The Right to Health for the Lesbian, Gay, Bisexual and Transgender (LGBT) Population in Nigeria? – An Exploration of Access to, And Delivery of Healthcare Services.

By

Adekemi Sekoni

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Abstract

Lesbian, Gay, Bisexual or Transgender (LGBT) individuals experience challenges in accessing culturally and clinically appropriate healthcare services. The aim of this research was to generate scientific evidence on barriers and facilitators influencing access to healthcare services for LGBT people living in Nigeria. Three empirical studies and a systematic review were carried out. The first study, a cross-sectional survey among undergraduate students in Lagos examined the existence and severity of homophobia against men who have sex with men. Findings showed that for heterosexual individuals, the criminalization of same-sex relationships provided justification for denial of rights including access to healthcare services. This study was followed by semi-structured qualitative interviews among LGBT people living in two cosmopolitan cities in Nigeria, exploring their experiences of accessing healthcare services. Analysis of the data generated a framework for social determinants of LGBT health in Nigeria and an adapted three-level intersectionality wheel displaying the factors responsible. These studies provided evidence on barriers to healthcare services. A systematic review to synthesise evidence of the effectiveness of educational training programs on LGBT health for healthcare students and professionals showed that such training programs have the potential to improve the knowledge, attitudes and practices of professionals. Finally, a mixed-method case study of a college of medicine showed deficiencies in the current state of teaching and learning about LGBT health and service provision. The findings above were used to modify the WHO social determinants of health framework to address LGBT health within the Nigerian context.

I dedicate this thesis to God Almighty.

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GLOSSARY

ART	Antiretroviral Therapy
CASP	Critical Appraisal Skills Programme
CMUL	College of Medicine, University of Lagos
DSD	Disorders of Sex Development
ERIC	Education Resources Information Center
GLBWBM	Gay, Lesbian, Bisexual Women and Bisexual Men
LASUCOM	Lagos State University College of Medicine
LGBT	Lesbian, Gay, Bisexual and Transgender
LUTH	Lagos University Teaching Hospital
MSM	Men Who Have Sex with Men
NDHS	National Demographic and Health Survey
NGO	Non-Government Organisation
NHREC	National Health Research Ethics Committee
SSA	sub Saharan Africa
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/Acquired Immune Deficiency Syndrome
UNILAG	University of Lagos

Chapter One: Introduction

Access to healthcare extends beyond physical access to encompass person centred culturally appropriate care. Lesbian, gay, bisexual and transgender (LGBT) people experience discrimination, harassment, disadvantage and inequality in accessing healthcare services.(1, 2) This arises most often from heterosexism and heteronormative assumptions by healthcare professionals providing mainstream services.(3, 4) Structural barriers to healthcare linked to sexual and social stigma has resulted in a higher proportion of morbidity and mortality for the LGBT population.(5, 6) Hence, they bear a disproportionately high burden of preventable and curable diseases. This thesis presents a cross sectional descriptive study, a qualitative study, a systematic review and a mixed method study design to examine issues that affect access to healthcare services for LGBT people. The aim of this thesis is to use mixed methods to examine access to quality health services for LGBT people in Nigeria.

Chapter 2 (Background): In this chapter, I review the existing literature on the health care experiences of LGBT people and practices of clinicians treating LGBT people. The literature that is reviewed focuses on the sub-Saharan African context, but also reviews literature from other countries. I also describe the criminalising law in Nigeria that came into effect in 2014.

Chapter 3: (The Criminalising Law and Healthcare Services for Men who have Sex with Men [MSM] in Nigeria): This chapter addresses my first research question – What is the effect of the criminalising law on attitudes towards MSM and provision of healthcare services for this population group in Nigeria? The answer was obtained using a cross sectional descriptive study. This is an original contribution to science that was published in 2016.

Citation: Sekoni AO, Jolly K, Gale NK, Ifaniyi OO, Somefun EO, Agaba EI, Fakayode VA. Provision of Healthcare Services to Men Who Have Sex with Men in Nigeria: Students'

Attitudes Following the Passage of the Same-Sex Marriage Prohibition Law. J LGBT Health 2016; 3(4): 300-307. Contributions: AS, UN and OI conceived the study, AS, UN, OI, ES, EA and VF conducted literature review and protocol design; AS, UN, OI, ES, EA and VF were involved in data collection; AS, KJ, NG, OI and UN analysed the data; AS, KJ, NG prepared the manuscript; AS, KJ, NG, OI, UN, ES, EA and VF critical reviewed it.

Chapter 4 (The Hidden Costs of Healthcare for LGBT People in Nigeria: An Intersectional Analysis of the Healthcare Experiences): This chapter addresses my second research question – What are the experiences of LGBT people while accessing healthcare in Lagos and Abuja, Nigeria? I conceived the idea for this study with my supervisors. The question was answered using a qualitative study design, I undertook all the interviews and analysis. This qualitative study provided the data for an intersectional wheel describing LGBT health inequity in Nigeria, which is an original contribution to knowledge. In this healthcare research, I also developed a framework for social determinants of health inequity for LGBT people living in Nigeria that incorporated religion, politics, laws and policies.

Chapter 5 (Training of Healthcare Students and Professionals [Global]): This chapter addresses my third research question – Are educational curricula and training on LGBT health for healthcare students and professionals effective? I carried out a systematic review to answer this question. This is an original contribution to evidence that was published in 2017.

Citation: Sekoni AO, Gale NK, Manga-Atangana B, Bhadhuri A Jolly K. The effects of educational curricula and training on LGBT-specific health issues for healthcare students and professionals: a mixed-method systematic review. J Int AIDS Soc 2017 19; 20(1): 21624. doi: 10.7448/IAS.20.1.21624. Contributions: AS, KJ and NG conceived the idea for the study and developed the protocol; AS developed the search strategy, AS, BM-A undertook the screening

of the abstracts, AS, KJ and NG screened the full-text articles for inclusion; AS and AB undertook data extraction; AS, NG and KJ interpreted the data; AS drafted the manuscript with critical input from NG and KJ; all authors read and approved the final manuscript.

Chapter 6 (Health Care Students and Professionals' Training, Knowledge, Attitudes and Practices [Nigeria]): This chapter addresses my last research question – What is the current state of teaching and learning about LGBT health in a medical school in Nigeria? I conceived the idea for this study with my supervisors. I developed a mixed method study, conducted all data collection, interviews and analysis required to answer this research question. This study is an original contribution to knowledge in an area where there is paucity of research. I generated evidence on the training, knowledge, beliefs, attitudes and practice of healthcare students and faculty living, working and learning within the constraints of religious, legal and cultural barriers to LGBT identity.

Chapter 7 (Discussion): Chapters three to six have individual discussion sections placing the results within the context of literature, highlighting the limitations, conclusions and policy implications of the findings. In chapter seven of this thesis, I summarise the findings of the four empirical chapters and bring together the evidence generated from the general population (chapter three), members of the LGBT community (chapter 4), educational training of healthcare professionals (chapters five and six) to generate a holistic view of access to healthcare services for LGBT population in Nigeria within the context of the 'Right to Health'. This process resulted in an adaptation of the World Health Organization model of the social determinants of health to incorporate religion, criminalising law and colonialism in Nigeria.

Chapter Two: Background

The background chapter in this thesis is divided into four main sections:

1) A discussion of lesbian, gay, bisexual and transgender (LGBT) related terminologies

LGBT related terms have expanded over the years with some terms retaining their original meaning while others have been modified and new words added. This section describes the common terms currently in use.

2) Inequalities in health status of LGBT people

This section, explores some of the evidence available relating to research carried out among the LGBT population documenting health inequalities.

3) The social environment of LGBT people

The social environment section reviews literature to bring out issues related to the social environment, namely politics, laws, culture and religion which influence societal attitudes towards LGBT people and ultimately their health. Starting from the historical period and culminating in contemporary times, it covers long-standing, interrelated issues as well as recent events which have contributed to the current level of homophobia and transphobia in some African countries including Nigeria. This is important, because a clear understanding of the current synergy between the political climate which shapes the laws and policies governing the country, the culture, religion and the social environment in which LGBT people live in Nigeria will guide the design of effective and acceptable interventions for reducing health disparity experienced by the LGBT population in Nigeria. This will provide the context for the research reported in chapter three of this thesis.

4) The provision of medical care for the LGBT population - which informs the main research questions that the thesis addresses.

This section looks at the individual, institutional/organizational, community and legal factors which influence access to healthcare services for LGBT people.

2.1 Describing the terminology relating to LGBT people

LGBT is an acronym for lesbian, gay, bisexual and transgender.

Sex refers to the biological make up of an individual at birth determined by genital, gonadal, hormonal and chromosomal characteristics. A person is assigned male or female sex at birth based on the appearance of the external genitalia.(7)

Sexual orientation describes the sex of the people to whom an individual is sexually and emotionally attracted to. Classification based on sexual orientation includes homosexuality; bisexuality and heterosexuality.(8) Traditionally, heterosexuality has been presumed the only psychologically normal and legitimate sexual orientation (normativity) while the other variants are considered deviant or abnormal behaviour (heterosexism). Based on sexual orientation, an individual can therefore identify as heterosexual, lesbian (L), gay (G) or bisexual (B).(7-9) The majority of women are sexually and erotically attracted to men and vice versa hence, lesbian, gay and bisexual people are sometimes referred to as sexual minority men (SMM) and sexual minority women (SMW) by the wider society.(10)

Sexual orientation is a combination of sexual identity, sexual attraction and sexual expression. However it is not always straightforward; for instance, an individual can identify as a heterosexual but may also be sexually attracted to members of the same sex.(8, 9, 11, 12) Lesbian or gay woman are terms used to describe women who are sexually attracted to women.

Gay man is the term used to describe men who are sexually attracted to men. A woman or man can be described as bi or bisexual if the individual is sexually attracted to both women and men (not necessarily equally). Some individuals are uncertain of their sexual attraction and therefore categorised as questioning (Q).(12, 13) Homosexual is an older term coined in the nineteenth century to describe people who are sexually attracted to members of the same sex, but is generally avoided now as it has derogatory associations around outdated medical practices.(8, 11, 14)

Sexual identity and sexual behaviour are two separate entities. For instance, a person could engage in same sex sexual behaviour and still identify as heterosexual or a person who identified as lesbian, gay or bisexual could be sexually inactive.(12) Lesbian and bisexual women, gay men, bisexual men and other men who have sex with men may engage in same sex behaviour.(8, 9, 11) The term MSM is used to refer to men who have sex with men; this group includes gay men, bisexual men and other men who have sex with men but self-identify as heterosexuals.(8, 9, 11) Other health related terminologies are "key population at higher risk of HIV/AIDS" made up of men who have sex with other men (gay and bisexual men), sex workers and people who inject drugs. In this thesis, the various terminologies will be used interchangeably depending on the subpopulation involved and also as used by individual authors in reviewed literature. Terminologies used in Nigeria maybe regarded as derogatory in the UK or other countries that are more respectful of the rights of LGBT people.

Gender refers to the feelings, attitude and expected behaviours linked to the experience and expression of gender. Gender is usually assumed when sex is assigned at birth based on sexual anatomical structures possessed by the child, who is usually classified as male and female. Traditionally an individual is assigned female at birth if they possess a vagina/vulva or male if a penis and testicles are present.(7, 15) Gender identity is the personal experience and

identification of oneself as a boy/man, girl/woman, as a mix of the two, as neither, or as a gender beyond those already mentioned. This is irrespective of the biological sex at birth.(15) Gender expression is the way and manner people express their gender identity.(7) This reflects in the physical appearance and mode of dressing, and sometimes through behaviour and interests. Gender stereotypes often influence gender expression. These are the set of ideas, current in the culture and times in which a person lives, about the different characteristics and roles ascribed by the society to men and women. Non-conformity may attract varying levels of sanctions ranging from mild to severe.

Gender questioning refers to an individual who is currently processing, questioning or exploring how to express their gender identity while a cisgender person is an individual whose gender identity matches the sex assigned at birth. These individuals do not experience gender incongruence.(15, 16)

Two elements are considered in categorising the transgender population namely; assigned sex at birth and gender identity. Transgender people have a current gender identity or expression that is different from the sex assigned to them at birth. A Transgender person experiences gender incongruence between their personal experience of gender and the gender assigned at birth which can lead to gender dysphoria.(15) The individual may decide to alter their body or appearance through surgery or treatment with chemical substances (hormones). The transgender population is sometimes referred to as trans or gender minority (GM).(17) A transgender person can identify as heterosexual, gay, lesbian or bisexual.(18)

The definition and terminologies used to describe transgender people differ across social context and time globally. Currently, a transgender man is a person who was assigned female

at birth who identifies as a man while a transgender woman is a person assigned male at birth but identifies as a woman.(18)

The terminology relating to LGBT has evolved over time and is still evolving. It has had different meanings within various cultures and at different periods overtime. LGBT people are a diverse group who come from different backgrounds all over the world and have diverse sexual orientation identities, attractions, behaviour and self-expression. A transgender man who is sexually attracted to a female may identify as a heterosexual, alternatively if he is attracted to a man he may identify as gay.(8, 9, 11, 12)

2.2 Health Inequality and the LGBT population

In most countries, surveillance data and the census collect information on binary sex assigned at birth and do not collect information on sexual orientation. It is therefore difficult to estimate the proportion of the population globally who self-identify as LGB and/or Transgender. As a result of this omission, research on population based samples of LGBT people is limited. Consequently, most studies are based on venue based samples leading to paucity of information on the health of LGBT people. Overconcentration on behavioural risk factors compared to physical health outcomes for chronic non communicable diseases is also a contributory factor to this problem.

Depending on the dimension used to measure sexual orientation i.e. sexual identity; sexual attraction and or sexual behaviour various estimates of population size has been reported. The United Kingdom (UK) office for National Statistics report showed that 1.7% of the adult population and 3.3% of the young people in the UK identify as LGB in 2015.(19) This proportion increased to 2.0% and 4.1% respectively in 2016.(20) Public Health England sponsored a systematic review of available national surveys on LGB adults, published in 2016.

This included fifteen eligible studies and generated a pooled mean estimate that 2.5% of the UK adult population identify as LGB.(21) In the United States (US) a similar result was obtained from the 2015 National Health Interview Survey which reported that 2.4% of the adult population identify as LGB.(22)

Nationally representative estimates for transgender population are limited, studies that collect information on sexual identity from MSM participants often fail to include gender identity. Estimates suggest that close to 1% of the global seven billion population might be a transgender person.(17) A meta-analysis of 12 surveys in the USA in 2016 suggested an estimate of over one million transgender people.(23) Compared to the MSM population, research and evidence on lesbian, bisexual and transgender health lags behind.(24, 25) However, available evidence from different regions of the world has consistently demonstrated poorer health outcomes among LGBT people compared to the general population.(8, 26, 27)

Review of data from publications in scientific literature about transgender health published between January 2008 and December 2014 showed a lack of studies from most countries, with only one publication from sub Saharan Africa.(28) Synthesis of the data showed that transgender populations worldwide face a high burden of adverse health and disease outcomes even though the global burden of disease and health needs among this population remains inadequately quantified.(17) The prevalent health outcomes were classified into six domains: mental health, general health, sexual and reproductive health, substance use, violence and victimization, stigma and discrimination. However general health including non-communicable diseases like diabetes mellitus and cancers is an under studied area with a paucity of information and data with which to make informed decisions.(17) Violence and victimization perpetuated against transgender people was high, with a median prevalence of sexual and physical violence of 44% across the studies in the review. However inability of the primary studies to explore the

linkage between social stressors and health outcomes; between substance use and exposure to multiple social stressors was a limitation to the use of the data in filling the existing research gaps.(17)

A systematic review of thirty one studies assessing CVD risk factors globally within the sexual minority and adult heterosexual population over a period of thirty years (1985 – 2015) identified higher prevalence of modifiable risk factors for chronic diseases: tobacco and illicit drug use among sexual minority populations compared to their heterosexual peers.(29) In addition, lesbian and bisexual women were more likely to consume alcohol and possess a high BMI. The pattern of these behavioural risk factors were observed to change across the lifespan. However, this review did not generate evidence in support of differences in the prevalence of cardiovascular disease.(29)

Analysis of data from the 2013 and 2014 USA National health interview survey completed by 67,150 heterosexual people and 1,664 self-identified LGB individuals showed that compared to their heterosexual peers, LGB individuals were more likely to report moderate/severe psychological distress and health risk factors such as heavy drinking and moderate to heavy smoking. In addition, compared to gay men, lesbian and bisexual women were more likely to report multiple chronic conditions and poor health.(30) With regards to behavioural risk factors, the 2013 to 2015 data of the same population based survey, with 2.4% (5,356,759) identifying as LGB respondents, showed that LGB people were more likely to be current smokers, prevalence of obesity was higher among lesbian and bisexual women. However, binge drinking was commoner among bisexual people. (31) Also in the US, the 2015 and 2016 National Survey of Drug Use and Health corroborates previous findings of elevated odds of alcohol and substance use disorder in bisexual women namely: episodic drinking, marijuana use and illicit drug use. However, it also identified age and gender based vulnerabilities with bisexual women

vulnerable at all ages, gay and lesbians more vulnerable at younger ages (18-25 years) and bisexual men at middle age (35-49 years).(32) The same health disparity was noticed in analysis of a 2013 -2016 survey regarding cancer, which showed that gay men and bisexual women were more likely to be diagnosed with cancer compared to their heterosexual counterparts of the same age. The difference was very prominent in individuals above 65 years of age.(33)

The report of the population based Swedish national public health survey (2008 – 2015) revealed sexual orientation based differences in substance use, with a higher prevalence of high risk alcohol use, cannabis and daily tobacco smoking observed among LGBT individuals compared to heterosexual people. High levels of psychological distress arising from experiences of discrimination, social exclusion and victimization was also reported by the sexual minority population. The association between psychological distress and substance use was observed among gay versus heterosexual men and bisexual versus heterosexual women.(34)

A systematic review assessing prevalence of obesity included studies published over a period of eight years (July 2006 – February 2014) and included 20 population based studies and 17 with non-probability samples. This found that, compared to heterosexual women, lesbian and bisexual women had higher BMIs and specifically a higher proportion with a BMI greater than 30. This difference began in adolescence and was seen across the lifespan. Obesity is a known risk factor for several chronic and metabolic conditions including diabetic mellitus. However, the review did not generate evidence of higher prevalence of physical health conditions associated with high BMI among LB women.(35) The evidence linking high BMI and increased prevalence of a chronic disease among LB women comes from a large cohort study of ninety four thousand lesbian, heterosexual and bisexual women carried out in the USA from 1998 to 2013 to estimate the incidence of type 2 diabetes mellitus. The findings showed that lesbian and

bisexual women were twenty seven times more likely to develop type 2 diabetes than heterosexual women. This difference was greater during younger ages, while body weight index (BMI) was identified as a predisposing factor.(36)

Intergroup comparison within the SM population shows differentials in report of health indicators. For instance, a ten year (2001 – 2010) longitudinal survey of 11,114 adults in the USA showed that gay and bisexual men were more likely to report sexually transmitted infections including HIV, self-reported gonorrhoea and Chlamydia while lesbian and bisexual women were more likely to report risk factors for chronic diseases including binge drinking, smoking and illicit drug use.(5)

A systematic review of eleven studies from 2000 to 2015 carried out in high income countries (USA, Denmark, Belgium, UK, Sweden and Canada) assessing women's gynaecological health conditions found higher rates of chronic pelvic pain and cervical cancer among bisexual women compared to their heterosexual counterparts, while lesbians had a lower rate of uterine cancer compared to heterosexual women.(37)

The 1993-2003 USA national health interview survey (linked to the national death index) revealed a higher risk for breast cancer mortality among LB women.(38) However, in contrast to these findings, a systematic review, published in 2013, of twenty primary studies carried out to investigate incidence, prevalence, risk factors and risk models for breast cancer did not generate evidence suggestive of higher incidence of breast cancer in LB women compared to heterosexual women.(39)

To evaluate chronic diseases namely cardiovascular disease, diabetes, hypertension and respiratory diseases among sexual minority women, a systematic review of incidence, prevalence and mortality studies published between 2010 and 2016 was carried out. The result

shows a higher prevalence of asthma in sexual minority women compared to heterosexual women but not for cardiovascular disease, hypertension, respiratory diseases and diabetes.(40)

Further evidence of health disparity between LB and heterosexual women was shown by a systematic review of PubMed publications from March 2009 to June 2013. The review included eleven population based surveys in the USA assessing nine health outcomes namely: asthma; hypertension; obesity; cardiovascular disease; diabetes; high cholesterol; arthritis; cancer; global ratings of physical health. A higher burden of disease was identified for asthma, obesity, arthritis, global ratings of physical health and cardiovascular disease among LB women compared to their heterosexual peers.(41)

A scoping review of eighteen studies from Latin America and the Caribbean to assess LB women's health revealed higher rates of current tobacco and alcohol use and eating disorders compared to their heterosexual counterparts. The majority of the studies were from Brazil and Mexico providing an insight into the health and health behaviours of LB women from middle/low income countries. The review reported that LB women consider the healthcare system heteronormative and believe that healthcare providers lack the prerequisite knowledge and skills to provide patient centred care to SM women.(42)

The 2018 Stonewall LGBT health in Britain report based on data collected from more than five thousand LGBT individuals in England, Scotland and Wales shows a high prevalence of behavioural risk factors such as alcohol and substance abuse.(43)

2.2.1: Inequality in Health Status - Human Immunodeficiency Virus (HIV) infection among MSM and Transgender people

Research on SM men has mainly focused on three sexual health outcomes: sexual risk behaviour, HIV and other sexually transmitted infections (STIs). Where data is available, it has consistently shown higher prevalence among MSM and transgender women. A systematic review of quantitative studies on MSM related health published in 2010 showed that 38.0% were about sexual risk behaviours, 20.8% were on STIs and 34.8% on HIV/AIDS; only 6.4% of the studies assessed other health related problems.(44)

A systematic review and meta-analysis estimating the prevalence of HIV from 88 studies carried out in the USA among transgender people between 2006 – 2017 showed disparities in HIV burden between the subgroups. A laboratory based diagnosis of 9.2% was obtained for the transgender population overall; transgender women had a disproportional burden of 14.1% compared to a prevalence of 3.2% among transgender men. (45)

Over the past decade, significant improvement has been made in the global effort at slowing the pace of the HIV epidemic. A high proportion of people living with the virus are on life-saving antiretroviral drugs and achieving good health.(46, 47) Subsequently, the incidence and prevalence of HIV infection and HIV-related mortality has dropped within the general population.(48) However, gay, bisexual men, other men who have sex with men, sex workers and transgender women carry a disproportionate burden.(49-51) Discrimination in healthcare settings has created barriers to accessing HIV prevention services, HIV and STI testing services, enrolment and retention in treatment, and care and support programs for LGBT people infected with HIV.(52, 53) Despite the overall progress recorded against the pandemic, the resultant

inadequate access to healthcare is a threat to achieving an AIDS-free generation and ending AIDS by 2030.(52, 54, 55)

There is a dearth of data on HIV infection among LGBT people in many countries. HIV /AIDS infection among lesbians in the UK and several other countries is not subject to surveillance. In regions where surveillance data exist, higher prevalence and incidence of HIV were recorded among MSM in 2014 compared to any other population group.(52, 56-60) Apart from female sex workers and people who inject drugs, MSM have been identified as one of the key populations affected by the HIV epidemic.(52) In the United Kingdom(58) and Nigeria(60), a high prevalence of HIV was recorded among MSM compared to the general population.

As a result of exclusion from the workplace, many transgender women get involved in commercial sex work, often in conditions that put them at risk of acquiring HIV and other STIs. A study in the USA found HIV prevalence of 49% among transgender women, which has been linked to discrimination; alcohol and substance use.(17, 61) However, non-infectious sexual and reproductive health concerns, including cancers, among gender minority people remains understudied.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) 2017 report showed that key populations account for almost half of all new HIV infections even though they represent a small proportion of the world population.(62) Globally, an increasing incidence of HIV infection within a slowing HIV pandemic has been observed among MSM who are twenty eight times more likely compared to heterosexual males to acquire the infection.(62) In the UK, the recorded number of new cases increased from 1440 per year to 3250 over a fourteen year period from 1999 to 2013.(63, 64) Twelve percent of new HIV infections in west and central Africa occurred in gay men.(62)

The main barriers to ending HIV infection are stigma and discrimination, violence, marginalization, laws and policies as well as poverty and inequality.(63, 65-67) Multiple forms of stigma and discrimination, including structural barriers within the health system against LGBT individuals, occurs on a global scale.(66, 68) This results in limited engagement by MSM in sexual health education and limited uptake of HIV services, inhibiting coverage of services, early diagnosis, and long term retention in care, effective and sustained intervention.(62)

Among the LGBT population, coverage rates of effective interventions, even when available, is extremely low especially in places where a supportive social and political environment is lacking.(62) In Nigeria, there is insufficient data on key population program coverage and outcomes.(62) Religious, political and cultural opposition to equality for LGBT people in Africa has increased in recent years with health related consequences.(69) Individuals with the double burden of HIV and LGBT identity are underserved and lack access to the minimum package of essential services.(66) Structural interventions to address stigma and discrimination within healthcare settings could turn healthcare facilities into safe spaces for LGBT people living with HIV.

