	Gilliam P.P. <i>et al.</i> 2010.	1				1						
24	Glatthorn A. A. & Joyner R. L. 2005.							1				
25	Gray D. E. 2009.							1	1	1	1	
26	Haidet P., Stone D.A., Taylor W. C. & Makadon H. J. 2002.	1	1		1	1						
27	Hart C. 1998.	1										
28	Hoffman N. D., Freeman K. & Swann S. 2009.		1			1						
29	Holmes, J. & Meyerhoff M. 2003.						1					
30	Johnston L.G. <i>et al.</i> 2010.			1	1	1						
31	Keiswetter S. & Brotemarkle B. 2010.	1			1	1						
32	Keller. D. K. 2006.						1			1		1
33	Kimmel, A. J. 2005.						1					
34	Kreiss J.L. & Patterson D. L. 1997.					1						
35	Kunaga M. & Rosenfeld W. D. 2004.				1		1					
36	Langlois – Klassen D., Kipp W. & Rubaale T. 2008.						1					
37	Leedy P.D. & Omrod J.E. 2005.							1				

No.	ARTICLE USED: AUTHOR ONLY - SEE REF LIST	HIV and AIDS	Sexual Orientation	Health Service Delivery to LGBTs	Social Risk Factors & Discrimination	Needs and Programmes for LGBTs	Health promotion and communication	Research Approaches	Qualitative Research	Sampling	Data Collection	Data analysis
38	Low K. 2010						1					
39	Lunenburg F. C. & Irby B. J. 2008.							1		1		1
40	Mahalik J. R., Burns S. & Syzdek M. 2007.				1							
41	Maree K. 2007.							1	1	1	1	
42	Maticka-Tyndale E. <i>et al.</i> 2007.		1									
43	Medhurst A. & Munt, S. R. 1997.		1									
44	Mitchell K., Nyakake M. & Oling J. 2007.						1					
45	Neale D. 2009.										1	
46	Nerdahl P. <i>et al.</i> 1997.					1						
47	Pinkham S. & Malinowska-Semprun K. 2008.				1	1						
48	Rakotananahary A., Rafranzoa Z. & Bensaid K. 2002.					1						
49	Rich E. 2006.			1	1	1						
50	Rispel L. C. & Metcalf C.A. 2009.	1	1		1	1						
51	Romeo K. E. & Kelley M. A. 2009.		1			1	1					
52	Rudestam K. E. & Newton R. R. 2007.										1	
53	Saewyc E. M., Bearinger L., McHamon G. & Evans T. 2006.			1	1							
54	Saewyc E. <i>et al.</i> 2004.				1	1						
55	Santelli J. <i>et al.</i> 2006.					1						
56	Satterfield J.M. & Crabb R. 2009.		1			1						
57	Saxe J. M. <i>et al.</i> 2004.					1						
58	Shapiro K. & Ray S. 2007		1			1						
59	Smith I. 2003.			1								
60	South African Health Review 2006.											
61	Stott R. 2000.						1					

No.	ARTICLE USED: AUTHOR ONLY - SEE REF LIST	HIV and AIDS	Sexual Orientation	Health Service Delivery to LGBTs	Social Risk Factors & Discrimination	Needs and Programmes for LGBTs	Health promotion and communication	Research Approaches	Qualitative Research	Sampling	Data Collection	Data analysis
62	Strydom J., Jooste C. & Cant M.C. 2000.						1					
63	The HIV & AIDS and STI National Strategic Plan 2006.				1		1					
64	Thomas M. R. & Brubaker D. L. 2008.											1
65	Thornhill L. & Klein P. 2010.					1						
66	Vogt W. P. 2005.									1		1
67	Walliman N. 2005.							1	1			
68	Wells H. 2005.			1	1	1						
69	Wells H. & Polders, I. 2004.			1	1	1						
70	Welman C., Kruger F. & Mitchell B. 2005								1		1	1
71	Wilton T. 2000.			1	1							
	POINTS	7	9	10	17	26	19	12	5	6	6	7
	THEME WEIGHT (i.e total = 10, 20 & 30 scale)	10	10	10	30	30	20	20	10	10	10	10
	PERCENTAGE SCORE (e.g 7/10 x 100%)	70.00%	90.00%	100.00%	57.00%	87.00%	95.00%	60.00%	50.00%	60.00%	60.00%	70.00%
THEME WEIGHTS												Total Score
Most important theme						30						73.00%
Average important theme						20						
Least important theme						10						