2.2.2: Inequality in Health Status - Mental Health of LGBT People

Mental health is determined by an interplay between a host of factors which include social, economic, psychological, biological and environmental factors.(70) People who experience mental health problems are also at risk of developing other diseases because they are less likely to deploy health promoting and preventive measures or to seek treatment for emerging health issues.(70) As a socially marginalised group, sexual and gender minority population are exposed to multiple social stressors which has been described as one of the factors undermining the physical and mental health of the population.(71)

A multistate population based data analysis of 518,986 individuals in the USA revealed a difference in the mental health of transgender and non-binary adults compared to the general population with the former more likely to complain of frequent mental distress.(72) The estimated lifetime prevalence of suicidal ideation and attempted suicide was 56.4% and 16.1% respectively in a cross sectional sample of 1309 transgender men and women in China.(73).

Half of the participants in the 2018 'LGBT health in Britain' report experienced depression in the previous year; within the same time frame, an estimated 46% of transgender people and 31% of LGB people had suicidal ideation.(43) This prevalence was obtained within the context of psychological stressors such as experiences of unequal treatment while accessing healthcare, witnessing discriminatory remarks from service providers on the basis of sexual/gender identity and 14% avoiding healthcare services out of fear.(43)

A systematic review of twelve population based surveys to assess common mental health disorders among the LGB adults in comparison to heterosexual people in the UK(74) corroborates previous findings that the LGB adults experiences a higher disease burden, it also highlights that vulnerability varies across the lifespan. Younger (young adults) and older (middle age) LGB adults are more vulnerable to this mental health problems. The review used secondary data of 94,818 participants 2.8% of whom identified as LGB adults.(74)

An integrative review of twenty six published quantitative and qualitative articles until April 2015 shows increased lifetime prevalence of non-suicidal self-injury among sexual and gender minority populations, as well as increased vulnerability to risk factors.(75)

A systematic review of thirty quantitative studies carried out in 2014 to assess lifetime prevalence of suicide related behaviour among sexual minorities in the USA, Canada, Europe, Australia and New Zealand gave an estimate of 11% in population based samples of sexual

minorities compared to 4% among heterosexual people; this estimate rose to 20% for LGB community venue based samples.(76) However, intergroup variation has been observed in the prevalence of mental health related disorders among SM populations. A systematic review reported that poor mental health was commoner among bisexual women compared to gay men and lesbians.(29)

A ten year longitudinal study of adults in the USA showed that SM populations had elevated risks of developing mental health problems compared to their heterosexual peers.(5) This finding is corroborated by a population based study that compared the mental health of 1903 German SM men with that of 958 men from a population based sample. A higher prevalence of mental health problems was found among the SM men associated with occurrence of minority stress that gay and bisexual men experience.(77)

In assessing mental health outcomes among transgender and gender non-conforming populations, a systematic review of studies from January 1997 to March 2017 presented consistent evidence of elevated depressive symptoms, anxiety, general distress, substance use disorder and suicidality within the context of a host of social stressors including discrimination, bias and stigma.(78) Social support and community connectedness were however identified as beneficial coping strategies for mental wellness.(78)

The national prevalence of mental health problems in most African countries is largely unknown. However, in a small sample of 81 self-identified gay men and 81 heterosexual male students in a University in south-western Nigeria, the prevalence of depression was 16% and 4.9% respectively.(79)

People who are victims of human rights violations suffer from physical injury, psychological trauma, emotional distress and social stigma.(80, 81) People with mental health problems and

their families are subject to discrimination and stigmatization in most African countries and some other parts of the world.(70, 82) This makes the issue of social exclusion and poor mental health a vicious circle perpetuating health inequality. Increased acts of violence including rape/forced sex targeting LGBT people, most especially lesbian women, have been reported in Southern African countries(83, 84) and other African countries with homophobic laws.(85) This creates anxiety and fear, it also generates safety concerns and can cause panic attacks. The social stigma attached to rape victims in African culture compounds the distress of victims.(86)

In 2011, data from the majority of the UN member nations revealed that thirteen percent of the global burden of diseases was associated with neuropsychiatric disorders.(87) The 2013-2020 mental health action plan(82) lays emphasis on improving access to quality mental health related services for families affected by homophobic laws and sexual minority groups exposed to such environments. However, it recognises the challenges posed by the inadequate number in the mental health workforce and the unequal distribution within and between countries.(87) Reports from high income countries show that this group of healthcare professionals, when available, were frequently not knowledgeable about LGBT mental health related issues and were therefore not able to provide a culturally competent service.(88) In some cases clients were prevented from mentioning matters relating to their gender identity or sexual orientation during sessions with the mental health care professional.(88) The psychological trauma resulting from clinical encounters can tip the mental health status of LGBT individuals negatively and can also lead to alcohol and substance abuse.(89-91) Promulgation of antidiscrimination laws and protection of human rights has therefore been proposed by the WHO as one of the ways by which governments can promote and protect the health of their LGBT citizens.(70)

2.3 Social Environment – Equality and Inclusiveness of LGBT People

2.3.1 Social exclusion of LGBT individuals in the twenty first century

The legal and political climate impacts on the rights of LGBT people and the attitude and practices of the general population. Therefore, the degree of exclusion experienced by LGBT people varies among nations and communities at different points in time. In countries where discrimination is severe, a very harsh, hostile and sometimes violent social environment develops.(65, 92, 93) The physical violence is sometimes extended to organizations providing health related services to LGBT people.(94, 95) This can result in denial of resources and opportunities for LGBT people.(96) Over a period of time, stress, economic deprivation, poor quality of life, increased rate of suicide and suicidal ideation will increase among the oppressed group.(97)

On the other hand, an inclusive culture is developed by communities when the members recognise, respect and promote individual differences. This establishes a society where people are treated equally while paying attention to their specific health needs.(98) In the absence of segregation and discrimination, individuals can work towards achieving their full potential and optimum health.

While LGBT rights are recognised in some countries and attempts are made to ensure inclusiveness for all, in some countries measures have been put in place to increase the dimension of exclusion and enforce it.(99, 100) To secure an enabling social environment, recognition of LGBT rights was preceded by gay rights activism in most countries.(101, 102) In England for example, the timeline of LGBT history based on records showed that as far back as 1300AD LGBT people were persecuted.(103) In spite of criminalizing laws, by the late nineteenth century and early twentieth century there was a flurry of public activities including

publications (books and newspapers), release of films and television programs. Pride parades and establishment of LGBT organizations aimed at sensitising people on issues pertaining to LGBT identity.(103) Over the decades, the non-violent struggle by sexual and gender minority populations for recognition in the UK intensified and the efforts were successful. The gains included the decriminalization of same-sex sexual behaviour in 1967, and a sexual offences amendment act in the year 2000 which brought about equality in the age of consent for homosexual and heterosexual sexual acts in Great Britain.(103)

Gay activism in twenty-first century UK has brought about more rapid and enabling policies and laws including the employment equality regulation of 2003, the civil partnership act and gender recognition act of 2004, all these laws created an enabling social environment for LGBT people.(104) In 2007, the Minister for Women and Equalities was created.(104) Legislation, policies and an equality strategy were put in place to protect the rights of minority groups, examples of which include the same sex couple marriage act of 2013 and the equality act of 2014.(104) Attempts to correct the wrongs of the past were put in place by providing citizens with an opportunity to apply for deleting past criminal records of conviction for homosexual behaviour [Turin's Law in the 2017 policing and crime act]. (105)

To fully understand the stance taken by Nigeria and some other African countries with regards to inclusiveness of sexual minority people, it is necessary to explore the historical context. The confusion created in the minds of Africans by past events is currently shaping policies, religious beliefs and preventing the inclusion of LGBT people. This is having a negative effect on their health and contributing to the observed health inequalities.(106)

2.3.2 Historical background of homosexuality

Some African leaders including the presidents of Zimbabwe, Zambia and Uganda have been cited to declare that homosexuality is a Western import and that it is un-African.(107-109) The use of the word homosexuality in the African cultural context here applies to any form of same sex behaviour. It does not take into cognisance the gender identity and or sexual orientation of the parties involved. It is therefore important to provide a brief historical background on same sex behaviour from Africa and some other parts of the world.

Historical evidence supports the fact that same sex sexual relationships have existed for millennia, and have been reported more commonly among males than females. As far back as the era of the ancient Greek and the early Roman civilizations, descriptions exist of males who dressed as women (colloquially described as cross dressing), had effeminate behaviour and engaged in sexual activity with other men.(110) In the Athenian setting, same sex sexual relationships among males were socially acceptable if the passive partner was a younger person. Such relationships were regarded as an important aspect of the social life of the young because it was considered to help them to acquire the prerequisite knowledge and experience to transform into an adult Athenian citizen.(110)

Early documentation of historical facts about Africa are usually derived from diaries, letters and writings of the colonialists who went on expedition to African countries.(111) This limits the amount of information available as well as knowledge about behaviours and practices of the precolonial African. The colonialist writers of African history have been accused of racial prejudice and the issues documented and individual interpretations of observed events are believed to be inaccurate and out of context.(111) This is not unexpected, considering the cultural differences, language and communication barriers. The influence of religion, social

class, upbringing and moral status of the observers and writers comes across in some of the writings.(111) Acknowledging this, the United Nations Educational Scientific and Cultural Organization commissioned a group of African experts to construct the general history of Africa in 1964.(111) Some of the details in this chapter are from African writers who re-wrote the general history of Africa. They therefore have an African perspective, which might not be in consonance with the perception of people from other cultures and must therefore be interpreted in the African context at that period in its history.

Historical descriptions of powerful and respected people including warriors and leaders of traditional African religion who engaged in same sex relationships are available. In north central Africa, the Azande warriors were notable for the practice of age-defined homosexuality which was institutionalized.(112) The warrior was the dominant/active sexual partner and the much younger partner the receptive/passive partner. Lesbianism, however, was frowned upon and women who were accused of same sex sexual behaviour were punished.(112)

Traditional religious belief among some African kinship is that direct transfer of spiritual power, knowledge and skills can only be accomplished during copulation between the apprentice and the master. This ancient practice was shrouded in secrecy. It was revealed in contemporary times by traditional healers (female master trainers) in South Africa when they narrated their experiences of living with and having same sex sexual behaviour with their masters/trainers who were also considered to be their ancestral wives.(113) The same practice was reported among people who live in the mountainous regions of Northern Morocco in the early twentieth century.(113)

Same sex marriages among men existed side by side with heterosexual marriages. This was described among several tribes in the horn of Africa. Among the Korongo tribe in Sudan an

effeminate man was allowed to marry a man with the exchange of bride price.(114) This did not preclude the man from also marrying women and instances have been described where a man was married to both a man and a woman at the same time. People were allowed to assume alternate gender expression and identity openly by cross dressing and performing the role of the alternate gender they identified with. This was commoner among the men than women.(114)

Survival and wealth of kinship in traditional Africa, where the primary occupation is subsistence farming is related to the size of the family. Males and females were therefore expected to get married and produce children. Up until the 14th century when Islam gained a stronghold among the Hausas in Northern Nigeria, cross dressing and male homosexuality were reported as an established part of the culture among the Bori cult who were the ruling tribe.(11) Among this cult however the societal expectation was that the adult men should get married to a woman and have children irrespective of their homosexual practices.(11)

Males who engaged in same sex sexual behaviour performed sexual roles based on the binary gender of male /female and followed the male dominance and female passive role. Some of the males cross dressed and expressed the alternative gender identity while some did not.(114) The African construct of male and masculinity resulted in effeminate men not being accorded the respect normally shown to men because they did not fulfil the societal gender role of male dominance. However they were not killed, harmed or excluded from communal life.(114)

Among several East African tribes including the Kuria, Gusii, Nandi, and the Kukiyu, marriage between two females was a recognised traditional practice.(114) In certain instances, same sex relationships and marriage between females was considered useful/beneficial by filling some gaps that heterosexual relationships could not fill with regards to strengthening kinship ties. Same sex female marriage, especially among the patrilineal tribes, appeared to be geared

towards providing an alternative, but not the preferred method for ensuring that lineage and kinship is maintained. The marriage was not on the basis of love, individual preference or the sexual satisfaction they hoped to derive from it. This route was taken if the prospective female husband was unable to fulfil her primary responsibility of bearing children in a heterosexual relationship. Among the Zulus in South Africa and the Ibos in Southeast Nigeria, traditional custom allowed a female to marry another female legally through the payment of bride price in the form of cattle or farm land.(112, 114, 115) All the children of the wife in this type of marriage however belonged to the female husband's lineage. (114, 115) No articles confirm that the female husband had sexual relationships with the wife/wives as the case may be. Rather in some instances the wives were impregnated by a male in the lineage of the female husband, a man chosen and approved by her or chosen by the wife.

Among some African tribes, people who cross dressed were believed to be spiritually powerful. Among the Yoruba ethnic group in Nigeria, the high-priest for a male deity (Sango) who was usually a male wore the apparel of a female, plaited his hair in an elaborate manner and was referred to as the wife of Sango.(116) Initiation into the deity priesthood was considered a marriage ceremony between the high priest and the deity. This allowed the transfer of spiritual authority and power from the deity to human being.(116) This implied that gender diversity was also allowed or acknowledged among the deities, who were considered powerful and on a higher level compared to human beings.

Recognising that this not an exhaustive review of the literature on the history of same sex behaviour in Africa it is impossible to conclusively say what might have happened in some tribes. However, given the historical background above, it is important to note that none of the reviewed literature on precolonial Nigeria revealed any tribe where people, who engaged in

same sex sexual relationships were killed, imprisoned, socially segregated or excluded from communal life.

Colonization led to the partitioning of the continent. Africa came under the influence of various cultures including the Portuguese, British, French, Arabs and the Dutch based on who controlled the country. The West African coast was divided between the British and the French. Nigeria was colonised by the British.(117)

To have a clear understanding of what happened in Nigeria, it is necessary to review the British law with regards to homosexuality. In 1533, the Buggery Act of Parliament came into effect after the English Protestant Reformation during the reign of King Henry VIII.(118) Same sex relationships were still referred to as sodomy and the punishment of the death sentence, which was instituted under the ecclesiastical law and enforced for centuries, was retained until 1861 when it was replaced with life imprisonment.(119) In eighteenth century England homosexuals were actively persecuted by the police who carried out raids on meeting venues. Historical records of arrest as well as the subsequent trials exist. The men were tried for committing sodomy, fined or sent to prison and in very rare cases hanged.(120) This was the social environment of the British who came to colonize Nigeria. They brought new legal structures, religion, laws, values and belief systems. This made administration of the provinces easy but at the same time ensured that the native beliefs, norms and existing cultural values became diluted and were considered inferior to those of the masters.

With the outright disapproval, dismay, condemnation and horror exhibited by colonists towards public displays of any form of same sex sexual relationship by the natives, the practice gradually went into hiding.(112) In the presence of a law prescribing life imprisonment for such acts it went further underground.

According to some Christians, homosexuality is against God's will. LGBT people are perceived as sinners or people possessed by demons. The soul of perpetrators of sodomy (regarded as unnatural acts) are supposed to 'burn in hell fire'.(108) The establishment of Christian schools which taught the new religion created a new generation of African people who strived to be like their masters and forsake the ways of the ancestors.

2.3.3 Decriminalization of homosexuality

Same sex sexual behaviour for men has been decriminalised in England and Wales since 1967, Scotland 1981, Northern Ireland 1982, Germany 1968 and New Zealand in 1986.(121) Also, a number of countries have made same-sex marriage (or partnerships) legal, including, most recently, Ireland in May 2015 with a referendum, and the United States in June 2015 with a Supreme Court ruling. As at 2017, twenty four US states recognise same sex marriage while another twenty eight recognise same sex partnerships.(122) Most of the countries that decriminalized same sex sexual behaviour did so in the late twentieth century/early twenty first century.(123) This would not have been possible without the development of gay activism which started in 1969 with the Stonewall uprising in New York.(124) Since then several human rights organizations, United Nation organizations, heads of states and notable people within societies and non-governmental organizations have campaigned for the recognition of the fundamental human rights of LGBT people.(96) Societal perception of what same sex sexual behaviour signifies has therefore undergone a radical change. However, most African countries including Nigeria have actively resisted the leading of the more liberal developed countries, claiming that homosexuality is a western phenomenon. Rather, more stringent laws prescribing jail sentences, beatings, or even death for LGBT people have been enacted, thereby creating homophobic and unsafe environments for this population.(125-127)

2.3.4: Health of LGBT people in Nigeria – Exploring the Intersectionality of Culture, Religion and Laws

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The write up is reproduced in this chapter with some minor changes to clarify points and avoid repetition of sentences/paragraphs in the thesis.

Discrimination and criminalising laws are barriers which have excluded LGBT people from being recognised as equal citizens within their own countries.(106) Social exclusion places individuals in a disadvantaged position among their peers, within families and communities, thereby preventing them from participating in activities that will lead to development, progress and empowerment. It also leads to inability to access resources and opportunities in life. Socially excluded people are thereby segregated to the fringe of society and become invisible to the public and healthcare system.(128)

In contemporary Nigeria, gay is a popular derogatory word commonly used as a noun to refer to men who engage in same sex sexual behaviour (i.e. "gays"). Lesbians are not recognised by any word, but come under the umbrella term 'homosexual'. People who assume alternative gender identity and expression are also commonly referred to as gay/homosexual, in the northern part of the country, male cross-dressers are referred to as "yan dandu" in the local dialect. Being identified as a gay man or woman/homosexual can result in arrest, imprisonment and physical violence.(92, 129) The physical violence is sometimes extended to organizations providing health related services to LGBT people.(95)

People who are gay, lesbian, or bisexual have generally lived secret lives. However, in 2006, the first media report emerged of a gay reverend who was conducting regular Sunday services at his church in Lagos. This generated criticism and condemnation from the public. The church members were physically attacked, ejected from the premises and the reverend had to escape from the country.(130) After this incident, many homophobic acts were reported by members of the LGB community.(131)

Nigeria does not recognise same sex marriages or civil union for same sex couples. Shortly after he assumed office in July 2015, the current president of Nigeria, President Mohammadu Buhari publicly reiterated his support for the Same Sex Marriage Prohibition Law passed by his predecessor President Goodluck Jonathan in January 2014.(129) The law was first proposed as the Same Sex Marriage Prohibition Act by the Executive Council in 2006. Three years later, during a public discussion of the act on the floor of the National Assembly, gay activists came out to speak against the proposed law, which generated negative public response and increased public support for the law.(132, 133) The law states that individuals convicted for contracting same sex marriage are liable to fourteen years imprisonment. People who register, operate or participate in gay clubs/societies/organizations and their supporters are liable to ten years imprisonment. The type, extent and scope of support prohibited by the law is not specified (medical, financial, research based, educational etc); it is therefore subject to individual interpretation. The president thereby effectively put an end to efforts to get the law reversed during his tenure. By criminalising family members and friends this law robs LGBT people of social support and introduces multiple layers of discrimination and oppression against LGBT people. The penalty for offenders is also tougher than that prescribed by the criminal code. This law fuelled a renewed wave of discrimination, rejection, violence, and persecution targeted at

LGB people, forcing them to conceal their sexual orientation to avoid victimization and arrest.(99, 134)

Nigeria has been ranked as one of the most intolerant African countries towards LGBT people because of this law, which violates the African Charter on Human and Peoples' Rights adopted by the African heads of states and African governments in June 1981 in Nairobi Kenya.(135-137) Attributing the political climate solely to this law alone will however be misleading, because Nigeria's criminal code remains unchanged since the colonial era with regards to imprisonment for homosexual behaviour.(138) The 1999 constitution developed for the federal republic of Nigeria post-independence retained various sections of the criminal and penal code inherited from the British.(138, 139) Over the years, some sections have been amended, but not chapter 21 section 214, which stipulates that any person having carnal knowledge of another person against the order of nature or allows a male person to have carnal knowledge of him or her against the order of nature is liable to imprisonment for seven years.(138) The focus is on gay men/MSM, lesbian relationships are not recognised. The Sharia law, which became operational in twelve states in northern Nigeria in the year 2000 recognizes same-sex sexual relationships among females and males.(140, 141) The penalty for conviction could be whipping/imprisonment or death penalty as the maximum punishment for male offenders. All the laws are silent on trans people. LGBT individuals in post-colonial Nigeria occupy a unique position. They live in a country that has multiple laws criminalizing same sex activity hence are victims of multi-layered political exclusion.

Apart from the variety of laws, one of the barriers to the inclusiveness of LGBT people in Africa and Nigeria is religion, which is a central part of most African culture.(142) The way of life of the average African person is mostly influenced by the teachings of one of the two dominant religions; Islam and Christianity. Both religions in Africa very strongly oppose same-sex sexual

behaviour and the leaders have been quick to lend support for anti-same sex laws.(143) Religious organizations and members of their congregations in Nigeria have used the law in preaching.(108, 144) The Sharia law operated by some states in the northern part of Nigeria criminalises homosexual practice with severe sentences. LGBT people living in Nigeria therefore occupy a unique position of being criminalised by three distinct laws, all the religions and the culture of the three main ethnic groups in the country.

The Same Sex Marriage Prohibition Act was applauded by religious leaders in the country. The Nigerian government in power at the time of the introduction of the law benefitted from the positive publicity generated within the country with improved rating of their performance by the populace.(136, 145) This is however contrary to reactions from the international community. The law was widely condemned by Western leaders. The condemnation was subsequently followed by the threat of economic sanctions including withdrawal of funding for donor funded programs against the country if the law is implemented.(146) This sequence of events made Nigerians suspicious that there was a hidden Western agenda. This was a tactical error that resulted in greater acceptance of the law by Nigerians as shown by the opinion polls.

A subsequent opinion poll however showed a decline in general support for the law from 92% in 2010 when the same sex marriage prohibition act was proposed to 87% in 2015 a year after the same sex marriage prohibition law was passed.(147, 148) This result has been disputed by people who claimed the study was biased because the researchers were from LGBT organizations. In the absence of scientific studies, people have had to rely on information from key interviews and opinion polls to make decisions about LGBT related issues in Nigeria. By 2018, four years since the law was passed, reports of persecution, arrest or violence against LGBT people have dwindled but the law remains in place. A state of uneasy calm exists where

LGBT people are constantly on edge and critical issues pertaining to the health of LGBT people in the mainstream health sector remains largely unaddressed.

The unfavourable social environment created by the current synergy between the laws, religion and culture will inevitably negatively impact on the physical health and social well-being of LGBT people living in Nigeria leading to health disparity.(97) The immediate effect of the law on use of HIV related services by HIV positive MSM, which included avoidance of healthcare and loss to follow up of HIV positive MSM, has since been published.(149) There is a dearth of evidence on the health problems of LGBT people in Nigeria, almost all the available studies were conducted among the MSM community and they revolve around HIV and sexually transmitted infection. This has hampered generation of evidence-based recommendations for tackling the social environment of LGBT people in Nigeria.

For young LGBT people the challenge is compounded by their dependent status on parental support for feeding, accommodation and schooling. To continue to enjoy this support, they are expected to conform strictly to the societal norms with regards to sexual orientation and gender identity. Having to lead a double life places a lot of stress on these young people, which if not properly managed may lead to anxiety and depression.(150) Nigeria is lagging behind in provision of sexual and reproductive health (SRH) services to young people.(151) Culture, religion and country-level policies influence provision and use of SRH services. The 2013 National Demographic and Health Survey (NDHS) shows that the majority of adults in Nigeria oppose teaching adolescents about condoms to prevent HIV infection.(152) In a national survey of one thousand sexually active adolescents (15-19 years) less than half (45%) reported having ever used a male condom.(153) Testing for HIV was a rare occurrence while self- reported symptoms of STI was high.(152) This has had an adverse effect on the health of the estimated

seventy million young people but is expected to have an even bigger impact on LGBT and questioning young people.

Globally, the health of LGBT people has been identified as an area demanding urgent research and intervention.(27) Research has shown a relationship between state level policies and the well-being of citizens(96) therefore, LGBT health disparities resulting from lack of access and poor use of health services documented in literature is expected.(27) Achieving good health and wellbeing (Sustainable Development Goal 3) will remain elusive as long as LGBT people are not part of the mainstream in societies. The slogan "leaving no-one behind" emphasizes the United Nations commitment to ensuring that all people from all segments of society are entitled to good health.(154) However there is a recognition that tackling the social environment needs local input and locally designed interventions based on data from local research.(154)

Research on the health of LGBT people in Nigeria has focused primarily on HIV and other sexually transmitted infections.(155-159) Even though a high burden of disease exists, as established by available data, providing health services to sexual minority groups remains a huge challenge.(123, 160) In a country where HIV-positive people experience stigma as a result of their HIV status it becomes a double jeopardy for an individual to be an HIV positive LGBT person.

2.4 Provision of medical care for the LGBT population

Equitable, safe and people-centred healthcare is required for good health and wellbeing of the world population.(161) Therefore, improving patient experience of healthcare is essential to achieving health for all.(161) Core expectations from a clinical encounter are respect, professionalism and engagement with the health service.(162, 163) Patient satisfaction is a desired outcome of care which can be used as a measure of the quality of care.(162) Apart from

the technical component of care, management of the interpersonal process is important, as this influences the whole process of service delivery.(164) Effective communication during the interpersonal exchange provides vital information to the health care professional (165) to inform diagnosis of the health condition, while the professional gives information about the health issues and preferred management to the patient for both to agree on a treatment plan. The technical performance of the health care professional therefore relies on ability to manage the interpersonal process.(164) Negative interpersonal interactions are sometimes perceived as rejection.(164, 166) Prejudice hampers effective professionals' communication culminating in embarrassment and reluctance to discuss LGBT health-related issues.(167) Anticipation of prejudiced behaviours creates fear and reluctance of LGBT individuals to disclose their identity. Failure of communication has been linked to reduced illness-related education, and inadequate uptake of preventive services and interventions to prevent STIs.(168)

Social stratification confers a diverse range of social categories on individuals. These categories may not be mutually exclusive. The intersection of social identities can create a unique form of oppression for people who possess multiple marginalized minority identities that are subject to stigma and discrimination. This can result in differences in health status within population groups that are sometimes considered homogenous. Healthcare experiences of some privileged members of such a group may not be a true reflection of the entire group's experiences. An intersectional framework,(169, 170) allows exploration of an individual's social categories as mutually constituted interactive entities occurring within a dynamic process. This recognizes that at varying social hierarchies, across time and geographic location, a particular social category can embody privileges or disadvantages. This represents the uniqueness of individual lived experiences within a specific social context including healthcare.(171, 172)

Individual perception of problems, diseases, experiences of healthcare utilization and potential solutions is influenced by interactions with others within the social environment. These interactions occur at multiple sites and are shaped by all aspects of an individual's categories. This encompasses multiple layers of social privilege and disadvantage operating within a fluid and dynamic social context created and maintained by relations with multiple levels of power. The power is wielded by families, organizations, and government institutions, including healthcare facilities using laws, policies, sociocultural norms and religion.(172)

2.4.1: Provision of healthcare to LGBT people

Healthcare professionals develop implicit bias in reaction to societal and institutional conditions.(173) Patients that are perceived to be different from the norm are likely to experience discrimination.(174) Apart from the LGBT population, discriminatory behaviours have been reported from healthcare professionals based on patient's socioeconomic status.(175)

In recognising and addressing the multiple layers of privilege and disadvantage inherent in institutional cultures (including healthcare) that are considered normal practices and which may appear neutral, an intersectional analysis will unveil the interaction and exposure that occurs when oppression and advantage as well as privilege and advantage intersects. This is useful in explaining differentials in intra-group health outcomes among marginalised population groups and a useful guide in designing health-related intervention programs. Furthermore, it draws attention to the complexity of the interplay that occurs in the multi-factorial disease causative process across the various stages of the life course.

Anticipated and enacted stigma within health facilities are known structural factors limiting use of health services by LGBT individuals.(176, 177) The assumption of heterosexuality and use of heterosexist language hinders disclosure of LGBT identity, effectively silencing the LGBT

population.(178, 179) Healthcare professionals have been described as wary, uncomfortable and hostile during clinical encounters.(180) Lack of knowledge about LGBT health issues has been reported as an obstacle to healthcare access.(178, 179, 181) This combination of lack of knowledge and bias synergistically lowers quality of care. Therefore, recommendations have been made to incorporate LGBT health topics into the curricula of health care students with the objective of improving healthcare professionals' cultural and clinical competency and ultimately reducing LGBT health disparities.(182)

The WHO's agenda for zero discrimination in healthcare recommends that consumers of healthcare should be treated with respect and dignity, as healthcare consumers are more likely to avoid oppressive healthcare experiences.(165, 183) Competent human resources are the driving force of the health system. Patient-professional interactions take place within a sociocultural context. The culture of the healthcare professional and the culture of the patient are important considerations in achieving cultural competency of the health workforce.(184) It has been reported that in low-income countries, social norms influence the attitude of HCP and patients(185) which ultimately reflect on the performance of the health system. The level of comfort experienced by an HCP when interacting with an LGB or T patient impacts on the patient-provider relationship and subsequently the quality of care provided. A patient's perception of a non-judgemental relationship is an essential component of culturally competent care,(166, 167) which can only be provided by respectful and compassionate professionals. Empathetic and friendly health care professionals are therefore essential in achieving satisfaction with care for all population groups.

Public health facilities are not available in sufficient quantity in Nigeria. With a low physician client ratio, the facilities in Sub Saharan Africa (SSA) are overburdened.(186) Apart from the

geographic and economic barriers, systemic barriers such as absence of non-discrimination policies also reduces access to services for LGBT people. Compared to their heterosexual counterparts, LGBT individuals have been observed to have less access to quality medical care in some developed countries.(187, 188) In sub-Saharan Africa, LGBT-specific health services are few, of those there are the majority are clinics/facilities specifically for MSM, creating inequalities between groups within the LGBT umbrella.(189) Community health centres friendly to gay and bisexual man and run by non-governmental organizations provide HIV counselling and testing as well as other specialised sexually transmitted infection related services in some urban cities in Nigeria.(190)

Increasing opportunities for contact between known LGBT individuals and healthcare professionals is a potential strategy for ameliorating implicit bias. However, in Nigeria, the criminalising law and the threat of a jail sentence for the LGBT individual and the healthcare professional limits such opportunities.(63) Therefore, clinical contact with LGBT people may not necessarily reduce prejudice and stigma from healthcare students and professionals.

Individuals exposed to healthcare professional insensitivity develop anxiety and fear, and are unable to trust or confide some personal details during clinical encounters.(67, 191) Fear of anticipated and enacted stigma can result in avoidance of health facilities, delay in accessing services, and non-disclosure of potentially risky behaviour. Poor health can therefore become an outcome of structural barriers within health facilities.(63) The high level of internalised stigma reported among gay and bisexual men in Nigeria is partly a consequence of sustained exposure to enacted and anticipated stigma.(67, 156) The combination of poor health seeking behaviour and reduced access to health services generates an explanation for the health disparities reported for the LGBT population.(189)

The depathologizing of homosexuality following its removal in from the American Psychiatrist Association diagnostic and statistical manual removed the label of a disease.(192) However, some clinicians who are proponents of Psychoanalytic theory still retain the belief that homosexual identity should not have been declassified.(193) The HIV pandemic refocused attention on MSM. In an attempt to ensure equity in access to HIV-related treatment and care services, this population group acquired the label of a population at high risk of HIV infection. This had unintended negative consequences because of the stigma associated with HIV infection. Medically, MSM individuals transitioned from a population group with a 'non-communicable disease' to a population infected with an incurable communicable disease. It was therefore merely a change of nomenclature and not depathologizing per se within the medical community. Globally these disease conditions are highly stigmatised irrespective of culture, age, race, ethnicity or socioeconomic status.(194) With respect to training of healthcare professionals and students, MSM remain linked with disease conditions and are mentioned in relation to or in conjunction with disease states for decades. For example, the high prevalence of mental health disorders and HIV/AIDS among MSM .(195)

2.4.2: Experiences of Healthcare by LGBT People

The health-related needs and challenges experienced by individuals within the LGBT community differs based on gender identity and sexual orientation, with transgender people having a higher burden of challenges in accessing quality care.(8) The sub-populations are commonly grouped together because of the social marginalization they experience. Discrimination in healthcare settings against LGBT people, which occur frequently due to heteronormativity, can manifest as outright denial of care, disrespect and abuse, low-quality care, negative attitude and behaviour of professionals, and lack of confidentiality and privacy in service provision.(196)

2.4.3: Experiences of Healthcare by LGBT People in Developed Countries

The studies used in this section are all from Europe and America. All the countries have anti-discriminatory laws protecting the rights of LGBT people and healthcare systems that have funding mechanisms such as health insurance. These are factors which promote access and continuity of care with a designated healthcare professional and services, which may have an indirect bearing on the perception of clients. However, other environmental influences which result in social exclusion such as culture, economic and social factors cannot be disregarded. Available literature from the UK shows that individual and facility level factors such as poor knowledge of LGBT terminologies/health related issues, communication barriers, lack of appropriate protocols, referrals, confidentiality of patient information, continuity of care, LGBT-friendly resources and training for healthcare professionals contribute to the experiences of clinical encounters.(3, 24, 197, 198)

Comparative analysis of healthcare experiences in England using reports of the 2009/2010 English General Practice Patient Survey involving over two million respondents [27,497 of whom identified as LGB] showed that sexual minorities were 1.5 times more likely to report negative experiences while accessing primary care. This revolved mostly around communication with general practitioners and nurses. (199)

Hungary is one of the countries in Eastern Europe considered to be advanced in terms of the laws protecting the rights of LGBT people, having legalised same-sex activity since 1962. However, the result of the first national study on discrimination against LGBT people showed that the restriction placed on donation of blood and other body organs for this population was a cause of great frustration and the basis for report of negative healthcare experiences. It created

great mistrust from healthcare professionals who treated LGBT clients with suspicion, distrust and sometimes disrespect.(200)

In Bosnia and Herzegovina, where sexual orientation and gender identity has been decriminalised, but same sex sexual relationships remains socially unacceptable, MSM report fear, distrust and uncertainty when accessing services.(201) Contact with healthcare professionals is restricted to when it is absolutely necessary. MSM avoid family physicians so as to avoid breach of confidentiality, while some LGBT individuals report professionals advising them to look for more accepting GP practices or to go for spiritual cure.(201) In comparison to non-government organisation (NGO) clinics, individuals opined that GPs were insufficiently educated and possess negative attitudes.(201)

In Turkey, LGBT individuals recruited through NGO provided services, reported experiencing problems while trying to access services at a healthcare centre.(202) They recounted instances where professionals exhibited heteronormative assumptions, they were denied treatment or given poor quality care, subjected to verbal and non-verbal acts of discrimination, violation and disrespect. Some respondents reported that it was difficult to have a positive communication with the professional. Participants considered the physicians ignorant and inexperienced in dealing with LGBT health issues.(203)

Exploring healthcare experiences of four hundred and thirty six LGBT clients using primary care services within rural communities of southern states in the USA revealed that transmen and transwomen were more likely to report instances of abuse and disrespect from healthcare professionals compared to the cisgender counterparts.(204) The acts of discrimination were mainly harsh abusive words, being blamed for the health problem and refusal of care. Overall close to a third reported negative experiences, with participants expressing the opinion that

healthcare professionals require more education on LGBT health issues.(204) An online study among four hundred and thirty eight LGBT people living in New Jersey, USA reported that a vast majority did not use healthcare services on a regular basis.(205) Negative experiences such as previous refusal of care by the healthcare professionals created fear of anticipated discrimination among this population. This, in addition to lack of knowledgeable and competent professionals, were some of the deterrents to seeking care in health facilities.(205) Research from Wisconsin in the United States that compared healthcare experiences of sexual minority women and heterosexual women during visits to general practitioners (GP) showed that overall patient satisfaction with the healthcare professional was higher among heterosexual women. The four hundred and twenty individuals who participated in the survey were recruited from attendees at an LGBT pride festival hence the findings cannot be generalised.(206) In comparison, in the state of Hawaii, a study carried out within the LGBT community to assess experiences of discrimination and violence reported that refusal of treatment and low quality of treatment was repeatedly mentioned by LGBT individuals as acts of discrimination encountered within the healthcare system, resulting in delay in accessing care.(207)

2.4.4: Experiences of Healthcare by LGBT People in Sub Saharan Africa

There is a paucity of published research on experiences of healthcare by LGBT people in sub-Saharan Africa. Results of studies carried out in Southern African countries are presented in this section. The studies encountered during literature searches were mainly about MSM, only one recruited lesbian women and none recruited trans people.

The findings from a prospective cohort study of 1480 MSM accessing HIV related services at a community centre in two urban cities in Nigeria showed that men who received HIV counselling and testing services at public health facilities did not reveal their sexual orientation

to the healthcare professionals, mainly because of fear of anticipated stigma. Participants reported previous experience and witnessing of discrimination in health facilities against LGBT individuals hence the need to protect their identity in order to be safe. The men were of the opinion that the HIV related services received were adequate.(67)

In describing their experiences of stigma and discrimination while accessing HIV related services from public health facilities in South Africa, the study participants reported instances of verbal abuse including use of offensive slang by healthcare professionals.(208) Other instances of human rights abuse included breach of confidentiality, blame of culpability, unethical, inappropriate and insensitive care.(208) Other factors that indicated exclusion for this population included the inappropriateness of the routine risk assessment forms used in collecting information from them, and lack of HIV related commodities (such as clean injecting equipment for people who inject drugs). Internalized stigma was believed to be a consequence of the enacted stigma which led to delay in seeking further care even for people on antiretroviral therapy (ART). (208)

For the LGBT population in Zimbabwe, in a qualitative study, experiences of healthcare were sometimes described by participants as humiliating.(209) In some instances the healthcare professional blamed them for their health problems, some people complained that they were ignored by professionals, confidentiality was breached, there were non-verbal acts of discrimination, and professionals used excessive precautionary measures during physical examination. The inability to produce a sexual partner prevented individuals from following up on treatment. For individuals who had accessed services in sexual and reproductive health (SRH) clinics specifically catering to the LGBT population, the professionals in public health

facilities were considered inexperienced and lacked adequate LGBT related knowledge and competencies.(209)

A survey of MSM in Tanzania in 2016 identified that accessing healthcare was problematic. Participants described feeling anxiety in health facilities, worrying about the health professional's response if they had to disclose their sexual orientation because of the large number of clients and the lack of privacy. Instances of denial of care, verbal abuse, being ignored by professionals and having unaddressed healthcare needs were also reported. Inequality exists in the extent of human rights abuse based on sexual positioning with men who received penetration in sexual intercourse (known as bottoms) experiencing more frequent and severe forms of abuse.(210)

2.5: Approach

At this point in time in Nigerian history, gay activism appears not to be very successful at changing the laws criminalising LGBT individuals. Therefore, in trying to propose an agenda for inclusiveness of LGBT people into contemporary Nigeria society, I am of the opinion that, a health-based approach (right to health) rather than a legislative measure to repeal the law may be beneficial in tackling the existing health disparity. At the same time this shifts the conversation from religion and culture to promoting, maintaining and restoring the health and wellbeing of all people from all segments of the society.

Within the African context, the need to continually assert and confirm African identity as a 'free nation' implies that for African leaders to be popular they have to promote traditional "African values" which is a mixture of the dictates of the major religions and the prevailing culture. In this instance there is legal, religious and cultural prejudice for same-sex sexuality.(116, 211) Attempts by the global north to ease this situation in Nigeria was considered high handed and

created suspicion of a western agenda to impose imported ideas and a return to colonial rule. The same attitude applies to research sponsored and conducted by external agents on LGBT related issues, hence the need for local researchers and communities of LGBT people to collaborate and generate the evidence required for advocacy locally.(212) A case study involving teaching of a same-sex sexuality class by faculty from a Canadian University in a Nigerian university in Nigeria created an obstacle for students with strong nationalist sentiments. In an attempt to establish that the faculty had an anti-imperialist stance, the students asked him several questions including his stand on slavery and the crimes of the colonialists. At the end of the intervention, the students were unequivocal in their opinion that research on same-sex sexuality related issues in Nigeria should not be carried out by foreigners.(212)

As a Nigerian living in Nigeria, I am well placed to gather information about the experiences of people who identify as LGBT in Nigeria and to explore the views of the health care professionals treating them. This should overcome the critique of work undertaken by agencies from outside Africa previously cited.

I belong to the Yoruba ethnic group, one of the three main ethnic groups in Nigeria. Within my culture, procreation is the main reason for marriage and any union that fails to produce offspring is considered joyless and lifeless.(116) Procreation is therefore tied to heterosexuality and considered the norm. Non-heterosexual humans are considered to be disruptive to the peace and stability of the society, for the high priests and deities this rule is however does not apply.(116) However as a public health physician with years of experience as the project manager and clinician in an antiretroviral (ART) clinic of a local NGO involved in healthcare service provision to the marginalised population, I have seen the damaging effects of lack of access to quality health care on people. My perspective therefore includes a belief in fundamental human

rights, especially the right to health for all, which differs from that of the present government and possibly many citizens of Nigeria.

After joining academia, in 2014, the following discussion about clerking and taking a sexual history took place with a final year medical student.

Student: I clerked a young man in the surgical outpatient clinic, we are suspecting anal cancer

Myself: Did you take a sexual history including gender of sexual partners and anal sexual intercourse?

Student: "Is the patient possessed by the devil? Why would he do a thing like that (referring to anal sex)? "

I realised from this encounter, the need to assess the curriculum for areas of improvement with regards to LGBT-related health and sexual health components. The absence of credible publications as evidence to guide this process was a hindrance since anecdotal evidence is insufficient justification for a review. Nevertheless, I wrote a concept paper for this PhD based on this and several other related incidents that took place since then. The intention is to generate evidence for informed decisions on teaching and learning about LGBT health in Nigeria, which will ultimately impact on healthcare service provision and use.

2.6: Summary

In this chapter I have discussed the terminologies relating to LGBT health, described the inequalities in health status of LGBT individuals and discussed the social environment in which LGBT people live and how this impacts on their health. Finally, I have described the literature on the provision of medical care for the LGBT population. HIV/AIDS related health disparity within the LGBT population has been explored and documented,(6, 213, 214) while current

evidence suggests that healthcare workers are generally homophobic and transphobic.(215-219) In section 2.2, I described the difficulty in obtaining the true estimates of health disparity experienced by LGBT people and the sparse evidence available on the excessive burden of disease within the LGBT population using one communicable disease and a chronic non-communicable disease. Section 2.3 describes the social environment created for LGBT individuals by non-LGBT people using laws, religion and culture. It provides a journey through history until the present time, showing that at different points in time, countries and nations transit from varying degrees of homophobia to varying degrees of acceptance of LGBT people. This section also provides a detailed review of the Nigerian situation with the enactment of a criminalising law. Furthermore in section 2.4 I presented the evidence on access to, and experience of healthcare of LGBT people drawing on evidence obtained from the global north and SSA. This highlighted that there were insufficient facilities and the lack of research into the experiences of healthcare encounters by LGBT individuals globally. It also identified a lack of data on the provision of services or the outcomes of care for this group.

Gaps exist with regards to local knowledge about experiences of healthcare encounters by LGBT individuals in Nigeria. Existing literature covers studies carried out among MSM. To date, lesbians and trans people have been excluded in research. Furthermore, the local context for HCP behaviour leading to inadequate access to quality healthcare for LGBT individuals in Nigeria is yet to be investigated and explained.

The overall aim of the thesis was to explore the barriers and facilitators that affect access to healthcare services for LGBT people in Nigeria. This was addressed through four studies.

These are my research questions:

1. What is the effect of the anti-same sex marriage prohibition law on:

a. Attitudes towards MSM

b. Attitudes towards provision of healthcare services to MSM

For this study, I used a cross sectional design. The study was carried out among undergraduate students in Lagos. It involved medical and non-medical students. Using highly literate individuals was considered important for two reasons: A self-administered questionnaire can be used which ensures that individuals can fill in their responses privately without answering questions from a stranger (research assistant); secondly a literate person will have a better understanding of the law compared to a non-literate. Answering this research question was considered important at that point in Nigeria history because credible estimation of the hostility levelled against MSM in 2014 based on scientific evidence was lacking even though media reports suggested that the whole populace was homophobic. At the same time, it was expected to provide the background for why a HCP living and working in Nigeria might offer poor quality care to an MSM patient.

2. What are the experiences of LGBT individuals living in two cosmopolitan cities in Nigeria while accessing healthcare services?

A qualitative study design was used to explore the experiences, while two cosmopolitan cities were used to ensure adequate access to the various subgroups under the LGBT umbrella. As of 2019, there is no published qualitative research from Nigeria that reports the experiences of LGBT people in relation to their health and their experiences of accessing healthcare. This study aimed to bridge that gap.

3. Are educational curricula and training on LGBT related health issues for healthcare students and professionals effective?

Having identified both homophobia and transphobia in the general population and in healthcare students, there is a need to consider interventions that address this in health care students and HCPs. However, there was no published systematic review that synthesised the evidence as to how effective such training is, or the features of effective training programmes. Therefore, a systematic review of educational interventions was carried out.

4. What is the current state of LGBT related knowledge, attitude and inclusive training in a College of Medicine in Nigeria

The literature review identified a paucity of evidence about what is taught to health care students and professionals or the acceptability to students and faculty of such training, or confidence/willingness of faculty to deliver such training. This would be needed to develop a programme that is acceptable within the Nigeria context.

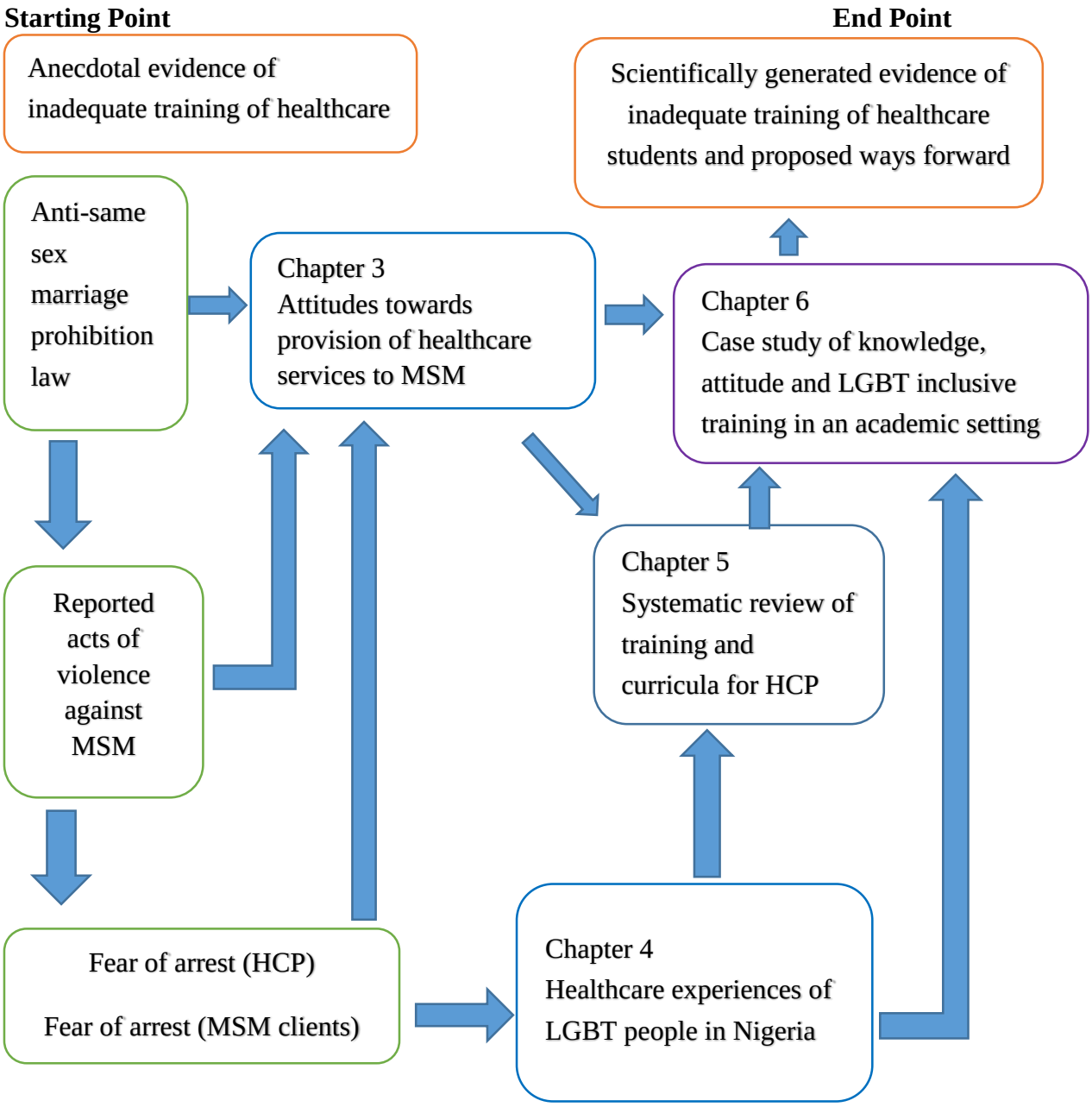
A mixed method study design was used to generate descriptive information of what currently takes place, the attitudes and meanings that people attribute to their practices, and providing a context for recommendations for change within the socio-cultural and religious context of Nigeria in 2018.

This multi-methods thesis examines access to quality healthcare services for LGBT people exploring training of healthcare students and professionals within the context of homophobia/transphobia resulting from multiple criminalising laws, religion and African culture. This is the first Nigerian study employing an intersectional lens to explore health related events among LGBT people from the perspectives of both health care providers and LGBT people. This work was conducted in collaboration with UK academics, ensuring external critical scrutiny of emerging ideas, but allowing the African voice to remain as the central driver in the research. The findings will therefore provide scientific evidence that can be used to advocate

for policy change and informed decision making in keeping with universally accepted human rights.

The next chapter (chapter three) reports the findings of a survey undertaken among students in two universities in Lagos State. Locally available evidence suggests that the majority of people who identify as MSM individuals are young people. The study therefore collected information from a similar age group about attitudes towards gay and bisexual men. This provides new evidence which contributes to available knowledge on the social environment in which they live, as well as attitudes towards healthcare provision for this group. This study was undertaken in late 2014, shortly after the same-Sex marriage Prohibition Law was passed in Nigeria.

Figure 2.1: Flowchart of PhD Thesis



HCP: health care professional; LGBT: Lesbian, Gay, Bisexual and Transgender; MSM: men who have sex with men;

Chapter Three: The Criminalising Law and Healthcare Services for Men who Have Sex with Men in Nigeria

This publication has been edited, specifically the introduction section has been reduced. The paragraphs/sentences that were removed were added to the appropriate sections in the background chapter to enhance flow and avoid repetition.

3.1 Introduction

This article reports findings from a study that was carried out to assess the attitudes of university undergraduates in Lagos state toward provision of healthcare services for MSM. This study population was chosen, because previous studies carried out among MSM in Nigeria showed that the majority of self-reported MSM were younger than 30 years of age.(156, 220, 221) It is hoped that the findings from this research will contribute to filling the gap in knowledge available on this topic. This article focuses particularly on our analysis of the differences between medical and nonmedical students. The medical students were considered particularly important to the study because of their role in the delivery of care, and we hypothesized that medical students might have an ethical framework that encompasses a belief in fairness and equality among individuals. These are features of justice, which is one of the four principles of biomedical ethics put forward by Beauchamp and Childress.(222)

3.2 Methods

The only two existing universities in Lagos state were the settings used for the study. The University of Lagos (UNILAG), one of the Federal Universities in Nigeria, has 12 faculties and 85 departments offering a total of 73 undergraduate programs. In the 2013/2014 academic

session, more than 22,000 students registered for undergraduate programs.(223) Lagos State University (LASU), a state-owned institution with 11 faculties, had more than 12,000 students in various undergraduate programs during the same academic session.(224) Both universities have medical colleges.

A cross-sectional descriptive study was carried out among undergraduates of the UNILAG and LASU to assess attitudes toward provision of healthcare services for MSM. The minimum sample size of 400 per faculty was determined by using the formula(225) for descriptive studies $p=pq/d^2$ (power of 80% and p being the proportion of students likely to have a negative attitude towards MSM from previous studies. In the absence of local data, 50% was used, which ensures maximum variability. $Q = 1 – p$ at 95% confidence interval).

Faculties were assigned a sequential number, and then five faculties were randomly selected from each institution by using random number selection. The faculties of Engineering, Science, Education, Business Administration, and Social Sciences were from UNILAG and the faculties of Law, College of Medicine, Arts, Management Sciences, and School of Communication were picked from LASU. In the selected faculties, students were approached in the lecture auditoriums while waiting for lectures to start, immediately after the lectures, and between lecture-free periods to complete questionnaires. Four hundred questionnaires were distributed to students who were willing to participate in each faculty (4000 total).

The questionnaire was developed based on statements made during interviews by politicians, religious leaders and other Nigerians about gay/homosexual people following the passage of the same-sex marriage prohibition law. Some of the statements were published in the print media (local newspapers and magazines) while some were aired on the local electronic media (television and radio). This was done to verify the acceptability of such statements by young

educated Nigerians and gauge the severity of homophobia among this group. The media representation in 2014 was suggestive that the entire country was highly homophobic. This opinion was supported by an opinion poll reporting that 92% of the populace supported the law.(148) The questionnaire was pretested among out of school youths in a local government area to improve reliability.

Information was collected from each student by using anonymous self-report questionnaires that were distributed and collected back by four trained research assistants. The students filled the questionnaires independently. The class representatives who were fellow students and who were responsible for coordinating effective running of the class assisted in informing the students in the selected faculties about the research.

The questionnaire deployed was divided into three distinct sections. Section A collected information on socio-demographic characteristics of the respondents. Section B contained 14 questions geared toward assessing general knowledge regarding the same-sex marriage prohibition law. Section C consisted of a 14-item scale assessing the extent of homophobic attitudes toward MSM and a four-item scale related to provision of healthcare services for MSM. Responses were scored by using a three-point Likert scale from 1 to 3; higher scores on the scale represent a higher level of tolerance for LGBT people. The maximum score for attitudes toward MSM was 42, and the maximum score for attitudes toward provision of healthcare services for MSM was 12.

Ethical approval was obtained from the Health, Research, and Ethics Committee of Lagos University Teaching Hospital (LUTH) —ADM/DCST/HREC/APP/1887 [Appendix 1]. Permission was also obtained from the Dean of Student Affairs, UNILAG and LASU. Participation in the study was voluntary, and written informed consent was obtained from each

student after explaining the nature and purpose of the study. Respondents were assured of the confidentiality of the information provided.

3.2.1: Data analysis

Four thousand questionnaires were distributed (400 per faculty), of which 3537 were completed (88.4% response rate). Data entry and analysis was carried out by using Epi info version 3.5.3 (Centers for Disease Control and Prevention, Atlanta, GA) and IBM SPSS version 20 computer software (Released 2011, IBM SPSS Statistics for Windows, Version 20.0; IBM Corp., Armonk, NY). Frequency tables were generated for categorical variables. Knowledge was reported as the proportion of responders who knew various components of the law. Bivariate analysis was carried out to explore associations between variables by using chi-square, with statistical significance set at $P<0.05$. Medical and nonmedical students' attitudes toward MSM and provision of healthcare services for the population group were compared.

3.3: Results

3.3.1: Characteristics of the sample

Table 3.1 displays the characteristics of the samples from the two universities and compares medical students with other students at the State University. Overall, slightly more than half of the respondents in both universities were men (51.6%). A slightly higher proportion of the undergraduates in the State University were women (49%) compared to those in the Federal University (47.0%). More than three quarters of the respondents were young undergraduates who were less than 25 years of age (79.1%). The State University, however, had a significantly lower proportion of respondents in the 15–24 year age bracket compared to the Federal University (77.7% vs. 84.0%, $P=0.000$). Both universities essentially comprised unmarried young people. The State University had a higher population of Muslims compared to the Federal

University (39.6% vs. 22.3%, *P*<0.001). Only the State University had students in the sixth year of study representing about 1.4% of the total respondents. The study took place in the south-western part of Nigeria, home to the Yoruba ethnic group. It is, therefore, not surprising that more than three quarters of the respondents are from this group. However, because of the quota system used in federal institutions, the Federal University had a significantly higher proportion of other tribes (27.3% vs. 17.4%, *P*<0.001).

Medical students were only surveyed at the State University and represented 20% of responders from that institution. A statistically significant proportion of the medical students in this institution were men (57.7% vs. 49.3%, *P*=0.004) compared to respondents from other faculties. compared to their medical counterparts, a higher proportion of the nonmedical students were less than 25 years of age (81.6% vs. 61.4%). However, a statistically significant higher proportion of the medical students were from the Yoruba ethnic group (92.5% vs. 80.2%, *P*<0.001) and in their sixth year of study (9.9% vs. 0.8%, *P*<0.001). In terms of religion and marital status, there was no statistically significant difference between the medical and nonmedical students in the State University (Table 3.1).

Table 3.1: Socio-demographic Characteristics of Undergraduates

Variable	LASU Frequency (%)	UNILAG Frequency (%)	LASU Medical students Frequency (%)	LASU Non-Medical students Frequency (%)
Sex, n=3517			n=1916	
Female	940(49.1)	752(47.0)	157(42.3)	783(50.7)
Male	976(50.9)	849(53.0)	762(57.7)	762(49.3)
Total	1916	1601	371	1545
	X^2=2.41, p=2.414		X^2=8.37, p=0.004	
Age (years), n=3492				
15-24	1479(77.7)	1318(84.0)	1250(81.6)	229(61.4)
≥25	425(22.3)	251(16.0)	281(18.4)	144(38.6)
Total	1904	1569	373	1531
	X^2=27.38, p<0.001		X^2=70.95, p<0.001	
Religion, n=3492				
Christian	1152(60.4)	1233(77.7)	214(57.7)	938(61.1)
Islam	754(39.6)	353(22.3)	157(42.3)	597(38.9)
Total	1906	1586	371	1535
	X^2=119.69, p<0.001		X^2=1.47, p=0.226	
Ethnicity, n=3397				
Yoruba	1571(82.6)	1086(72.7)	335(92.5)	1236(80.2)
Others	332(17.4)	408(27.3)	27(7.5)	305(19.8)
Total	1903	1494	362	1541
	X^2=47.78, p<0.001		X^2=30.96, p<0.001	
Marital status, n=3501				
Never Married	1763(92.6)	1499(93.9)	347(94.0)	1416(92.2)
Married/Separated/ Divorced	141(7.4)	98(6.1)	22(6.0)	119(7.8)
Total	1904	1597	369	1535
	X^2=2.20, p=0.138		X^2=1.39, p=0.238	
Year of Study, n=3519				
100 (first year)	361(18.8)	264(16.5)	14(3.8)	347(22.5)
200 (second year)	295(15.4)	493(30.8)	58(15.5)	237(15.4)
300 (third year)	543(28.3)	518(32.3)	49(13.1)	494(32.0)
400 (fourth year)	479(25.0)	247(15.4)	641(7.2)	415(26.9)
500 (fifth year)	188(9.8)	81(5.1)	151(40.5)	37(2.4)
600 (sixth year)	50(2.6)	0(0.0)	37(9.9)	13(0.8)
Total	1916	1603	373	1543
	X^2=205.88, p<0.001		X^2=644.01, p<0.001	

LASU: state university. UNILAG: federal university

3.3.2: Knowledge of the same-sex marriage prohibition law

All of the respondents were aware of the same-sex marriage prohibition law. With regards to specific components of the law, about 90% knew that civil unions cannot be solemnized in a church, mosque, or any other place of worship. The same proportion of respondents knew the legal ramifications for individuals. These individuals face prison sentences of 14 or more years. A lower proportion (57.9%) knew that anybody who supports the registration, operation, and sustenance of LGBT organizations in Nigeria, if convicted, faces the penalty of incarceration for 10 or more years. However, 48.0% had the misconception that the law states that any healthcare service provider found guilty of providing health-related services or medical information to LGBT individuals or communities will go to prison for 10 or more years.

3.3.3: Attitudes toward healthcare provision for MSM

The majority of the undergraduate students (56.8%) were of the opinion that doctors and other health workers should be compelled to report homosexuals who come in for treatment. Overall, 45.7% felt that doctors and other health workers should be compelled to give priority to other groups before homosexuals if resources (drugs) are insufficient. Outright denial of healthcare services was supported by 37.6%, whereas denial of HIV prevention services was supported by 32.5%. Compared to undergraduates from other faculties, a significantly lower proportion of the medical students exhibited intolerance toward provision of healthcare services for MSM. Less than a quarter (23.7%) agreed with the statement that healthcare providers should not provide services to MSM, and 18.2% of medical students agreed that MSM should not have access to HIV prevention services compared to 38.7% and 34.1% of students from other faculties, respectively ($P<0.001$; Table 2). A lower proportion of the medical students supported the statement that doctors and other healthcare workers should be compelled to give priority to

other groups before MSM (29.4% of medical vs. 47.2% of students from other faculties), and a statistically significant difference was observed between the two groups of students (P<0.001). The medical students were less homophobic in attitude. The homophobic statement with the highest support across both medical and nonmedical students was that doctors and healthcare workers should be compelled to report MSM who come to access treatment (48.1% of medical vs. 57.4% of students from other faculties, P<0.001; Table 3.2).

Table 3.2: Attitudes of Medical and Nonmedical Students towards Provision of Healthcare Services to Men who have sex with Men

Variable	Agree Frequency (%)	Indifferent Frequency (%)	Disagree Frequency (%)	Total
MSM should not have access to HIV prevention services (n=3311)				
Other Faculties	1007(34.1)	631 (21.4)	1315 (44.5)	2953
Medical students	65 (18.2)	58 (16.2)	235 (65.6)	358
	X^2=59.57, P<0.001			
Doctors and other health workers should be compelled to give priority to other groups before MSM are considered if resources are insufficient (n=3304)				
Other Faculties	1390(47.2)	675 (22.9)	882 (29.9)	2947
Medical students	105(29.4)	100 (28.0)	152 (42.6)	357
	X^2=42.00, P<0.001			
Doctors and other health workers should be compelled to report MSM who come in for treatment (n=3309)				
Other Faculties	1695(57.4)	616 (20.9)	641 (21.7)	2952
Medical students	172(48.2)	67 (18.8)	118 (33.1)	355
	X^2=23.35, P<0.001			
Health care service providers should not provide services to MSM (n=3303)				
Other Faculties	1140(38.7)	554 (18.8)	1254 (42.5)	2948
Medical students	84 (23.7)	61 (17.2)	210 (59.1)	355
	X^2=39.44, P<0.001			
Overall Mean Attitude Score	7.73$\pm$2.55			
Mean Attitude Score Medical Undergraduates	8.78$\pm$2.42			
Mean Attitude Score Non-Medical Undergraduates	7.61$\pm$2.54			
t=174.642, p=0.000				

3.3.4: Attitudes toward MSM

The majority of the undergraduates agreed with the statements that homosexual acts are unnatural and should be prevented (79.7%) and that public show of love between people of the same sex is unpleasant (77.9%). They also held the opinion that homosexuality is alien to Nigerian culture and so should not be accepted (84.6%) and that MSM should go for ‘‘correctional’’ therapy (69.8%; Table 3). With regards to violence and social exclusion of MSM, less than a third agreed that MSM should be sexually (23.4%), psychologically (29.3%), or physically abused (24.0%). A quarter of the students were in support of rejection by friends and family members on the basis of sexual orientation (25.9%). Exclusion of MSM from the workplace was supported by a high proportion of respondents (40.9%). A low proportion (19.9%) were in support of MSM being denied accommodation and, therefore, being excluded from communities (Table 3). Support for human rights violation of MSM was indicated by a substantial proportion of the students; 27.7% of the respondents supported the statement that gays should either be sacked or not employed all. About a third of the students agreed that MSM should be expelled from schools based on sexual orientation (33.9%) and they should be treated with less priority than their heterosexual counterparts (32.4%). Another 18.5% supported the ejection of MSM from their residence (Table 3.3).

Table 3.3: Attitudes towards Men who have sex with Men

Variable	Agree Frequency (%)	Indifferent Frequency (%)	Disagree Frequency (%)
Homophobia			
Homosexuality is alien to our culture and so should not be accepted (n=3308)	2801 (84.6)	321 (9.8)	186 (5.6)
MSM should submit themselves for correctional therapy or rehabilitation (n=3306)	2306 (69.8)	524 (15.8)	476 (14.4)
Homosexual acts are unnatural and should be prevented (n=3311)	2639 (79.7)	417 (12.6)	255 (7.7)
A public show of love between persons of the same sex is unpleasant (n=3311)	2580 (77.9)	433 (13.1)	298 (9.0)

Abuse			
MSM should be raped to cure them of their homosexuality (n=3305)	776 (23.4)	567 (17.2)	1962 (59.4)
MSM should be abused verbally (n=3311)	970 (29.3)	581 (17.5)	1760 (53.2)
MSM should be abused physically (n=3311)	794 (24.0)	527 (15.9)	1990 (60.1)
Social exclusion			
MSM should be rejected by family and friends (n=3311)	856 (25.9)	657 (19.8)	1798 (54.3)
MSM should be denied accommodation (n=3295)	656 (19.9)	746 (22.6)	1893 (57.5)
Workplaces should not employ MSM (n=3291)	1348 (40.9)	714 (21.7)	1229 (37.4)
Human Right			
MSM should be sacked from work places (n=3301)	916 (27.7)	782 (23.7)	1603 (48.6)
MSM should be expelled from school (n=3307)	1121 (33.9)	593 (17.9)	1593 (48.2)
MSM should be ejected from their houses (n=3302)	609 (18.5)	691 (20.9)	2002 (60.6)
MSM should be treated with less priority than heterosexuals (n=3296)	1068 (32.4)	815 (24.7)	1413 (42.9)

3.4: Discussion

Acts of abuse, including murder, rape, physical attacks, torture, and arbitrary detention, against MSM sexual minorities have been recorded in Nigeria.(130, 226) This escalated after the passage of the same-sex marriage prohibition law. Media reports in Nigeria, including live interviews and written stories in newspapers, have portrayed a very homophobic environment not only for same-sex marriage but also for any form of same-sex relationship. Non acceptance of sexual minorities has been reported by previous studies from Sub-Saharan Africa,(227) in this instance, about a quarter of the undergraduates supported acts of abuse and human rights violation of MSM. In view of this, the environment can be unsafe for members of a sexual minority group. Evidence and media reports exists linking homophobia to hate crimes in the United States and Nigeria respectively.(228)

Reports from human rights organizations and organizations providing HIV-related services to MSM from various states in Nigeria described increased physical violence and other acts of

aggression (such as being stripped naked), including mob actions against LGBT individuals, by communities who claim they were ‘‘cleaning’’ their neighbourhood of ‘‘gays’’ after the passage of the same-sex marriage prohibition law.(85) The chairman of a Sharia Islamic court in one of the northern states admitted in a media interview that 11 men were arrested on account of being members of a gay organization. Some states in the northern part of Nigeria enforce the Sharia Islamic law.(140) In statements released from leaders of LGBT organizations, men suspected to be gay or belonging to gay organizations recounted acts of torture and human rights violation.(229)

Our survey shows that not all members of this (educated and young) population hold homophobic beliefs. The negative attitude of a large proportion of the medical students in this study toward provision of healthcare services to MSM could lead to unethical practices, for example, reporting patients who come to access healthcare to law enforcement agents, which is a breach of doctor–patient confidentiality. This could, however, be due to the misconception by this group of the educated populace that the law stipulates a jail sentence for healthcare workers who provide such services. Our study showed that a slightly higher proportion of medical students support provision of services to the LGBT population. However, a significant minority agreed that the services should not be provided to MSM (23.7%) and 18.2% agreed that MSM should not have access to HIV prevention services. If these attitudes translate to healthcare service provision, it is unlikely that Nigeria will be able to achieve the UNAIDS target of 90-90-90 [90% of people who have HIV knowing their status, 90% of those with HIV receiving sustained antiretroviral therapy, and 90% receiving anti-retroviral therapy having viral suppression].(230) Within the prevailing homophobic culture of Nigeria, it is difficult to identify a solution to address the homophobic attitudes of some medical students. In some countries, applicants to medicine are assessed on a number of criteria, including ethics.(231)

Medical students are taught ethics, but the effectiveness in changing attitudes has not been established.(232)

The implication of promulgating laws against sexual minorities on access and use of healthcare services has been identified and raised in the past. Doctors and organizations wrote an open letter to the president of Uganda, highlighting the implications of a bill that proposed life imprisonment for gays in 2014. One of the issues raised is that the bill conflicts with a health worker's basic ethical obligation not to discriminate in the provision of medical services and would create a culture of fear of arrest and imprisonment among service providers.(233, 234) Even in countries that have laws protecting the rights of the LGBT population, namely Britain, the United States, and South Africa, reports of negative experiences in interactions with healthcare providers when accessing healthcare services have been documented.(235-237)

Discrimination and societal stigma, in addition to individual-level behaviours, have resulted in the LGBT population having a disproportionately high burden of some diseases and health-related conditions.(238) In spite of this high burden, the attitude among a high proportion of this study population is that healthcare services should be denied. This will further increase health inequity. Societal stigma enacted at the national, community, school, healthcare, and interpersonal levels, apart from being a predisposing factor to health inequity for LGBT individuals, also acts as a barrier sustaining the poor health status of this marginalized population.(239)

3.4.1: Limitations

Our study has some limitations. Only two universities were used in this study and they were not randomly selected; hence, the findings cannot be generalized to the whole country. In particular, Lagos is less religiously conservative than other parts of the country. Even though the

questionnaire was pretested to improve reliability, the questions in it were not based entirely on previously validated questionnaires alone but also on statements made by people who had been interviewed on this topic in Nigeria. Because of the sensitive nature of the research, respondents were recruited based on willingness to participate. This could have introduced bias into the selection of respondents. Even though the questionnaires were anonymous, they were completed in the presence of their peers, which may have led to some social acceptability bias in response. Though the original aim of the research was to explore attitudes of all students, we undertook a post hoc analysis comparing the attitudes of nonmedical with medical students. Ideally, for this purpose, we would have surveyed medical students in both universities, but we believe that the reported analysis has value, and it enhances the relevance of the study for health policy and planning.

3.4.2: Conclusion

A very high proportion of the undergraduate students had negative attitudes toward MSM and provision of healthcare services to MSM in Nigeria. Even though the findings from this study should be considered preliminary, we provide an insight into the homophobic campus environment in Lagos in 2014. The medical students in this study were slightly less homophobic compared to their nonmedical counterparts, but a significant minority did report negative attitudes, which, if translated into lack of service provision, will result in barriers to healthcare provision and uptake by MSM. The attitudes of the students cannot be explained by social class, because the two public institutions used for this study are government funded and provide access to university education for all socioeconomic classes and ethnic groups within the country. The ambiguity in the same-sex marriage prohibition law with respect to the role of healthcare workers in providing services needs to be clarified urgently to prevent health inequity and worsening of the country's health indicators.

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Chapter Four: The Hidden Costs of Healthcare for LGBT People in Nigeria: An Intersectional Analysis of the Healthcare Experiences.

This chapter, reports the findings of in-depth interviews with LGBT individuals living in Lagos and Abuja Nigeria in 2016. It provides a rich description and new evidence about instances of abuse, rejection and marginalization by healthcare providers working in public and private healthcare facilities towards individuals based on sexual orientation and gender identity.

This particular research was carried out based on the evidence available from the wider literature that detailed reported instances of abuse and violations of human right by health care professionals during client- provider interactions. Secondly, the findings of the cross sectional survey in the previous chapter (chapter three), indicated poor support for the right to healthcare services for LGBT population in Nigeria. Finally, some of the participants in the cross-sectional survey were medical students, hence exploring actual experiences of client-provider interactions of LGBT individuals living within the same social context provided an opportunity to clarify whether some healthcare professionals possess similar attitudes and carry out actions suggestive of such beliefs.

In conducting this research, I leaned on the pragmatic approach to the philosophy of knowledge which is premised on inquiry and addresses the nature of human experience as the centre point of discussions relating to knowledge.(240) Feelings and emotion are the bedrock of beliefs and action. Individual and group actions are processed and subjected to interpretation by others. This interpretation based on individual belief and feelings constitutes our experiences. Therefore, beliefs and action actively and continually interact to generate knowledge. Human experiences are social in nature and shaped by interaction with others. Experience embodies a

social, emotional and contextual component.(240) Experiences have been described as satisfying when they possess a positive effect as well as a sense of fulfilling a need/expectation.

For this research, adopting the pragmatic approach ensured that I engaged in reflexivity while conducting in-depth exploration and interpretation of LGBT client-provider interactions within the social context of multiple criminalising laws, unfriendly culture and religion in a sub Saharan African country. This view point encouraged me to examine the beliefs I had, the actions I took and the outcomes of those actions in light of the historical, cultural and political context of Nigeria in 2016.

4.1: Introduction

Research with socially excluded and / or criminalised population groups as participants/subjects can be challenging. In certain instances, the safety of researchers including healthcare professionals and participants were reported to have been compromised.(241, 242) An unintended consequence of such research can be the increased visibility of a population that had hitherto lived a low-profile lifestyle and the subsequent identification of members for rights based abuses.(243, 244) Upholding the ethical principles of autonomy, justice, beneficence and non-malevolence is paramount in conducting research with human subjects.(191) However with LGBT people living in criminalised settings additional steps are needed to protect study participants and researchers.

In-view of the challenges inherent in identifying and engaging LGBT participants in research in homophobic and transphobic environments, researchers work with organizations providing services for LGBT individuals and known LGBT community organizations.(245) These include NGOs operating at regional, national and or local level. These organizations advocate for the human rights based approach to social development and public health. Collaboration with such

organizations builds legitimacy for the research and the research group and increases participation and retention of the study subjects.(246) Several studies carried out in SSA have used this method.(171, 247)

The respondent driven sampling method(248) is a modified chain-referral sampling technique frequently used for recruitment of hard to reach population groups. Recruitment is based on identification of a first set of interviewees (seeds) who are then tasked with the duty of recruiting a specific number of their peers (first wave of participants) from their social network. This first wave recruits the second wave of participants by giving identification coupons, the process is continued until the required number of participants is obtained. Two methods have been reported in choosing the seeds. In a study carried out in Togo, the seeds chosen were representatives of known MSM social sub-groups.(249) while in similar studies in Rwanda, Kenya and South Africa the leadership/workers of community based LGBT organizations assisted in identifying community members for recruitment purposes, but were not involved as participants.(250-253) In Nigeria, this method has reportedly been used in several studies(191, 241-243). Other methods include the use of on-line dating sites to recruit the initial seeds or all the study participants(254) online LGBT organizations(125) advertised web based anonymous surveys(244, 246, 255).

Two existing theories were used to explore the healthcare experiences of LGBT individuals within the Nigerian context.(256)

4.1.1: Theoretical framework (1) Social Determinants of Health

Exclusion of minority populations can occur in four main interacting aspects namely: political, cultural, social and economic.(257) These four aspects are not mutually exclusive. Social

exclusion occurs at the level of individuals, families, groups/communities or countries. It weakens social bonds and robs people of social support and relationships, which are vital for good health.(257) Political exclusion occurs when there are policies, legislation, and constitutions which lead to unequal power distribution, thereby restricting rights for some people.(258) Politics and political ideology have a huge influence on the promulgating of policies that can minimize health inequalities. Cultural exclusion arises when there is a clash between the norms, ideas, and values of a group and the way of life of some individuals within the group (nonconformity). Economic exclusion arises where there are barriers that prevent equal access to economic goods and services including income, employment, and housing.(258)

4.1.2: Theoretical framework (2): Intersectionality

The use of intersectionality in qualitative research was brought to public attention by Kimberlé Willams Crenshaw, a black American Feminist legal scholar who used the concept to explore the multifaceted expression of oppression experienced by black women in the USA.(259) This focused attention on the need to include all possible interacting elements which reinforce each other rather than consider the issues independently when exploring experiences of oppressed groups. Over the years other researchers have also used the theory to demonstrate that discrimination arising as a result of belief-based oppression does not occur in isolation.(260) Rather, the component identities are inextricably linked, overlap and interact to form a complex system of oppression.

In this chapter, I make the case for developing the theory of intersectionality in the African context and consider gender presentation and gender diversity (rather than gender binaries) and sexual orientation as important dynamics in intersectionality. Unlike the North American

original construct of intersectionality where race played a key role, this factor is much less relevant in sub-Saharan Africa where social class/status is more important.

4.1.3: Purpose of the study

The goal of the chapter is to (a) document the experience of LGBT people, (b) apply intersectionality as a theory in an African context and (c) extend the model of the social determinants of health to inclusion of issues of religion, law, and colonialism. These are previously unexplored and provide a novel perspective. The findings will help fill the gap in knowledge and allow program managers to understand the multi-layer influence of political, cultural, religious and social exclusion on access to health services for LGBT people in Nigeria. It is also hoped that it can be used as an advocacy tool for making health facilities safe spaces for LGBT people in Nigeria.

4.2: Methodology

In this qualitative study, I drew on some of the components of Grounded Theory Methodology (GTM) – such as constant comparative analysis, data saturation and theory development - to guide data collection and analysis.(261) For theory construction, with my supervisors I analyzed the empirical data using an abductive approach whereby in a systematic manner the data were interrogated in dialogue with two existing relevant theories, namely social determinants of health and intersectionality. This enabled exploration of social determinants of health and intersectionality from the structural and political perspective. This study design provided empirical evidence based on real life data collected in the context of the social and legal circumstances of LGBT people, which is used to propose unique recommendations tailored towards the needs, desires and particular circumstances of LGBT people in Nigeria.

Ethical approval was obtained from the Lagos University Teaching Hospital Health and Research Committee (see appendix 2) as well as the University of Birmingham Research Ethics Committee (ERN_16_0373). To protect research participants and researchers, the National Health Research Ethics Committee (NHREC) guidance to ethics committees throughout Nigeria on the Ethical Review of Research within the context of activities that may be unlawful in Nigeria was used. Discussion of ethical issues will be integrated throughout the methodology section as they are crucial.

4.2.1: Access, recruitment and sampling

The study population is LGBT people living in Nigeria. The LGBT community in Nigeria is mostly hidden and hard to reach because of the negative attitude towards LGBT people. I therefore worked with non-governmental organizations (NGOs) known to provide services to LGBT individuals in Lagos and Abuja, the Federal Capital Territory. As a public health physician, I have a track record of advocating for LGBT health, conducting ethical research and publications with the LGBT community in Lagos, Nigeria and is trusted by the leadership of the two collaborating NGOs. Recruitment commenced initially in Lagos, with members of the social networks of two organizations using the snowball method. The organizations work with two groups of people: gay and bisexual men referred to as men who have sex with men (MSM) and lesbians. The research subsequently moved to Abuja because the city has a highly diverse network of LGBT people. To ensure national representation, LGBT people from a variety of ethnic groups who are attendees of two additional NGOs, some of whom migrated from other states to live in Abuja and Lagos were interviewed.

The initial sample was identified through convenience sampling of members of NGOs advocating for the sexual health and rights of LGBT persons, social networks and key

informants, then snowball sampling. This was followed by theoretical sampling based on concurrent data collection, coding and analysis of data which determined subsequent data collected and the next set of interviewees for theory generation. The individual had to be at least 18 years of age. For MSM, inclusion criteria were cisgender men, self-identifying as gay or bisexual. For lesbians, the inclusion criteria were cisgender women, self-identifying and known by key informants as a lesbian. For Trans, the person must self-identify and be known by key informants as a trans person; this is because there is paucity of verifiable information on networks of trans and lesbian NGOs or organizations working with trans people and lesbians. Trans participants could identify in any way in terms of sexual orientation. All the interviewees were Nigerian.

4.2.2: Data collection, management and analysis

Data collection took place from April to December 2016. This involved ongoing collection, coding and constant comparison of data collected. Thirty five face-to-face in-depth interviews took place between one interviewee and myself except in instances where an interpreter was used. Most of the interviews were conducted in English language, while some were conducted in Yoruba and Hausa (local dialect). I am fluent in Yoruba but not Hausa therefore an interpreter chosen by the interviewee was used for all the interviews conducted in that language. A semi-structured interview guide (see appendix 3) with prompts was developed and used for data collection which was analyzed immediately in line with grounded theory. After the thirty five interviews were conducted and analysed, the team concluded that data saturation had been achieved, with respect to the central research question about LGBT health experiences.(262) The interviews took place in a private room at LGBT community centers operated by the NGOs while a few took place in a hotel at a time considered safe and convenient by the interviewees.

All the interviewees agreed to the conversation being recorded on audiotape. The interviews took between 30 to 90 minutes each.

I transcribed the interviews verbatim (MS word) and erased the interviews from the tapes once the transcript had been checked for consistency, to minimize risks to participants. Transcribed data was immediately anonymized, hard copies were stored in a safe and secured locker at the University of Lagos, Nigeria while electronic copy was stored on an encrypted computer at the University of Birmingham UK. During this process, I visited the websites of NGOs advocating for the sexual health and rights of LGBT persons in Nigeria to collect relevant information from documents available on the websites. Information was collected on the socio-demographic characteristics of each interviewee, namely age, ethnic group, religion, level of education and occupation, sexual orientation and gender identity. Identifying information such as name and home address or employers address were not collected.

Results

The characteristics of the 35 participants are shown in table 4.1.

Most of the participants are in the 25 – 30 years age group, had formal education, were Christians and currently unemployed. With regards to residence, close to a third had lived in other states apart from Lagos and Abuja.

Table 4.1: Summary of socio demographic characteristics

Variable	35 participants
Age	
<25 years	11
25 -30years	20
>35years	4
Region (Nigeria is divided into the Northern and Southern region)	
South east	5
South-south	10
South west	11
North	9
Education	
Primary school	2
Diploma	13
Secondary school	8
Higher education	12
Sexual orientation (self-defined)	
Gay	14
Bisexual	8
Lesbian	8
Questioning	2
MSM	1
Heterosexual	2
Gender identity (self-defined)	
Male	13
Female	7
Transwoman	10
Transman	2
Questioning Transwoman	2
Neither male/female	1
Religion	
Christian	23
Muslim	11
Spiritual	1
Residence	
Always lived in Lagos	18
Lived in Lagos and other states	4
Always lived in Abuja	6
Lived in Abuja and other states	7
Employment status	
Student	3
Employed	13
Unemployed	19

I kept a fieldwork diary throughout the period of data collection which was used for reflection. This activity involved writing down my thoughts, opinions and ideas, which helped in generating questions for the interview guide to focus on emerging themes to be explored in more detail thereby enhancing innovation.(263) The information in the field note diary and transcribed audiotapes were used to generate data for the study. On-going discussions with my supervisors supported the reflective process, helped in making decisions about further sampling and analysis, minimized researcher bias, and brought clarity to emerging findings and development of the theory.

Data were analyzed and interpreted in a reflexive manner following an interactive and iterative process to provide meanings to reported life events and experiences.(264) During this stage, I followed the methodological sequence of constant comparison and sorting of data, memo writing and diagramming memos. While analyzing the data, issues raised and identified which were not asked before in the initial interview were incorporated into subsequent interviews and explored at length.(263) The data reported in this chapter is relevant to health and healthcare. The data were coded line by line thereby transforming it into manageable smaller similar groups. Categories were identified and developed by putting related data together, built up and checked continuously to look for relationships and establish links between them. Constantly comparing across events, codes and categories against the theoretical background of social determinants of health and intersectionality was a crucial element of our abductive analysis. This helped to identify the six themes that were generated from the empirical data collected in this study.

4.3: Findings

The concept of the "hidden" speaks about the unseen or invisible aspects of LGBT experiences and explores what it takes for an LGBT person to seek healthcare beyond the normal psychological and emotional effort. It also looks at the damage inflicted on the individual following exposure to oppression from a healthcare provider. This story telling is in the context of postcolonial Africa where homosexuality is often considered un-African, the laws and religion inherited from that era form the basis for promulgating more stringent laws against LGBT people, and discrimination is a method for holding onto what is culturally African. Colonialism and laws therefore play an important role as social determinants of health. This study was able to bring to the fore the hidden fact that there are levels to the degree of disadvantage experienced by subgroups within the LGBT community. The extent of inequality is determined by the intersection of factors beyond the control of affected individuals.

"You feel rejected" and "hear stories" --- experience of, and storytelling about health services within the LGBT community

The participants in this study reported that healthcare providers in Nigeria behave in a manner that can be interpreted as homophobic, biphobic and transphobic which does not conform to the expectations of LGBT people who believe that it is unethical and falls short of the professionalism expected by clients/patients.

> *Sometimes the way they look at you and their body language you feel rejected. Most especially their body language is the most annoying part* (R12 *22 years, from south-south region, Christian, Gay, Student, Questioning Trans woman, lives in Lagos)*

> *Let them know by virtue of the medical ethics they are bound by this discipline to treat people regardless of their sexuality. I am sure in the medical school they were not saying so, when you are treating a straight man this is how you should do it I am sure they don't say that (R35 32 years, from South-west region, Christian, Employed graduate, Bisexual, not male/female, lives in Lagos)*

This perception is reinforced by numerous stories circulating within the LGBT community. Subsequently, people with symptoms that could be linked to same sex sexual behaviour have modified their health seeking behaviour. Friends and social networks play a major role in providing health related information and sign posting individuals to where they can access safe healthcare services.

> *Some will say when they go to the hospital to access healthcare the doctor will start preaching to them. You will just hear stories. The nurses or the receptionist in the hospital talking, looking down on them, openly condemning them, pointing at them, I have heard stories (R3 26 years, from the South-east region, Christian, Gay, Gender??, Employed graduate, lived in Anambra & Lagos)*

> *They will tell their friends and seek advice from them. It is what the friends tell them that they will do. They feel comfortable telling them, they feel their friends have an idea maybe he has been into the game for a very long time. So he can expatiate more on that. They feel they can rely on their person (R12 22 years, from south-south region, Christian, Gay, Student, Questioning Trans woman, always lived in Lagos)*

Theme 1: Synergy of formal and informal social institutions in erecting structural barriers to healthcare

In Nigeria, the dominant culture and religions consider heterosexuality and binary gender as 'normal'. All other expressions are considered abnormal and sinful.

> *Of course there is a difference, they feel these people are not normal due to their religious beliefs, they just feel they don't exist and finding someone that is an LGBT person is alien to them" (R11 21 years from the south-east region, Christian, Gay, Undergraduate, Questioning Trans woman, lived in Lagos)*

> *When I went to the hospital, I now told him that this is who I am I am a gay person. He was like I am sorry but we can't attend to you. It's a private hospital. I now asked him sir please why can't you attend to me I am a human being now. He said what you are saying is abnormal how can a man be having sex with a man. (R9 24 years, from South-east region, Christian, Gay, Apprentice, Male, lived in Lagos)*

By introducing a penalty for LGBT people as well as their "collaborators", the criminalizing law made identification and reporting of LGBT people for persecution and imprisonment a

public responsibility. The law therefore became the catalyst galvanising people to take social and legal action based on existing prejudice. This synergy between culture, religion and the criminalising law manifests as discriminatory acts during clinical encounters. It cuts across health professionals in private and public health facilities as well as various healthcare professional groups.

> *I went to a private hospital when the doctor test me, the doctor say noooooh, I am not the kind of doctor that treats MSM, its either you go or I call police to arrest you. I say will you treat me he said no there is no treatment for me in that hospital (R19 26 years, from South-south region, Christian, Peer educator, Trans woman, lived in Port Harcourt and Abuja)*

> *When I got to seeing the counsellor, I had to tell her I am gay and she started to tell me this is the way I should live, I should try to repent she gave me a pamphlet collected my number and told me she was going to get back to me on church issues she invited me to her church, she gave me books about spirituality and told me to always pray. When I also got to the doctor and he asked me how I came to be like that and I told him I was gay and stuffs he started to tell me he had a friend in secondary school who is gay and his father had to send him overseas and he became a full blown homosexual man I think he said his friend had to go for deliverance and stuffs like that also advised me to do such (R13 25 years, from south-west region, Spiritual, Gay, Unemployed graduate, Man, lived in Lagos)*

> *I now went to the general hospital with my mum, the doctor said she would do HIV test for me I now said that she should wait that the thing is hope it is not because I am gay. She now dropped what she was doing and now focussed on me why why will you be doing such? That I should give her a second I should just excuse her and that she will call me back. I was outside for like close to 3 hours she was just coming and going she was attending to other patients …… she said she didn't have my time (R4 25 years, from South-west region, Christian, Peer educator, Questioning gay/bisexual, Man, lived in Lagos)*

Therefore, during client provider interaction, LGBT individuals are always on the look-out and often quick to pick up subtle signs such as a disapproving look or change in countenance of the provider because it represents an early danger sign. The hidden cost of illness transcends the obvious and extends beyond the physical to the psychological cost of accessing care. Sometimes, the non-financial hidden cost of accessing healthcare services by individuals can

be as mild as anxiety and stress arising out of concern about confidentiality of information given to the healthcare provider and its implication on the social standing of the individual, to unnecessary death.

> *Me too I carry my friend go one private hospital because he is sick, when doctor come I tell am say this person is a gay and HIV positive say doctor wetin I go do now. I begging doctor he say nothing he can do, he no go treat, we look for money carry the person go village and 3 days later he died (R18 28 years, from the Northern region, Muslim, Peer Educator, Trans woman, lives in Abuja)*

Theme 2: Psychological stressors in a challenging social environment, resiliency and mental health

Apart from the healthcare sector, numerous agents exist within the everyday life and social environment of LGBT people in Nigeria that serve as psychological stressors. LGBT people living in Nigeria are constantly under pressure from family and friends to conform to cultural norms. At the same time, the social safety net and social support provided by the family is lacking for openly living/people suspected to be LGBT persons. This inability to share thoughts, feelings and relationship related experiences with family members and friends creates a psychological pressure which can in some instances tip the mental balance negatively.

> *That thing was weighing me down like psychologically I was having the issue everybody here and there attacking me. They are not concerned about my happiness all they are concerned about is marriage, marriage, marriage to a man. I have tried to kill myself before but I didn't die. (R16 30 years, from South-west region, Christian, Unemployed Diploma certificate, Lesbian, Woman, lives in Lagos)*

> *Before if I feel very sad I cry, some months back I attempted suicide. I wasn't working, things were just not balanced for me, things were just going wrong. I was having this issue with my family concerning my sexuality they were just pushing me and I am not ready to come out to them. I know I have to come out to them eventually. I started hearing stories from other people about their attempts to commit suicide; they were saying if I tell you what I did ----- (R3 26 years, from the South-east region, Christian, Gay, Employed graduate, Male lived in Anambra & Lagos)*

LGBT people living in Nigeria have had to develop capacities for dealing with and handling their unique everyday life to prevent depression and improve their quality of life. People engage in social activities that make them happy and provide a booster to their mental health, the most popular being in the midst of community members for companionship. This alleviates loneliness, feelings of isolation and affords the opportunity to come out of hiding and express self openly.

> *I wouldn't allow depression, I fight depression, I know it hurts me more when I am depressed. It pains me when someone is insulting me and I can't talk back, I feel more pain so I ignore him. I try to be myself, forget him, feel free, I try to be happy whether there is food or no food to eat. Just laugh. Just be happy (R1 26 years, from South-south region, Christian, Unemployed graduate, MSM, lived in Delta & Lagos)*

> *Most of the time I go and visit a friend that will make me laugh, laugh, some of the MSM are very funny, or I come to the community centre because I don't have a job, for me not to be thinking, chat with friends, laugh. When I go home I feel better (R2 22 years, from South-east region, Christian, Awaiting University admission, Gay, Male, lived in Warri & Lagos)*

> *What I do to always make myself happy, I always like myself being in the midst of my fellow LGBT we can discuss so many stories, small, small gossip about our friends we are always happy if we are just in a group (R24 24 years, from South-south region, Christian, Employed, Trans woman, Gay, lives in Abuja)*

Participants talked about using their religious conviction to accept who they are and achieve mental stability. Ironically, it is the same religious beliefs that society uses to persecute members of the LGBT community. Religious beliefs in this study therefore assumes dual role i.e. justification for discrimination against "other" and acceptance of "self".

> *If he think and he feel bad he think about anything from God then if he think that he can place his mind he talk with his partner so he pray to God and talk say God know anything about him so after that he come face his life. If he think according to who you be sometime he may vex but if he think everything is from God naa God give you anything so if he think that he think say everything is from God that he come rest him mind and remove everything from his mind and continue doing his life (R26 18 years,*

from Northern region, Muslim, Unemployed Secondary school certificate, Trans woman, lives in Abuja)

I am happy now, sometimes I am sad, but if I'm think anything is coming from God I'm not sad. (R21 26 years, from Northern region, Muslim, Unemployed with Diploma certificate, Trans woman, lives in Abuja)

Theme 3: Adaptive mechanisms and coping strategies when healthcare providers are perceived as unfriendly and healthcare facilities become unsafe spaces

In response to this state of affairs and to avoid any negative repercussion, individuals will rather not disclose their sexual orientation or gender identity to their healthcare provider.

I have never disclosed my sexual orientation to a healthcare worker; I am just trying to be careful. I don't know what the outcome will be like. I am just trying to be careful. I don't know what will be going on in their mind. It is best if one keeps it. One should be very careful (R2 22 years, from South-east region, Christian, Awaiting University admission, Gay, Male, lived in Warri & Lagos)

For STI symptoms that are not related to the anus, MSM reported accessing services without disclosing sexual orientation or the gender of the sexual partner because the healthcare provider did not ask.

I have had an STI, normal STI that a normal guy will have. It is not gonorrhoea of the anus. I went to a private hospital, our family hospital. I told the doctor I have gonorrhoea. He asked me how I got it and I said I can't really tell. I just told him I had the droppy stuff from my penis. He thought maybe it was from a woman. He didn't ask me who I had sex with. He asked to see it and prescribed some drugs ……. I have never had to tell a doctor/nurse my sexual orientation (R9 24 years, from South-east region, Christian, Gay, Apprentice, Male, lived in Lagos)

For people who do not have a choice, contemplation of a clinical encounter is a psychological stressor that requires emotional and mental preparation. The individual takes time out to think/rehearse a lie or plausible explanation which attracts less stigma for engaging in same sex activity or disguise as a "normal patient"/heterosexual patient. Individuals with high self-esteem reported taking a stand and speaking for self to counter discrimination from providers.

The fear was they will ask you how did you have it? He can't just open up so we had to kind of agree on the trick to use. He went to a private hospital. When the interview was going on, the doctor said he should tell him the truth are you gay? My friend confessed and the doctor still tried to kick against it. He had to tell the doctor that, he sleeps with men to get money to take care of himself, he is staying with his aunt who doesn't take care of him. That was the lie he had to give to escape being asked to bring his sexual partner. (R1 26 years, from South-south region, Christian, Unemployed graduate, MSM, lived in Delta & Lagos)

In the University Teaching Hospital they don't know I am a gay person they asked if I had a girlfriend but I lied. They were like, did you bring your girlfriend so that we can counsel and run test? I keep on posting them until I was able to transfer from there (R24 24 years, from South-south region, Christian, Secondary school certificate, Peer Educator, Gay, Trans woman, lives in Abuja)

But me I tell people I have high self-esteem anywhere I will walk into anywhere I want to walk into if you talk any jargons I will stand up and tell you, are you done? Can I see the next person. That's it I don't allow anybody to intimidate me oooh. I will just walk in and say my own if you are not ok with it show me someone I can meet. (R6 30 years, from South-south region, Christian, Employed graduate, Bisexual, Male, lives in Port Harcourt & Abuja)

Theme 4: Availability and quality of healthcare services for LGBT people

The options available for accessing healthcare by LGBT people in Nigeria are limited based on the attitude of healthcare providers. Improvement in service provision over the years was reported, however, this falls short of what is required to eradicate the health inequality experienced by LGBT people.

I wouldn't say there is completely no improvement there is but it's not so significant like that to say organizations can now rely literally on all healthcare facilities within the state to send people to for referrals and things like that (R35 32 years, from South-west region, Christian, Employed graduate, Bisexual, not male/female, lives in Lagos)

Mental health services are available only in specialised as well as tertiary health facilities in Nigeria. For LGBT people who require this service and make an attempt to access such, interaction with providers can be very unsatisfactory and may worsen their mental health status. The notion that homosexuality is a colonial import expressed by a healthcare provider shows

the degree of sexual prejudice harboured within the individual and reflects inability to balance scientific evidence with societal beliefs, culture and religion.

> *I now explained everything that happened to me to the psychiatrist, he now said wait, do you know that this thing you are doing is illegal in this country, if you want to practice all those things your homosexual acts you should travel out of the country, yes. In ICD8 homosexuality was once a mental disorder but now the white men are trying to do what suits them that is why they decided to remove it from subsequent ICDs they produced. That was how I was attended to that day and I had to leave (R5 27 years, from South-west region, Muslim, Unemployed graduate, Gay, Male, always lived in Lagos)*

A few respondents recounted instances of receiving inclusive care from healthcare providers working in public facilities. Even though this is the exception it shows that it is possible even in this challenging cultural/political context to provide quality healthcare.

> *There is this pharmacists I had he is a very good pharmacists. I told him I had anal sex he is learned he treated me. I think he felt comfortable more when I opened up to him because he told me I have made it easy for him to know what prescription to give me. He gave me good treatment (R15 28 years, from South-west region, Christian, Employed graduate, Bisexual, Male, lives in Lagos)*

> *I have had to disclose my sexuality to our family doctor at General Hospital. He was just his usual self and he didn't tell anybody. He said oh, really, take good care of yourself oooh many diseases are out there. (R10 22 years, from South-west region, Muslim, Self-employed graduate, Gay, Male, lives in Lagos)*

Most public health facilities were perceived to offer services targeting only heterosexual clients making such services irrelevant in improving LGBT health and unacceptable to non-heterosexual people.

> *Because if you walk into a hospital, when they talk about sex education there is nothing that is talking about those who are same sex persons. They tell you OK to prevent infection from HIV, have protected sex use condoms male and female. They are leaving out the other sexual minorities who are very important like gay men and bisexual men (R8* 34 years, from South-south region, Christian, Employed graduate, Gay, Male, lives in Lagos)

NGOs have trained LGBT people as peer educators to provide information and educate community members. This has helped in bridging the gap left by the lack of mentors, role

models and LGBT knowledgeable parents/elders within the wider society. Generally, NGO clinics were observed to provide culturally appropriate care and patient satisfaction with services was rated highly.

> *If I am sick, I will go NGO [non-governmental organisation offering healthcare services to MSM]. They know I am a Trans now and they treat me very well and still, they give me lubricants, condoms. Now I happy for being health know where can I get solution advice before (R21 26 years, from Northern region, Muslim, Unemployed Diploma certificate, Trans woman, lives in Abuja)*
>
> *Before we dey go government and private hospital, Now we go only NGO. We thank God for some NGO clinic in Abuja that provide health services, me too I dey go there to access services for free. (R18 28 years, from the Northern region, Muslim, Peer Educator, Trans woman, lives in Abuja)*

Theme 5: Intersectionality, health inequity and the LGBT community

Rural/urban divide – Access to healthcare for LGBT people in Nigeria is influenced by several factors. Individuals living in rural areas are prone to experience a higher degree of stigma/discrimination, poorer access to healthcare and inevitably a higher burden of health inequality compared to their LGBT peers within more urban settings. Participants reported that NGOs providing culturally appropriate healthcare services are available in a few states and only in urban areas. LGBT patients sometimes have to travel to other states to access services. When available the perception of healthcare by participants from outside Lagos and Abuja was that the quality of service is generally inferior and of lower standard.

> *They need to expand the healthcare service so that they don't have to stress themselves to come to the city when they are sick so they will be able to treat themselves there you understand my point. It's not every state that we have in Nigeria like now we have 36 states plus Abuja 37 maybe I don't think we have like --- maybe it's like 10 for the whole Nigeria (R23 33 years, from Northern region, Muslim, Self-employed graduate, Bisexual, Male, lives in Abuja)*
>
> *There are 3 people in my place there is no centre where you go and collect drugs. It is a very big town. The only government hospital you cannot dare it to go there. The last time I travelled to --- I went with ARV but reaching there I know they have to be tested and couldn't give them the drug because they don't know their CD4 (R19 26 years, from*

South-south region, Christian, Peer educator, Trans woman, lived in Port Harcourt and Abuja)

There is no place in [mentions the town] they treat MSM that is why MSM in --- are scared to go to hospital, In --- dem they don't do seminar, no lecture, no orientation on how to protect themselves nothing it's only in Lagos here that I see things like that. (R2 22 years, from South-east region, Christian, Awaiting University admission, Gay, Male, lived in Warri & Lagos)

HIV status – The LGBT community, retains some of the core values of the wider society, which includes enacted stigma against people with an STI including HIV/AIDS. For an HIV positive LGBT person, life experience is compounded by the discrimination they can be subjected to by their HIV negative peers, friends/family and the general population. In trying to guard against segregation and exclusion to the fringe of the LGBT community, people who are HIV positive hide their HIV status. This results in the creation of mini communities consisting of vulnerable people (LGBT and STI, LGBT and HIV, LGBT and STI & HIV). The choice of venue for accessing HIV or STI related services is dependent on keeping the status a secret from friends, family, the general population and LGBT community. This influences the decision of if, where and when to screen for HIV and other STIs, as well restricts the choice of where and if to assess treatment services. Some HIV-positive individuals would rather not use ARV facilities known/patronised by community members to ensure that their HIV status remains a secret. Therefore, some LGBT individuals will lack access to acceptable healthcare services even though it is available.

Even when I heard of the community centre ----- I didn't want to be seen entering the pharmacy because I have been there and people are like haaaa what is he doing in the pharmacy and people are like they probably want to give him ARVs and I don't want to be so identified I have been getting them from General Hospital. I still have to deal with the crowd. (R5 27 years, from South-west region, Muslim, Unemployed graduate, Gay, Male, always lived in Lagos)

Because if I am popular now so if I walk in there and I meet like a fellow gay man there instantly I will just think maybe he is HIV positive so most of them don't even go to [mentions name of an NGO clinic] anymore because they don't want to go there and meet known faces and the story behind that is because they just feel anyone that goes

there is going for ARV. (R8 34 years, from South-south region, Christian, Employed graduate, Gay, Man, lives in Lagos)

This decision to remain in an individual closet within the LGBT closet results in the creation of a complex web to hide the sexual orientation/ gender identity from the general population and the HIV status from community members. Some LGBT people are practically living in two different closets at the same time. This exposes such individuals to a higher level of minority stress and its subsequent deleterious effect on their emotional and psychological health and wellbeing.

Gender presentation – While some individuals are able to evade discrimination by 'passing' as cisgender and straight in most situations, individuals with non-conforming physical appearance, particularly those exhibiting differences in gender identity or presentation have no hiding place. This appears to be an aggravating factor, such individuals are continually exposed to negative attitude and stigma from all segments of society compared to their peers and therefore they bear a higher burden of the psychological stress and its health related complications.

I have never had to tell healthcare worker that I am a Trans person. If they just see me like this even if they are many there they will just ask. It's even the person you think that is responsible that will say hey are you a girl or a boy they will start looking like this "what's that". (R20 25 years, from Northern region, Christian, Unemployed Secondary school certificate, Trans man, lives in Abuja)

One thing is that there are some people that are naturally effeminate gay guys so people take advantage of them and assault them and do so many things to them. I am not effeminate the people that had felt the brunt of the problems are the effeminate guys. (R6 30 years, from South-south region, Christian, Employed graduate, Bisexual, Male, lives in Port Harcourt & Abuja)

It's easier for the females than the males in the sense that I can still walk into any ----------clinic and see a doctor and tell them exactly how I feel I might actually change words I might not say who exactly I am referring to but it's more easier for the females than the males. (R17 22 years from South-south region, Christian, Diploma certificate, Unemployed, Lesbian, Tom, lives in Lagos)

Lesbians seek for health services in any facility; I don't think lesbians really have problems like that unlike MSM. It's only the tom boys when they see them like this they just conclude. They see females that act as chicks and they won't know they are into it and they don't tell people who are not members of the community so they don't have problems (R14 27 years from the South-west region, Christian, Lesbian, Self-employed, Tom, always lived in Lagos)

Education levels – Within the LGBT community, individuals with higher education reported access to health related information that can be used to stay healthy and help their peers. This was distinctly less common among the Hausa community compared to their peers from the other regions.

Prior to my diagnosis I didn't know any LGBT organization exists so I will think there are also people like this out there who do not know LGBT organizations where they can go to, to get information. Then I was just living my life. To access health information I go online on such but that is because I understood that I could get information from such, there are people who are not aware of getting information online. (R13 25 years, from south-west region, Spiritual, Gay, Unemployed graduate, Male, always lived in Lagos)

*In Kano they speak Hausa to them if you can't speak Hausa you get somebody that speak English ask them and later will be translating to you. That's a big problem we have in our community. Illiteracy is the worst stigma because most of them have something they have their handwork they have their business but illiteracy is the worst. (*R23 *33 years, from Northern region, Muslim, Self-employed graduate, Bisexual, Male, lives in Abuja)*

But most of Hausa community Trans are illiterate even me I just being manage to learn English in Abuja when I was in Kaduna my friends no speak English I just go to school and try to learn how to communicate with people with English. They were teaching in Hausa at the polytechnic, I know how to write it and read it but I cannot speak it very well you understand. The illiterate Trans are plenty. (R21 26 years, from Northern region, Muslim, Unemployed Diploma certificate, Trans woman, lives in Abuja)

Theme 6: LGBT community perception of an inclusive and acceptable healthcare provider

A welcoming healthcare provider who will be friendly, knowledgeable, accommodating, receptive to a patient's complaints, non-judgemental and assure clients of confidentiality of information will make all the difference to LGBT clients. Discrimination from healthcare

providers and facility support staff based on gender identity/sexual orientation was not acceptable to LGBT patients/clients.

> *There is no difference between LUTH and [mentions an NGO] they are both hospitals. The healthcare workers at [mentions an NGO] are not gay people. The only difference between LUTH and [NGO] is this warm welcomeness that you get at [NGO]. You feel like you are home. (R9 24 years, from South-east region, Christian, Gay, Apprentice, Male, lived in Lagos)*

> *If they can make you comfortable about who you are and can give assurance that they don't mind ……un un un……..whatever you are discussing with them is confidential. (R14 27 years from the South-west region, Christian, Lesbian, Self-employed, Tom, lived in Lagos)*

> *One thing I just want to say is that despite of your sexuality or difference ---------- straight, bisexual, lesbian, they should just accept everybody for who they are, then they should try and make sure they are so friendly to everybody not giving people bitching attitude because of this is who they are they start discriminating disrespecting people shouting on people as if those people they are not important. (R7 41 years, from South-south region, Christian, Secondary school certificate, Employed, Gay, Female, lives in Lagos)*

> *The major thing I am expecting is a qualified health worker, a confidential health worker who is going to attend to me for who I am who is not going to discriminate. Even if any other people in the society is discriminating it shouldn't be the health workers. (R4 25 years, from the South west region, Christian, Graduate, Employed, Questioning gay or bisexual, Male, lived in Lagos)*

> *MSM friendly health workers. I don't know how possible that is a health worker should be orientated eeemmmm --- much more on ---------- towards they should follow the book, follow what science says not what they think religion or society say. They should follow standard medical practice not because they think that hhhaaaaaaaaaaaa -------- their African values or their moral values does not support. (R5 27 years, from South-west region, Muslim, Unemployed graduate, Gay, Male, always lived in Lagos)*

Participants believe that training of healthcare providers is essential for LGBT patients to receive appropriate and acceptable care. Training will equip providers with the required knowledge and skill while inadequate training compromises professionalism resulting in unethical conduct.

> *I think public and private hospital should pass information to hospital that these people are also created by God for me that is enough because if they are trained they would get to know who these people really are because to me what most people that are not LGBT always say these people they are cursed. For me it's not only the healthcare they*

should train the public in general the information should be passed that these people were created by God they are not cursed people as they think. (R25 26 years, from the south-south region, Muslim, Polytechnic diploma, Unemployed, Gay, Transwoman, lived in Abuja for 12months)

More trainings because LGBT people are here to stay you understand what I am saying so give them their right to health. Don't say because he is a gay man or she is a gay woman or because he is transgender and or bisexual we should all have access to health. We have right to health I think we should just be given that right we should not be deprived of it that's just the issue (R15 28 years, from South-west region, Christian, Employed graduate, Bisexual, Male, lives in Lagos)

The only problem is these people are not even trained to know some kinds of diseases that infects the LGBT people. Because many doctors and nurses in the general hospital might not know what an anal warts is like. They should be properly trained and there should be close monitoring on the ethics of the job. (R10 22years, from South-west region, Muslim, Self-employed graduate, Gay, Male, lives in Lagos)

Participants were of the opinion that employing qualified LGBT community members in public health facilities as healthcare providers will improve access to inclusive and acceptable care

In the sense that they know exactly where you are coming from and the feelings you feel and it is em a bit comfortable to actually seek advice from them it is more comfortable. Well it is more comfortable because it is we we, we know ourselves it's a bit easier to actually say the terminologies we use when we talk so it is easier. Once that can be put in place it will be easier for lesbians to come out. It will be easier for lesbians to actually seek medical attention when they need it. (R17 22 years, from South-south region, Christian, Unemployed Diploma certificate, Lesbian, Tom, lives in Lagos)

LGBT community have many people that graduate, they should give them work in clinic or hospital. If I go hospital and I see Trans I will feel free to tell all my problems everything because I know say he is Trans like me. (R18 28 years, from the Northern region, Muslim, Peer Educator, Trans woman, lives in Abuja)

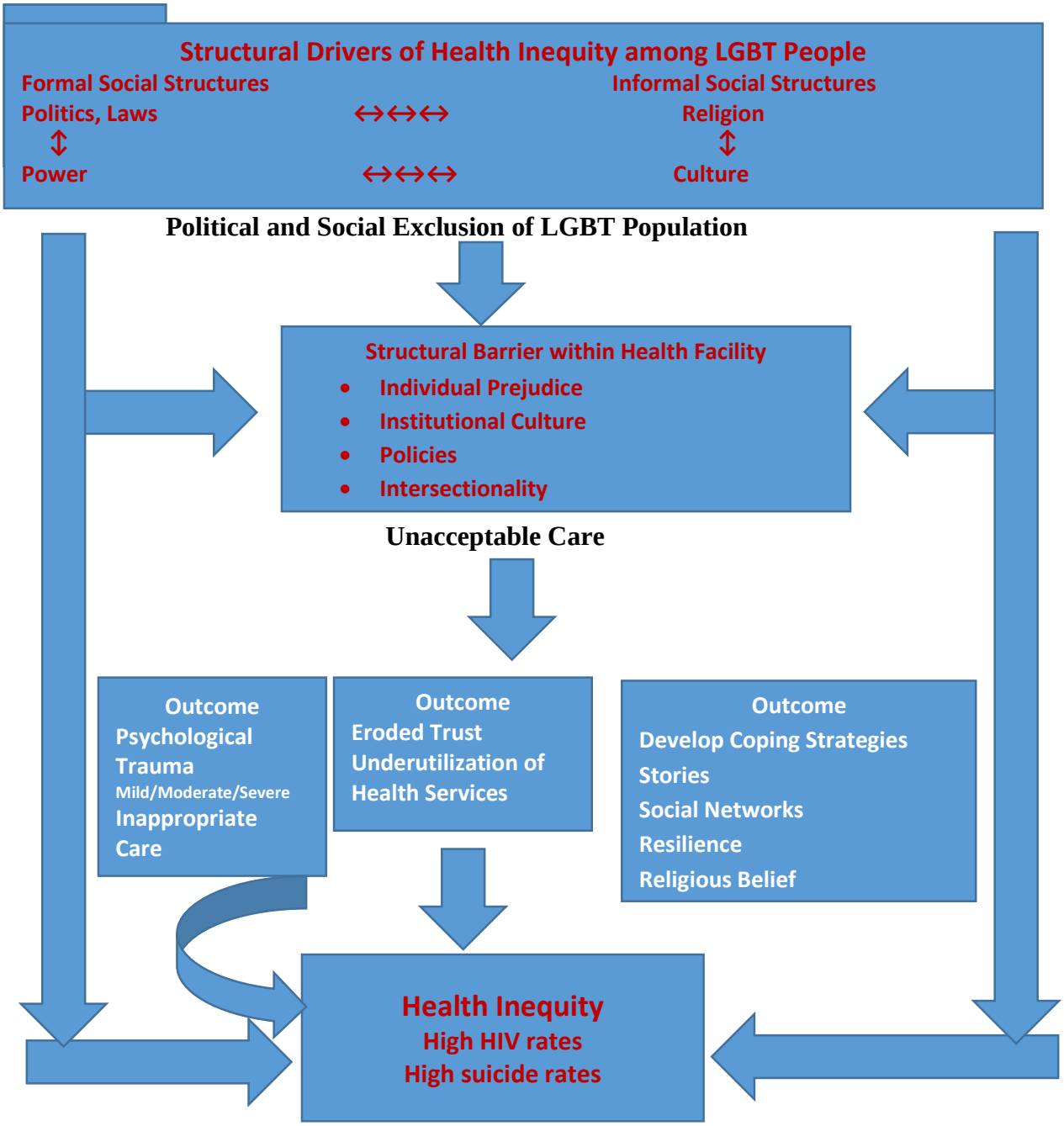
4.4: Discussion

Availability, access and use of healthcare services is a significant contributory factor to health inequity within and among countries. A missing element in previous discourse on health inequity and social determinants of health within the African context is the critical role played by religion, power and politics in generating, maintaining and exacerbating health inequity within countries. This study shows the multilevel synergistic effect of religion, power and

politics, both within and outside the health system, thereby highlighting their importance as structural drivers of health inequity in Nigeria.

Informal social structures in sub Saharan Africa including culture and religion dictates the norms and values of the people: acceptable communal characteristics and behaviours that are encouraged and respected. In this discourse, I propose that religion is the driving force of culture, the main nutrient feeding and sustaining the culture of social exclusion against the LGBT population in Nigeria. [see figure 4.1]

Figure 4.1: Framework for social determinants of LGBT health in Nigeria



The cultural and religious views on sexuality and sexual health are very similar: clearly defined binary gender based on primary sexual characteristics at birth; clearly defined gender roles and heteronormativity. Through the process of primary and secondary socialization, individuals who grow and live in the country develop a prejudice against people who identify/suspected to be LGBT individuals resulting in social exclusion, the gateway to health inequity.

The principal religion strongly condemns any variation/form of diversity with punishment and judgement for violators. In a country with diverse ethnic groups, split on the ethnic divide, religion provides the rallying point for all to speak with one voice and therefore becomes a powerful tool. Culture is dynamic and evolves over time but in this instance, religion serves as a powerful force supporting, strengthening and enforcing the entrenchment of social exclusion thereby preventing change.

Religion permeates every aspect of life in Africa and extends its influence to the formal social structure of politics and power. The politicians, legislative, executive and law enforcement agents in Nigeria are a product of a deeply entrenched heteronormative society. The same-sex marriage prohibition law in Nigeria demonstrates the power of religion/religious leaders wield within the political class and among the general population. By protecting the dominance of heteronormativity, the law resulted in the political exclusion of the LGBT population in the country, and strengthened and increased the power of religion/ religious leaders within the society. Subsequently, healthcare related policies, budgetary allocation and implementation of programmes specifically targeting LGBT people were negatively affected, further entrenching the existing health inequity. By creating power imbalance, this criminalising law provided legal backing/justification for individuals, including healthcare providers, to openly stigmatise/deny healthcare based on individual prejudice and at the same time denies LGBT individuals the right to seek justice.

Healthcare providers grow, live and work in environments shaped by policies, politics and the power of religion. In my study, this is an environment where LGBT people are subjected to social and political exclusion. Within health facilities, there is a power imbalance between the patient and the provider, with the latter occupying a higher power hierarchy. Healthcare providers with individual prejudice against LGBT people capitalise on this power imbalance to

exhibit enacted stigma during patient-provider interaction when they display hostility, violence, and other discriminatory acts. This confers differential status on patients/clients accessing services with LGBT patients at the lowest level, consequently setting the stage for health inequity.

The institutional culture of prejudice, hostility, and violence against LGBT patients, as reported by participants in my study, constitutes a structural barrier to healthcare access resulting in the inability to access health promoting interventions and lifesaving treatment, thereby constituting poor health or even a death sentence. In addition, the experience of accessing culturally and clinically inappropriate and unacceptable care is a psychological trauma that can have negative mental health effects including post-traumatic stress disorder, worsening the health inequity.

This study in Nigeria showed that the structural barrier experienced by LGBT people in health facilities is driven by a synergy between political exclusion (a product of politics and power) and the informal social structures (religion and culture) that supports traditionally constructed groups.[see figure 1] The two drivers operate on two levels: they support as well as reinforce each other. Health inequity in this discourse, therefore, has a direct and indirect cause. Firstly, it is a direct consequence of interaction with the healthcare provider. Secondly, it is an indirect consequence of unequal access to social resources arising as a result of restricted participation of individuals in social activities and unequal right to social resources including healthcare services. This limitation creates an unhealthy environment for development, and compromises the potential for wellbeing.

The role of religion is interwoven into the fabric of the input and output processes of social determinants of health, as a facilitator and barrier to good health and wellbeing. Religion in this discourse has a mechanism for driving social and political exclusion of the LGBT population

in Nigeria as well as a separate mechanism for ameliorating its negative mental health consequence on the affected individuals

Intersectionality

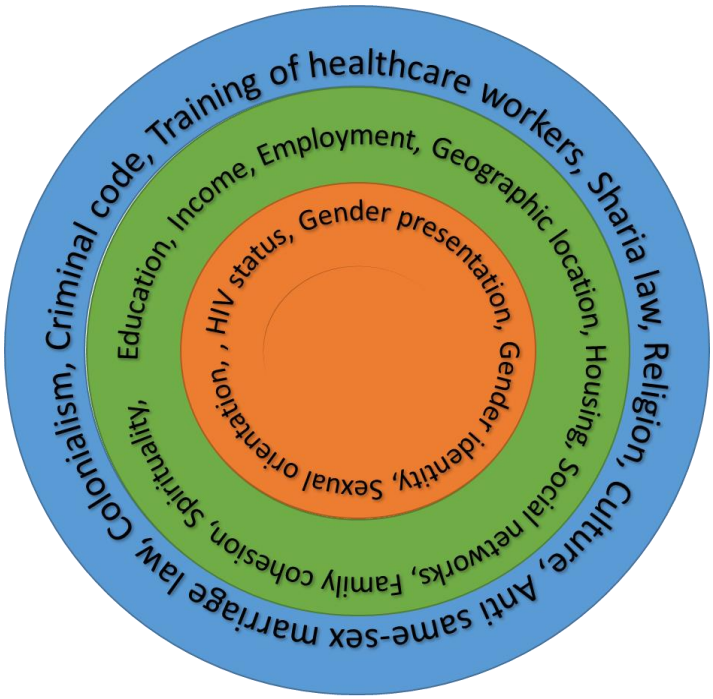
Social systems are maintained by multifaceted and interconnected formal and informal structures and processes of power. Privileges and disadvantages generated by power permeate the health system and can influence provider-client interactions. The position of an individual during such interactions based on the social context is determined by all aspects of the client's identity and social classification. This is shaped by membership of social categories and the accompanying power relations/structures that operates at each level. The intersectional approach to data analysis in this study describes how differences in individual level factors such as gender identity, gender presentation, sexual orientation and HIV status shape the provider-client interaction and relationship. Furthermore, it shows how interpersonal, social and structural stressors based on sociocultural, economic, religious and legal factors impact on the perception of care experienced among individuals within a population experiencing multiple overlapping marginalized identities. These stressors are also known to directly trigger negative health problems.

At the current time, within the context of the social environment of LGBT populations in contemporary Nigeria an intersectional lens provided detailed insight to the drivers of social inequality manifesting as health disparity. This enabled me to generate with greater precision the implications for practice for an effective policy and program development. In this study, it was used to demonstrate a link between the structural factors responsible for the social environment in which LGBT individuals live and work and the stigma and discrimination they experience. It thus provided an understanding of the multilevel influences and dynamic

interaction between individual attributes and social identities in relation to structural and social factors via power relations.

Multilevel analysis using the intersectionality lens in this study, generated a result incorporating power relations, social processes and individual identities at the micro and macro level represented as an adapted intersectionality wheel. This depicts how, within the Nigerian health system, individual level factors (first ring) interact with factors in the second and third ring (macro and structural level) to compound the experiences of individuals. It goes beyond showing intra-group inequality to describe how different social categories intersect to produce inequalities, and the reasons why.

Fig 4.2: Adapted Intersectionality wheel depicting the three levels of intersecting factors influencing healthcare experiences of LGBT people in Nigeria.



4.4.1: Strengths and Limitations

This novel study used a large diverse sample of the LGBT community in Nigeria, the methodology was robust and rigorous which ensured the collection of a rich narrative. It is likely that there are individuals concealing their sexual orientation or gender identity, or who may not have been willing to be interviewed for fear of being 'outed', but whose contribution might have enriched the study. The study was carried out in urban communities, even though attempts were made to include individuals who have lived in various geographical regions of the country there may be under representation of experiences of LGBT individuals living in rural and underserved communities in Nigeria.

4.4.2: Conclusion

Politics, power, and culture in Nigeria and some countries in Sub-Saharan Africa are moderated and influenced to a great extent by religion. Annexing the rich potential of religion in such a way as to maximally benefit from its powerful role as a social determinant of health in the quest to ameliorate health inequity is essential. Exploring social determinants of health with the lens of intersectionality allowed me to explore and analyse individual experiences without erasing the diversity within the LGBT community. It revealed the inequality that is hidden and embedded within the inequity that arises as a result of social and political exclusion. This study showed that individual-level factors intersect with social and community level factors to determine the extent of social and political exclusion experienced by individuals within the LGBT community. This discourse, therefore, posits that uneven distribution of the burden of negative health consequences exists within the LGBT community determined by the intersectionality of factors with subsequent variation in the degree of health inequity. It identifies the need to broaden the information to be collected on the national health equity surveillance framework to include gender presentation and gender diversity. The health system

in Nigeria needs to plan for the specific needs of the subpopulation within the LGBT umbrella to ensure that healthcare professionals respond appropriately and address individual health problems.

Achieving the sustainable development goal (SDG 3) of good health and wellbeing requires a deeper understanding of the nature of health inequities (catalyst, sustenance and maintenance). Scientific contributions are needed to handle global problems leading to health inequality. In recognizing that studies exploring dichotomies cannot adequately address the complexities of these problems I have proposed an intersectionality lens. This will provide a deeper insight into the complexity of the problems thereby highlighting the multifactorial causation of health disparities.

To reduce health disparity reported among the LGBT population, an individual level approach through interventions that buffer the impact of the psychosocial stressors is urgently needed, while waiting for the law to be amended to effect structural change. Recognizing that discrimination and stigma based on medical condition and social status are multifaceted, multilevel interventions are more likely to improve LGBT population health outcomes in Nigeria.

4.4.3: Policy implication

The power of religion/religious bodies and institutions were annexed for HIV/AIDS prevention in the 1980s in Nigeria. A successful case is the HIV/AIDS lifeline theological curriculum developed under the USAID IMPACT project which was used to train religious leaders of all faiths. They were subsequently empowered to implement HIV/AIDS prevention, care, and support programs. The religious organizations took ownership and were implementing these programs all over the country. This remains a success story and a game changer in the reversal

of the HIV epidemic in Nigeria. The path to health equity for criminalised and socially marginalised populations, therefore, requires a deep and critical understanding of the local power dynamics. This will guide the formulation of strategies and design of interventions to overcome barriers to health equity.

4.4.4: Way forward

Within the context of criminalising laws, there is an urgent need for studies. Firstly, to evaluate the extent to which LGBT individuals have been able to successfully use religion in achieving mental balance and reduce the impact of psychological trauma in Nigeria. Secondly to generate local evidence to direct harnessing of religious influence for the promotion of health equity and guide policymaking and program implementation. An urgent issue is the reinstallation of the 'Right to health' for marginalised groups within the context of criminalising laws. Civil society and advocates need evidence based on robust data demonstrating the negative health consequences of criminalising laws to convince religious leaders. This will allow a buy-in into the power of religion in amending the law, giving way for the formulation of health-promoting policies and programs. Moreover, identification of intersecting factors influencing the health of the LGBT population will expand knowledge on the individual level factors to be included in social determinants of health models. I also advocate for unbundling the term LGBT and propose that each subgroup should be treated as an entity in health research, program design and implementation because of their individual differences, needs and the intersection of factors which results in differences in the experience of health inequality across board. With regards to lobbying and advocacy in the political space, there is a benefit in numbers, hence solidarity between the subgroups rather than dividing will be beneficial.

4.5: Summary of the chapter

This findings from this chapter highlight the hugely problematic experience of LGBT people in Nigeria with respect to their health and healthcare. At the same time, it reveals the importance of health care providers delivering sensitive, non-discriminatory and culturally competent care. This is the first study from Nigeria giving voice to the transgender and lesbian population whose existence has hitherto not been acknowledged in any local publication. Using multiple theories in this chapter enriched the analysis and provided a detailed and comprehensive insight into the inequity prevailing in the life, health, and wellbeing of LGBT population in Nigeria. One of the key barriers to service provision identified by this study is the lack of professionalism arising from inadequate training of providers. The next chapter is a systematic review of the effectiveness of training programmes for healthcare students and healthcare professionals in delivering culturally competent care for LGBT individuals. This global picture will provide information necessary to have an insight into the training of healthcare professionals and students with regards to LGBT health.

Chapter Five: Systematic Review on Training of Healthcare Students and Professionals

In the previous chapter, the qualitative study carried out in two cities (Lagos and Abuja) in Nigeria provided evidence of unsatisfactory healthcare encounters. In certain instances, this was ascribed to lack of professionalism on the part of the healthcare professionals, thereby generating questions with respect to the training of healthcare students and professionals, which will be addressed in chapters five and six. This chapter provides a global picture of the effectiveness of educational curricular and training on LGBT related health issues for healthcare students and professionals focussing on knowledge, attitude and practise based on evidence available as at December 2015.

5.1: Introduction

Recognition of the impact of HIV-related discrimination in healthcare settings has brought to the forefront the urgent need to remodel education of the health workforce.(265) Theory suggests that specific training may result in better knowledge/skills of the health workforce when treating conditions of known high risk among the LGBT community and training may also reduce the stigma and discrimination of LGBT patients.(266) This systematic review assesses the effect of educational curricula and training for healthcare students and professionals on LGBT healthcare issues and offers a timely contribution to the debates about the role of professional educational interventions as the movement towards LGBT inclusion gains momentum globally.

5.2: Methods

All primary research designed as trials (randomised, non-randomised controlled, pre-post) and qualitative studies in all languages were considered eligible for this review. There was no restriction based on year or country of publication.

Eligibility criteria were defined (see Table 1) using the PICOS approach which defines the population, intervention, comparator and outcomes relevant to the review.(267)

Table 5.1: Eligibility criteria

Population	Medical doctors and dentists, nursing and midwifery professionals and pharmacists. Healthcare students studying for entry to one of the professions specified above.
Interventions	All forms of training given to healthcare professionals on sexuality and LGBT specific health issues at undergraduate and postgraduate level.
Comparator (if available)	Standard level training/No training on LGBT-specific issues.
Outcome	Change in participants' knowledge, attitude and or practice with regards to sexuality related issues and LGBT health.

Following an initial review of keywords in relevant literature, the search terms, strategies and overall search process was defined. A detailed search strategy is in Table 5.2.

Table 5.2: Search terms

- Homosexuality, Female/ or Bisexuality/ or Homosexuality/ or Sexuality/ or Minority Groups/ or Homosexuality, Male/ or Transgendered persons/
- Sex Education/ or Education, Medical/ or Education/ or Education, Medical, Undergraduate/ or Education, Nursing/ or Education, Dental/ or Competency-Based Education/ or Education, Medical, Continuing/
- "Attitude of Health Personnel"/ or Cultural Competency/ or Clinical Competence/

- Knowledge/ or Health Knowledge, Attitudes, Practice/
- Health Personnel/cl, ed [Classification, Education]

We searched the following databases; Medline, Web of Science, ScienceDirect, education resources information center (ERIC), TRIP, Google scholar, Zetoc, CINAHL, PsycINFO and Cochrane database of systematic reviews (CDSR)t. Other sources of information used were University of Birmingham library, Ethos electronic thesis, ProQuest and grey literature online resource. The search was from the inception of the databases to 15th December 2015. Two researchers (Sekoni AO and Manga-Atangana B) independently conducted the initial screening of titles and abstracts of articles identified through the search. The full text articles were reviewed by four researchers (Sekoni AO, Bhadhuri A, Gale N, Jolly K) for inclusion. The reference sections of included studies were screened to identify additional relevant studies.

A data extraction form was developed using the Cochrane consumers and communication review group's data extraction template.(268) It was pilot tested prior to final use. The final version extracted information on the following: The author's name, year and country of the study; the study design; type of population; characteristics of population; outcomes of interest; content of training; mode of delivery; time allotted for training; characteristics of the trainers; recommendations for future training. This process was carried out by three reviewers (Sekoni AO, Gale N, Jolly K) working independently.

A modified Downs and Black checklist (269) was used to assess the quality of non-randomised controlled studies and intervention studies without control. In grading the intervention studies without control, the following criteria were used: studies that scored $\geq$18 out of a maximum of 20 marks were graded as low risk, 15-17 moderate risk and <15 high risk. The Critical Appraisal Skills Programme (CASP) checklist (270) was used for qualitative studies. Scores $\geq$ 8 out of a

maximum of 10 were graded as low risk, 6-7 as moderate risk and <6 as high risk. Risk of bias assessment was undertaken by AS and checked by a second reviewer.

The review was registered on PROSPERO in March 2016 (CRD42016036430).

5.3: Results

Searches identified 1,171 studies. Removal of duplicates left 663 articles; 620 abstracts were excluded because they were not intervention studies. Of the remaining 43 abstracts, 27 were not eligible, 16 articles reporting 15 studies were eventually included. One study reported the quantitative and qualitative findings separately. The PRISMA flow diagram summarises the included studies based on the eligibility criteria (Figure 5.1).

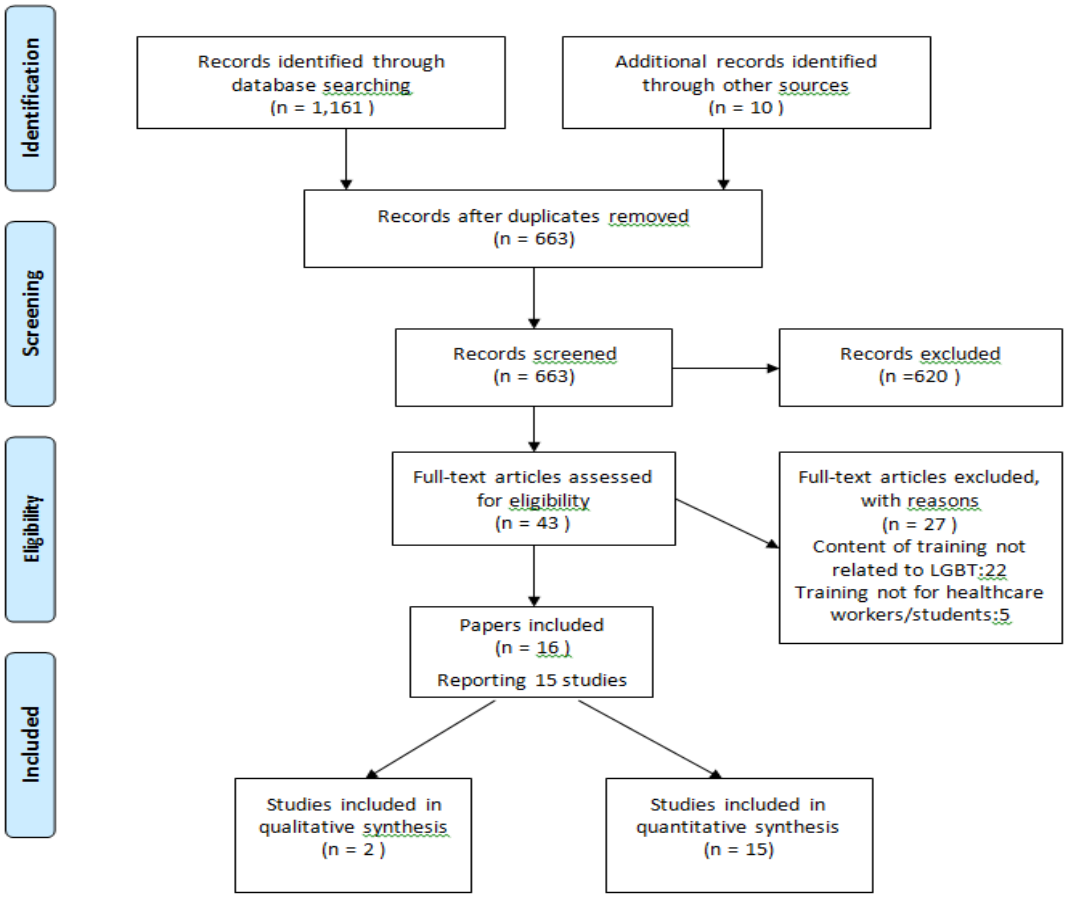


Figure 5.1: PRISMA diagram

Ten studies had student populations: medical (271-277), nursing (278, 279) and mixed population of students in nursing, pharmacy and the allied health professions.(280) Five studies presented data from healthcare service providers (281-285): medical residents(281-283), practicing nurses (285) and one had a mixture of clinicians, nurses, counsellors and administrators. Almost all studies took place in high income western countries: two UK (273, 277) twelve in the USA (271, 272, 274-276, 278-283, 285) and one in Kenya between 1977 and 2015. The Kenyan study used a mixed methods study design but published the quantitative and qualitative results separately.(284, 286) Five articles were published from 1977 to 1989, while the remaining eleven were published after 2000. The sample size for the articles ranged from 13 (274) to 217 (277) subjects (See Table 1). Most of the articles in this review did not report the sex and age distribution of the participants.

5.3.1: Study design

Three of the studies used a non-randomised pre/post design with concurrent comparators. (271, 274, 280) The remaining twelve studies had a pre/post intervention design without control; among this group two used a mixed methods design. (280, 284) Three of the quantitative studies had three months follow up (283) data. (274, 275, 285) One of the articles collected data using an online survey.(278)

The qualitative element of the Kenyan study, published separately (286), used focus group discussion and framework approach while the second mixed method study [USA] (280) used journal reflections and triangulated the findings with the quantitative results.

Table 5.3: Summary of Population characteristics and Settings

Author / Year	Sample size	Type of student	Country	Study design	Follow-up
Bauman et al 1985	16	Medical student year 1	USA	Non-randomised control	Post-intervention
Carabez et al 2015		Nursing student	USA	Pre/Post intervention	Post-intervention
Carmichael et al 1977	104	Medical student year 2	USA	Pre/Post intervention	Post-intervention
Hawala-Druy et al 2012	106	Nursing, pharmacy, Allied health students	USA	Pre/Post intervention Qualitative (Journal reflections)	Post-intervention
Hawton et al 1979	42	Medical clinical student year 1	UK	Non-randomised control	Post-intervention
Johnson et al 2015	13	Medical student year 1	USA	Non-randomised control (post intervention data not collected from the control group)	Post-intervention and 3 months
Kelly et al 2008	143	Medical student year 2	USA	Pre/Post intervention	Post-intervention
Loeb et al 2010	25	Medical Residents	USA	Pre/Post intervention	Post-intervention
Mcgarry et al 2002	137	Medical Residents	USA	Pre/Post intervention	Post-intervention
Rosen et al 2006	46	Medical Residents	USA	Pre/Post intervention	Post-intervention
Strong et al 2015	88	Nursing student	USA	Pre/Post intervention	Post-intervention
Thomas et al	145	Medical student year 2	USA	Pre/Post intervention	Post-intervention

1980					
Van der Elst et al 2013	74	Mixture Healthcare workers	Kenya	Pre/Post intervention Qualitative (FGD)	Post-intervention and 3 months
Wylie et al 2003	217	Medical student year 4	UK	Pre/Post intervention	Post-intervention
Young et al 1989	200	Registered Nurses	USA	Pre/Post intervention	Post-intervention and 3 months

UK: United Kingdom; USA: United States; FGD: focus group discussion

5.3.2: Risk of bias of included studies

Risk of bias is reported in Tables 5.4, 5.5 and 5.6.

The non-randomised controlled studies (271, 273, 274) were assessed to have high risk of bias due to confounding, and moderate risk in selection of participants. In all cases the control was students either in the same class or similar class who were not exposed to the sexuality related courses offered as electives. The students were allowed to choose their electives based on preference. Two studies had high risk of bias due to missing data.(271, 273) For measurement of outcomes, one study (274) did not have post intervention outcome data for the control group and was classified as having an unclear risk of bias, one study had a high risk (271) and the third had a low risk of bias.(273)

For intervention studies without control, five were graded as low risk of bias (275, 280, 281, 283, 284), five as moderate risk (272, 276, 279, 282, 285) and two as high risk. (277, 278) The articles did not provide enough information on the population included in the study, characteristics of subjects lost to follow up and estimates of random variability for the main outcome. One of the articles reported on change in knowledge and attitude following the training but the data collection tool did not capture the same information pre and post, hence

the result could not be compared.(282) The stand-alone qualitative study was classified as low risk (286), while the USA (280) qualitative study was classified as moderate risk of bias.

Table 5.4: Risk of bias for nonrandomised control studies

	Aim of the study clearly described	Main outcomes clearly described	Confounding of the effect unlikely	Selection of population described	Selection into the study unrelated to intervention or outcome	Clear description of study population	Start of study and follow up coincide	Intervention well described	Information on intervention status recorded	Information on intervention status unaffected by knowledge of outcome	Characteristics of subjects lost to follow-up described	Intervention status complete	Outcome data complete	Outcome measure objective	Appropriate statistical tests used	Findings clear, objective and sufficient	All possible logical interpretations of results considered
Bias in selection of participants																	
Bias due to confounding																	
Bias in measurement of intervention																	
Bias due to missing data																	
Bias in measurement of outcomes																	
Bauman	Y	Y	N	Y	U	N	Y	Y	Y	Y	U	Y	Y	N	U	N	Y
Hawton	Y	Y	N	Y	U	Y	U	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Johnson	Y	Y	N	Y	U	U	Y	Y	Y	Y	Y	Y	Y	N	U	U	U

Table 5.5: Risk of bias for Pre/ Post studies without control

	Is the aim of the study clearly described?	Are the main outcomes to be measured clearly described?	Did the authors describe how the population was selected?	Were the subjects asked to participate in the study representative of the entire population?	Are the characteristics of the population included in the study clearly described?	Are the interventions of interest clearly described?	Are the main findings of the study clearly described?	Does the study provide estimates of the random variability in the data	Have the characteristics of subjects lost to follow-up been described?	Have actual probability values been reported?	Were the statistical tests used to assess the main outcomes appropriate?	Are the findings presented clearly, objectively, and in sufficient detail?	Did the investigators avoid introducing new results in the discussion?	Did the investigators consider all possible logical interpretations of their results?	Are the results adequately compared to previous studies in this area?	Are the conclusions clearly stated?	Are conclusions substantiated by the data that are presented in the results section?	Are generalizations confined to the population from which the sample was drawn?	Are the limitations of the study considered and were they taken into consideration?	Are recommendations for future research made?
Cabarez	Y	Y	Y	Y	U	Y	Y	U	U	Y	Y	N	Y	N	Y	Y	Y	Y	N	Y
Carmichael	Y	Y	U	U	Y	Y	Y	Y	U	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y
Hawala-Druy	Y	Y	Y	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y
Kelley	Y	Y	Y	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y
Loeb	Y	Y	Y	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
McGarry	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Rosen	Y	Y	Y	Y	U	Y	Y	N	N	N	U	Y	Y	Y	N	Y	Y	Y	Y	Y
Strong	Y	Y	Y	N	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y
Thomas	Y	Y	Y	Y	N	Y	Y	Y	N	Y	Y	Y	Y	N	Y	Y	Y	Y	N	Y
Van der Elst	Y	Y	Y	N	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Wylie	Y	Y	Y	Y	N	Y	Y	N	U	U	U	Y	Y	N	N	Y	Y	Y	N	N
Young	Y	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y

Table 5.6: Risk of bias for Qualitative Studies

	Does the study address a clearly focused research question	Was the choice of qualitative method appropriate	Was the research design appropriate to address the aim of the research	Was the recruitment strategy appropriate to the aims of the research	Was the data collected in a way that addressed the research issue	Has the relationship between researcher and participants been adequately considered	Have ethical issues been taken into consideration	Was the data analysis sufficiently rigorous	Is there a clear statement of findings	How valuable is the research
Hawala-Druy	Y	Y	Y	Y	Y	U	U	U	Y	U
Van der Elst	Y	Y	Y	Y	Y	U	Y	Y	Y	Y

5.3.3: Training content

The content of the training can be grouped under the following five topics: key terms and terminology, stigma and discrimination, sexuality and sexual dysfunction, sexual history taking, LGBT specific health and health disparities. The Kenyan study specifically addressed the health of men who have sex with men (MSM) in sub-Saharan Africa.(284) All the training with the exception of two studies (272, 281) involved multiple topics, the maximum reported in any study was four. Information was not available on the depth and extent to which the topics were discussed.

Eight of the articles reported teaching key terms and terminologies, mostly related to gay and lesbian terms (271-273, 275-279) these studies were mostly from interventions carried out over ten years ago. Only four of the recent articles (275, 278-280) talked about trans related terminologies.

Stigma and discrimination related to expression of sexuality was discussed in eight studies (271, 275, 277-280, 283, 284). The content ranged from stereotyping of sexual minority populations, cultural and religious bias in some communities to the emergence of new non-discriminatory policies based on the healthcare equality index in the USA.(278)

In seven of the studies, the students were taught human sexuality (272-274, 276, 277, 282, 285). This was often done in conjunction with disease states such as sexual dysfunction, sexual problems and STI/HIV. Sexual history taking was a key feature of training for medical residents and one of the commonly recurring topics in the reviewed studies; however the effectiveness of this particular component of training was rarely assessed (271, 273, 274, 280-283, 285).

Healthcare issues specific to LGBT people were discussed under the following headings: HIV/AIDS and other STI (284, 285), primary care issues (271, 275, 284), sexual dysfunction

(277, 282) and barriers to healthcare.(282, 283) The study carried out in Kenya provided training on MSM specific healthcare including mental health (284). Transgender healthcare featured in three studies published in 2008 and 2015.(275, 278, 279) LGBT health disparities featured in only two curricula. (279, 280)

5.3.4: Trainers

In all but one study, the training was hosted and developed by universities and the facilitators/trainers were faculty in the institutions. The exception was the study carried out in Kenya where the training was carried out by an MSM counsellor, a community liaison officer, a social scientist, a senior research counsellor and two MSM who were members of a local non-governmental organization. In five studies, people from the LGBT community had been involved in the design or facilitated the training (271-273, 275, 279). [see Table 5.4]

5.3.5: Time allotted

A wide variation was reported in time allotted for the training ranging from one to forty two hours. The median was eleven hours. Six articles reported the use of four hours or less (275, 278, 279, 281-283) while in five studies more than twenty fours was devoted to training.(274, 276, 277, 280, 285) It was impossible to make any useful deduction using time allotted for training and outcome of training in this review because the number and type of topics used in the training varied. (see Table 5.4)

5.3.6: Pedagogical method

Most curricula used multiple training methods. All but three (275, 280, 281) interventions delivered some content in the form of didactic lectures and two articles reported using only didactic lectures.(276, 279) Other teaching and learning approaches reported by the articles were: small group discussions followed by student presentations or summaries of group

discussion(271, 273-275, 277, 280, 282, 284, 285); social events [film and documentary screenings, educational games, multimedia presentations and social gathering] (271, 272, 274, 280, 283-285) and clinic based methods such as patient interviews, shadowing and case reviews (271, 274, 275, 281-283). Other methods less frequently used were role play (271, 273, 274, 281), panel sessions (272, 282), pre-reading of study materials (272) and seminars (277, 283) (see Table 5.7).

Table 5.7: Summary Table for Training

Author, year & country	Topics	Hours allotted	Methods	Trainers
Bauman 1985, USA	Key terms & terminologies, Stigma & discrimination, Sexual history taking, LGBT health	11	Didactic lectures, Small group discussions, Social events, Case review, Role play	Faculty & LGBT people
Carabez 2014, USA	Key terms & terminologies, Stigma & discrimination, Sexual history taking	2	Didactic lectures, Readings, Instructions	Faculty
Carmichael 1977, USA	Sexuality & sexual dysfunction	10	Didactic lectures, Social events, Panel discussion, Pre-reading	Faculty & LGBT people
Hawala-Druy 2012, USA	Stigma & discrimination, LGBT health	42	Didactic lectures, Social events	Faculty
Hawton 1979, UK	Key terms & terminologies, Sexuality & sexual dysfunction, Sexual history taking	12	Didactic lectures, Small group discussions, Social events, Role play	Faculty & LGBT people
Johnson 2015, USA	Sexuality & sexual dysfunction, Sexual history taking, LGBT health	26	Didactic lectures, Small group discussions, Social events, Shadowing, Role play	Faculty
Kelly 2008, USA	Key terms & terminologies, Stigma & discrimination, LGBT health	2	Small group discussions, Patient panel	Faculty & LGBT people
Loeb 2010, USA	Sexual history taking	4	Case studies, Role play	Faculty
McGarry 2002, USA	Key terms & terminologies, Stigma & discrimination, Sexual history taking, LGBT health	3	Didactic lectures, Social events, Case discussion, Seminar	Faculty
Rosen 2006, USA	Sexuality & sexual dysfunction, Sexual history taking	3	Didactic lectures, Small group discussions, Patient interview, Panel discussion	Faculty
Strong 2015, USA	Key terms & terminologies, Stigma & discrimination, LGBT health	1	Didactic lectures,	Faculty & LGBT people

Thomas 1980, USA	Key terms & terminologies, Sexuality & sexual dysfunction	34	Didactic lectures	Faculty
Van der Elst 2013, Kenya	Stigma & discrimination, LGBT health	16	Small group discussions, Social events	Non faculty & MSM
Wylie 2003, UK	Stigma & discrimination, Sexuality & sexual dysfunction	24	Didactic lectures, Small group discussions, Seminar	Faculty
Young 1989, USA	Key terms & terminologies, Sexuality & sexual dysfunction, Sexual history taking	24	Didactic lectures, Small group discussions, Social events	Faculty

5.3.7: Quantitative Outcome Measures

Data available describes the direction of change in knowledge, attitude and practice of the subjects measured either directly or indirectly (see Table 5.5).

Knowledge – Seven studies measured change in participants' knowledge regarding the following topics: sexuality and sexual dysfunction (273, 274, 277), LGBT health related issues (274, 279, 284), key terms and terminologies.(278) Most of the studies did not teach the students about transgender health. All the studies reported a statistically significant improvement in knowledge immediately after the training and during the three months follow up evaluation.

Attitude – Thirteen studies reported change in attitude focusing on accepting sexuality (272-274, 276), masturbation (273, 276, 284), homosexuality (271-273, 275, 276, 279, 284, 285) and level of comfort/cultural competence.(280, 283, 284) Development of a positive attitude towards homosexuality was the most measured component. Attitudes towards transgender people were not mentioned by the articles. The instruments for attitude varied thereby making it impossible to determine which of the interventions was most effective regarding attitudinal

change. However all the articles documented a statistically significant increase in acceptance of LGBT people and sexuality related issues except for one study which did not provide information.(274)

In the non-randomised studies, pre-intervention attitudinal scores for the control group indicated negative attitude towards LGBT people.

Practice – One study assessed change in behaviour among medical residents in the USA. This was measured indirectly through the documentation and content of sexual history in patient charts. An overall improvement was reported, specifically with regards to current sexual activity, number of current sexual partners and gender of current sexual partners. However documentation of gender of sexual partners over their lifetime, history of specific sexually transmitted infections and sexual behaviour were still judged to be inadequate after intervention.(281) None of the publications mentioned training participants to record the Sexual Orientation and Gender Identity (SOGI) of patients, in order to improve national electronic health records.

Table 5.8: Summary for Outcomes

	Bauman	Carabez	Carmichael	Hawala-Druy	Hawton	Johnson	Kelley	Loeb	McGarry	Rosen	Strong	Thomas	Van der Elst	Wylie	Young
Knowledge															
Sexual health information					↑	↑								↑	
Sexual orientation		↑									↑				
Gender identity		↑									↑				
LGBT health							↑				↑		↑		
Attitude															
Accepting sexuality			↑		↑	↑						↑			
Masturbation			↑		↑							↑			
Homosexuality	↑		↑		↑		↑		→		↑	↑	↑		↑
Level of comfort and/ cultural competence				↑			→		↑				↑		
Practice															
Sexual history documentation								↑							

↑: statistically significant improvement; →: no statistically significant change; Rosen did not capture the same data pre/post

5.3.8: Qualitative outcomes

The qualitative studies were based in the USA and Kenya.

Two main themes were identified from the qualitative studies: the process of changing values and attitudes to be more LGBT inclusive, and the constraints to the application of new values in practice.

1.Changing values and attitudes: Both qualitative publications note that, after intervention, participants talked about the changes that had taken place as a result of the information they received.(280, 286) The US study gave examples of data where students initially held negative views (e.g. "*My aunt left three daughters to live with another woman, please explain to me why? She loved me, I was so close to her but that is against my religious belief.")* but then modified their views and behaviours afterwards to be more inclusive, in this case re-contacting

the estranged aunt. In the Kenyan study, participants were empowered to clarify their role and responsibilities as a professional, as being distinct from their role as an individual citizen, which was reflected in their attitude and practice in the workplace. As one of the participants from the study noted post-intervention:

"As a clinician, my duty is to treat without imposing my values on the patient. That's the positive thing I got from (the training program) and it's what I'm doing now"(286).

2. Constraints to application of values in practice: Both studies (US and Kenya) noted pre-existing cultural and religious prejudice against LGBT people or specifically MSM in African communities ("*How can I accept them (LGBT)? I can still hear the drums from my church days.".(280)* "*MSM are unheard of in the place I come from"(286)*); the experience of secondary stigma against the health facility from the community and against trained staff from professional colleagues (*"You know MSM, as he had mentioned, are regarded as outcasts. Therefore, if you offer to treat them in your clinic, the community will perceive it as ... the clinicians are also MSM"(286)*); inadequate training of healthcare providers and lack of tools and guidelines to support staff ("*Most of the medical personnel are not sensitized on issues to do with anal STIs and they are also not indicated in the STI charts(286)).* Finally, the Kenyan study noted that other pressures may limit the possibility to implement changes: *"You may want to give the best, but the patients and the workload are too much"(286).*

5.4: Discussion

This review assessed all the studies published up to December 2015, which evaluated curricula and non-curricula based training programs for LGBT-related health, specifically for training healthcare students and postgraduate healthcare providers. A systematic review methodology

was performed to enable a wide and thorough search of available studies and to extract and synthesize the study results in a robust way.

Some elements of measurement bias were observed in the studies. The measurement of outcomes did not cover all the topics that were taught in most of the studies and sexual history taking was rarely assessed. It is unclear how the authors made a decision on what was considered important enough to be measured. A huge gap, therefore, exists in determining the effectiveness of the interventions with regards to the various topics used for training.

Heterogeneity of topics in the training and the instruments used to measure outcomes precluded pooling of the results, hence the efficacy of the training could not be ascertained in a meta-analysis. Our main finding is the lack of a unified conceptual model for training with regards to duration, the content, the time allotted and training methodology. The evidence is therefore inconclusive.

A reoccurring recommendation from the articles was the integration of sexual health and LGBT health into the main curriculum as compulsory block postings for medical, nursing and allied healthcare students at undergraduate and postgraduate level. This stems from the positive feedback received from attendees following training. This proposed integration would increase the number of teaching hours allotted, allow faculty to increase the number of topics and promote the use of a variety of teaching methodologies. All students would also be exposed, rather than the few who choose such courses as electives, thereby paving the way for a more rigorous curriculum evaluation.

From the review, topics on transgender health only featured in the more recent articles which is not surprising. LGBT health is a rapidly evolving field and a lot of providers are unfamiliar with the terminologies, protocols, and recommendations for providing quality care. This could

be one of the underlying factors preventing them from teaching their students. Two issues require addressing in order to identify the root causes of the deficiency in training: the availability of an integrated curriculum for teaching and the availability of competent faculty.

To impact the required knowledge, skills and attitudes needed to provide comprehensive LGBT healthcare, sixteen topics have been recommended for medical colleges including chronic disease risk, unhealthy relationships, coming out, substance use, adolescent health, body image, transitioning and sex reassignment surgery.(287, 288) However, the way these topics are used in curricula should be adapted to suit local context.(289) In our review, the maximum number of topics taught in any training was four which is inadequate to achieve competency. More broadly, a high proportion of medical schools in the USA have been reported to lack formal curricula for teaching sexual health related topics(290) while public health schools did not address comprehensive LGBT healthcare in their planned curriculum.(291) Although considerable improvement has occurred over the years with regards to the number of institutions and the content of sexual and LGBT health taught in medical schools (292), a disturbingly high proportion of medical students and practicing health care providers have received minimal or no training on LGBT health.(293, 294) It is therefore not surprising that the authors of the studies included in this review consistently recommended that sexuality and LGBT healthcare courses should be mandatory to ensure that all healthcare students are exposed to the training.

In the last two decades, the time allotted for teaching LGBT-related topics has increased from a mean of two hours to five hours in the USA.(295, 296) The median recorded in this review was considerably higher and each of the interventions reported positive findings in relation to a short-term improvement in knowledge, attitude or practice.

Guidelines and training resources on LGBT healthcare(287, 296-299) are available for healthcare providers to improve their knowledge and skills, however, they have not been rigorously evaluated. Although these resources may be used as part of a curriculum, they cannot be used as a complete substitution for a formally integrated competency based training of the health workforce. Moreover, the reach of these resources is limited in low and middle-income countries. In some non-western countries, general attitudes are not inclusive or tolerant towards people who identify as LGBT;(126) this prejudice will influence the willingness to search for and use the resources to acquire knowledge and skills.

Five out of the sixteen studies involved people from the LGBT community in the design or facilitation of training. It is likely that training is enhanced through the direct input of LGBT people who are likely to have a strong awareness of the barriers towards accessing health care within the LGBT community.(288) However, it may be a challenge to recruit LGBT people to participate in curriculum development and implementation in countries with LGBT criminalizing laws.

In countries with criminalizing laws, evidence of effective interventions to improve access to healthcare services for the LGBT population is scarce. In these countries, stand-alone clinics providing specialized services to the LGBT community exist, manned by specially trained competent service providers and maintained by developmental partners/donors. This strategy can only be a temporary solution. There is limited access because these clinics are unavailable in most cities and rural areas, they are expensive to run and therefore not sustainable without external funding. The staff and clients also run the risk of being targeted for violent acts by people who hold negative views of the LGBT population. They further exacerbate the social exclusion of sexual minorities by keeping them outside the formal health sector.

The only way to ensure equitable access to services for all is to train all healthcare providers to be culturally confident (126, 275, 278) and equip them with appropriate knowledge and skills.(274, 282) The mainstream healthcare facilities and public health sector will then be able to provide competent and affirming care to clients and patients accessing services.

The Kenyan study, demonstrated the effectiveness of an intervention comprised of two teaching methods: web based self-directed learning modules, and group discussions. The participants were HCPs performing clinical and administrative roles in facilities providing antiretroviral services. These trainees cut across HCPs from government health facilities, faith-based organizations and NGOs. This is important within the African context where studies have shown that MSM clients report instances of discrimination from providers in public health facilities. In this review, this is the only study that mentioned training of providers in faith-based organizations.

In keeping with recommendations for best practices, the trainers were diverse in composition, made up of a team of: community liaison officers, AIDS/STI coordinators, research counsellors, MSM staff field officers, a social scientist, and members of a local LGBTI organization. The training took place over a period of two days. It took 8 – 16 hours to complete the modules, but it is unclear how long it took for each of the 4 discussion sessions. The topics treated were: MSM and HIV in sub-Saharan Africa; stigma; identity, coming out and disclosure; anal sex and common sexual practices; HIV and sexually transmitted infections; mental health, anxiety, depression and substance abuse; condom and lubricant use; and risk reduction counselling.

Multiple levels of assessment for the outcomes were carried out. For knowledge, this was at baseline, at the end of each module, immediate post-course and three months afterwards. For attitude, baseline and 3 months post training measurement was done with an adapted

homosexuality scale. In addition, study participants with a clinical role kept a journal for three months to reflect upon their work practices and personal attitudes towards MSM

The main outcomes were improved sexual health knowledge; HCP who felt empowered to discuss MSM behaviour and anal sex in their professional work; and reduction in homophobic attitudes. This study was also able to provide a direct link between improvements in knowledge and reduction in homophobic attitudes. The limitations arise from the development of the training solely for improving the health of the MSM population, as well as the study design (Pre/post, lack of control and randomization). However, the authors demonstrated immediate and sustained changes in knowledge and attitude. HCPs with adequate knowledge decreased from 95% immediately after the course, to 49% at three months post intervention,, but this was still considerably higher than the 14% at baseline.

5.4.1: Limitations of this review and the existing literature

The majority of the studies were from the USA. The methodological quality of most of the study designs is weak and studies were at high risk of selection bias which may lead to more positive findings than in unselected populations. The long-term impact of curricula in terms of changes in attitude and actual translation of positive attitudes into clinical practice during patient contact is yet to be determined. Four of the studies were prior to 1990 and attitudes towards LGBT in westernized countries have changed since this time. I acknowledge that at the initial screening of titles and abstracts of articles, some eligible studies may have been missed which is a limitation of this systematic review.

5.4.2: Recommendations for further research

There is an urgent need for well-conducted studies evaluating LGBT health curricula, particularly in countries outside of the USA and where discrimination against LGBT people is high. There is a particular need for studies with a longer follow-up period to enable greater understanding of whether the short-term gains of LGBT health-related training that were evident from this review translate over the longer run. Future studies should use curricula that have been developed with input from national bodies and health professional training schools with input from LGBT community-based research institutes. Future research should evaluate practice, as well as knowledge and attitudes and consider the importance of specific aspects of training including components relating to sexual health.

Finally, it was beyond the scope of this paper to address questions of educational theory – and the papers that met the inclusion criteria did not focus on this issue - but it could be extremely useful as this field develops, to use multidisciplinary approaches that explore and extend educational theory to complement evaluations of the effectiveness of educational interventions, so as to better understand why certain approaches work well for particular groups and particular contexts, and how these might change over time as societal attitudes change.

5.4.3: Conclusion

This review found relatively few, generally low-quality studies where educational interventions were effective in improving knowledge, attitude and practice of healthcare students and professionals towards sexual health and LGBT health. However, it did identify potential components of effective educational interventions, which could be transferable to and adapted to different contexts. This is important given the urgent need to scale up access to good quality healthcare services to LGBT people globally and most especially in countries with laws that

criminalize sexual minorities. However, the absence of good quality studies to inform decision makers on this crucial aspect of healthcare will delay this process and prolong the health disparities currently experienced by LGBT people.

Chapter Six: Educational Knowledge, Attitude and LGBT Inclusive Training in an Academic Setting: A Mixed Methods Case Study of Faculty and Healthcare Students in Lagos, Nigeria.

6.1 Introduction

The healthcare needs of communities and nations are not static but constantly evolving. It therefore becomes imperative that the training of healthcare professionals should adapt to the changing population health profiles. This will ensure that the health workforce remains relevant, are equipped with the right competencies and can provide the highest quality of appropriate care to individuals and communities.(165, 265) The transformation and scaling up of education and training for the health workforce has therefore been adopted by the WHO as the strategy for meeting the health care needs of the 21st century.(165)

Between the time period of declassification of LGBT as a mental health disorder and recognition as people at high risk of HIV infection, there was dearth of research and publications focusing on the LGBT population most especially from the global south.(300) Generations of medical professionals graduated in Nigeria knowing little or nothing about LGBT identities whilst living in communities/societies that discriminated against sexual minorities on the basis of culture and religious views. The social and legal oppression experienced by LGBT people ensured that a vast majority kept their sexual identity hidden. This invisibility was reinforced in the health system by healthcare professionals who had never

seen an openly living LGBT faculty, student, or patient leading to inadequate training, which has been implicated in the lack of skilled providers.(301, 302)

Lack of experience with LGBT populations during training has produced healthcare providers with poor knowledge about LGBT patient care issues,(303, 304) inadequately prepared to perform a comprehensive patient history and unable to develop satisfactory patient-physician relationships with LGBT individuals, resulting in poor quality of care and unsatisfactory experiences for LGBT patients.(305-308) The eventual fall-out of this is avoidance of healthcare providers, low uptake of preventive care, late presentation for treatment, poor health seeking behaviour and underuse of health services by LGBT people.(8) As a result, LGBT people experience poor health outcomes and are at increased risk of disability and premature death.(199, 309, 310)

Knowledge, attitude and skill acquisition are interrelated.(217) A positive attitude towards LGBT patients is an essential requirement for healthcare students and providers to achieve cultural competency, and research has shown that healthcare students who are knowledgeable about LGBT people had more positive attitudes towards LGBT patients.(214, 306, 311, 312) Efforts at promoting health equity for the LGBT population led to a critical evaluation of the curriculum and training for healthcare professionals in the USA.(296) Evidence generated from this evaluation revealed that healthcare students are either not receiving any education on LGBT health or the training is deficient in some key areas.(296) Globally, the number of hours dedicated to teaching LGBT health and sexual health topics has remained below optimum.(296, 313)

Even in countries with supportive policies, LGBT students and faculty have been victims of a negative institutional culture and in several instances have had to hide their sexual orientation,

resulting in the loss of opportunity of colleagues to achieve attitudinal change through positive contact experience.(314) Legal protection has not effectively ended stigma and discrimination in most societies.(315, 316) Omission of LGBT people in patient cases as teaching examples, also serves as an inhibitory signal to LGBT healthcare students and faculty.(317, 318)

In sub-Saharan Africa (SSA), there is dearth of data and research around this issue. A review of faculty in a South African health sciences faculty revealed the absence of LGBT health-related topics in the allied health student's curriculum as well as lack of an integrated approach to teaching LGBT health topics for medical students.(319) In spite of the negative social environment, reports from training programmes specifically designed to increase knowledge of healthcare professionals and provide contact with LGBT people in SSA showed a reduction in bias and increased comfort in providing healthcare services to the LGBT patients.(286)

6.1.1: Theoretical model: The socio-ecological model

The culture of the society, political system, health service organization and healthcare provider exist in a continuum.(320) The guiding framework for this study is the socio-ecological model.(321-323) At the hub of ecological models is the interaction between humans and their physical and sociocultural environment.(324) The socio-ecological model considers broader social influences including community, organizational and policy on health behaviours. This is in addition to individual characteristics, peer and family interactions. The model therefore provides a comprehensive approach to studying health related behaviour and a detailed insight to multilevel correlates. The socio-ecological model posits that for substantial change in behaviour to be maintained, a combination of individual, policy and environmental level interventions are required.(324) To gain insight to levels of intervention required for change, this model is used in this mixed methods study to explore and analyse the multilevel factors

influencing the attitudes toward LGBT people, teaching of LGBT health topics, healthcare delivery by students and faculty (academic staff), and the prevailing environment in Nigeria that shapes behaviours and access to healthcare services by LGBT individuals..

6.1.2: Aim and Specific Objectives

To assess the knowledge, attitude and teaching of LGBT related health topics among faculty and healthcare students in the College of Medicine, University of Lagos (CMUL), Nigeria.

1. To determine knowledge of LGBT related terminology among faculty, medical and nursing students in CMUL.

2. To determine the attitudes of faculty, medical and nursing students in CMUL towards LGBT people and LGBT patients.

3. To identify the content, allotted time and mode of delivery of teaching about LGBT related health topics by faculty in CMUL.

4. To identify barriers and facilitators to effective delivery of LGBT related health topics in CMUL.

6.2: Methods

6.2.1: Description of study area

CMUL was founded in October 1962 to train healthcare personnel and to conduct research into health related problems. The college has three faculties: Basic Medical Sciences, Clinical Sciences and Dental Sciences and 32 departments. As at the time of applying for ethical approval in 2017 for the study, CMUL had a student population of almost 2000 students and a staff strength of 1,850.(325)

The faculty of Basic Medical Sciences had ten departments namely: Anatomic and molecular pathology, Pathology, Anatomy, Biochemistry, Biomedical engineering, Medical laboratory science, Medical microbiology and parasitology, Pharmacology, Therapeutics and toxicology and Physiology.

The faculty of Dental Sciences had five departments namely: Child dental health, Oral pathology/biology, Oral and maxillofacial surgery, preventive dentistry and Restorative dentistry.

The faculty of Clinical Sciences had thirteen departments namely: Anaesthesia, Clinical pathology, Community health and primary care, Haematology and blood transfusion, Medicine, Nursing, Obstetrics and Gynaecology, Ophthalmology, Paediatrics, Physiotherapy, Psychiatry, Radiation Biology and Surgery. The faculty of Clinical Sciences was used for the study because the faculty and students were more likely to have patient contact and manage conditions more prevalent in LGBT people.

6.2.2: Study population

a. Tutors in Faculty of Clinical Sciences

There were 173 faculty members; Anaesthesia 7, Clinical pathology 5, Community health and primary care 24, Haematology and blood transfusion 8, Medicine 23, Nursing 5, Obstetrics and Gynaecology 13, Ophthalmology 5, Paediatrics 14, Psychiatry 8, Physiotherapy 16, Radiation Biology 22, and Surgery 23.

b. MBBS and Nursing students in their fifth year of training (known as 500 level); there were 144 MBBS and 68 Nursing students in 500L.

6.2.3: Sample size

All the Tutors in Faculty of Clinical Sciences and all the 500 level MBBS and Nursing students.

6.2.4: Sampling technique

No sampling required.

6.2.5: Questionnaire design

The questions and statements were adopted from the American Psychological Association definition of LGBT terminologies used by Parameshwaran et al 2017,(326) and four questionnaires: the attitudes towards Gay, Lesbians, Bisexual women and Bisexual men questionnaire,(303) the Attitudes Toward Transgendered Individuals Scale (327); the Attitudes Toward LGBT Patients Scale (328) and readiness to practise with LGBT patients questions.(319) The attitude section contains validated statements from previous studies. The list of 13 topics related to LGBT health was adapted from a previous study assessing University of Cape Town's medical curriculum.(319) The questionnaire was pretested in Lagos State University College of Medicine (LASUCOM), no changes were made to the questionnaire content [see appendix 4].

6.2.6: Data collection

For this study, the quantitative data were collected and analysed before the qualitative data collection..(329) The quantitative results were used to generate topic prompts and questions which were incorporated into the interview guide for the qualitative data collection. In the first phase quantitative information was collected from the tutors and students with a self-administered questionnaire using a cross sectional survey. In view of the fact that the students had completed their lectures, the investigator recruited the class captains as the research

assistants for the study. To advertise the study to their colleagues, the class captains sent What's App messages and bulk SMS texts providing a brief introduction of the study and invitation to participate to their colleagues. A seminar room was designated for students to use between 9.00am to 1.00pm over a period of five working days. Students could go to the room and pick up a copy of the questionnaire with the informed consent form and an unlabelled envelope. The student completed the questionnaire, put it in the envelope, sealed it and dropped it into a collection box before leaving. The class captain sent reminders to his colleagues regularly. After the first wave of participants (at the end of the five days) the recruitment strategy was amended due to low turnout. To encourage participation, questionnaires were put in envelopes and the class captains took the envelopes to the hostels and distributed them to willing individuals during room to room visits. The students were able to complete the questionnaires in their own time, place them into the sealed envelope, which was picked up by the class captain at an arranged time and venue.

The faculty members were informed about the study using an approval letter obtained from the Dean's office. Interested faculty members were given the questionnaire and the informed consent forms in separate envelopes. Questionnaires were distributed and returned to the department through the departmental secretary/representative in unlabelled sealed envelopes. For faculty members who were unavailable, the departmental secretary sent copies via email. Those returned by email were downloaded and printed and placed immediately into an unmarked sealed envelope. I opened the envelopes and collated the questionnaires. However, I was invited to address faculty at some department meetings on the objective of the study, some individuals also sent their envelopes directly to the researcher while some requested for individual one-on-one meetings to clarify some grey areas. Quantitative data collection took place from February to May 2018.

In the second phase, qualitative data collection to explore deeper understanding of the drivers of teaching and learning about LGBT health took place after the analysis of the quantitative data. The six levels of a modified socio ecological model were used to contextualise and generate ideas. Eleven faculty members from seven departments, four nursing students and six medical students were interviewed. To select faculty members for the interviews, I made phone calls to individuals who confirmed they participated in the quantitative study and invited them for interviews; conscious attempt was made to ensure inclusion of seven out of the thirteen departments and for gender representation. Selection of students was carried out by the student representative, attempts were made to include individuals who participated in the quantitative survey, people with diverse opinions on LGBT issues and gender equality.

The interviews took between 30 to 50 minutes, they were audio recorded with permission. The interviewer took field notes which were also analysed. The recordings were transcribed by a researcher assistant well versed in conducting qualitative interviews for an NGO providing services to LGBT populations in Lagos, checked for consistency and recordings destroyed. Data for faculty and students were analysed separately using thematic analysis. The process was inductive and commenced with coding, review of the codes, refining to generate the lean codes, generation of categories, review and generating a condensed codebook and thematic tables. This ensured identification of relevant themes and concepts. Data collection took place between June and July 2018.

The data from the quantitative and qualitative surveys were analysed separately before they were integrated and synthesized. The synthesized findings are presented in the results session.

6.2.7: Quantitative Data analysis

Quantitative data was analysed with IBM SPSS [version 20]. Knowledge and attitude questions were scored and graded. Knowledge questions carried a score of one for every correct answer with a maximum score of 22; participants who scored below the mean were classified as having poor knowledge.(330) Attitude statements were scored using a 5-point Likert scale; for each statement, the maximum score was 4 with the higher scores representing a positive attitude. Respondents who scored above the mean were classified as possessing a positive attitude.

6.2.8: Ethical considerations

The participant information sheet was produced and incorporated into the informed consent documentation.

Ethical approval for the study was obtained from the CMUL Health Research and Ethics Committee CMUL/HREC/08/17/240 (see appendix 5) and University of Birmingham Ethics Committee (ERN_17-1538). Permission was obtained from the Provost, the Dean Faculty of Clinical Sciences and all the Head of Departments in the Faculty of Clinical Sciences. Participation was voluntary. Written informed consent was obtained from the students and faculty. To protect the study participants, personal information such as gender and sexual orientation were not collected. To ensure that the students were not coerced into participating in the study the following steps were taken: none of the student's teachers were involved in data collection, analysis or write-up. Even though I am a faculty member in CMUL, I did not give any lectures to the 500L students and was not involved in setting exam questions, invigilating or marking scripts during the 2017/2018 academic session when data collection took place.

6.3: Results

The response rate was 88.2% for MBBS students (127/144), 66.2% for nursing students (45/68) and 60.7% for faculty (105/173).

6.3.1 Socio-demographic characteristics of respondents to the questionnaire

The students were predominantly young people below 25 years of age (86.0%), while the faculty were mainly married (88.6%) older people (85.7% were 40 years and above) who had been teaching for over 5 years (74.2%). Most of the respondents (students and faculty) were Christians (more than 85%), held religion in high esteem and belonged to the Yoruba ethnic group. [Table 6.1]

Table 6.1: Characteristics of the participants at the quantitative survey

Students (n=172)	**Frequency (%)**	**Faculty (n=105)**	**Frequency (%)**
Age (years)		**Age (years)**	
20 – 24	148 (86.0)	30 – 39	9 (8.6)
≥25	21 (12.3)	40 – 49	51 (48.6)
Non response (NR)	3	≥50	39 (37.1)
		Non response (NR)	6
Range 20 – 45 years, Mean 22.68±3.05		Range 30 – 67 years, Mean 49.06±8.44	
Religion			
Christianity	149 (86.6)	Christianity	95 (90.5)
Islam	23 (13.4)	Islam	10 (9.5)
Importance of religion			
Very important	133 (77.3)	Very important	79 (75.2)
Important	33 (19.2)	Important	22 (21.0)
Not important	6 (3.5)	Not important	1 (1.0)
		NR	3
Attendance at religious events			
Weekly	126 (73.3)	Weekly	81 (77.1)
Daily	17 (9.9)	Daily	8 (7.6)
Others	29 (16.8)	Others	16 (15.3)
Ethnicity			
Yoruba	101 (58.7)	Yoruba	82 (78.1)
Igbo	48 (27.9)	Igbo	18 (17.1)
Others	23 (13.4)	Others	5 (13.4)
Department			
MBBS	127 (73.8)		
Nursing	45 (26.2)		
		Marital status	
		Married	93 (88.6)
		Single	4 (3.8)
		Others	8 (7.6)
		Years as faculty	
		<5	20 (19.0)
		5 – 9	37 (35.2)
		≥10	41 (39.0)
		NR 7	7
		Mean 11.10 ± 8.24	

6.3.2: Socio-demographic characteristics of the participants of the in-depth interviews

Ten students (four from the department of nursing and 6 from 500level MBBS class) and eleven faculty (from seven departments in the faculty of clinical sciences) participated in the interviews. Most of the interviewees were female. [Table 6.2]

Table 6.2: Characteristics of the qualitative interview participants

Student (n=10)	**Faculty (n=11)**
Department n%	**Department n%**
Nursing – 4 (40)	Paediatrics – 2 (18)
MBBS - 6 (60)	Obstetrics & Gynaecology – 2 (18)
Age	Community Health & Primary Care – 2 (18)
21years – 3 (30)	Psychiatry – 2 (18)
22 years – 4 (40)	Physiotherapy – 1 (9)
23 years – 3 (30)	Nursing – 1 (9)
Sex	Surgery – 1 (9)
Male – 2 (20)	**Sex**
Female – 8 (80)	Male – 5 (45)
	Female – 6 (55)
	Position
	Lecturer 1 – 2 (18)
	Senior lecturer – 6 (55)
	Professor – 3 (27)

6.3.3: Integration of qualitative and quantitative results

Quantitative data analysis generated five tables. Qualitative analysis of the data generated five themes and seventeen categories. These are described in table 6.3.

Table 6.3: Table titles and Qualitative Themes

Quantitative result	**Qualitative result**
Table 4: Teaching about LGBT health	Theme 1 – Teaching and learning about LGBT health topics *Categories* *a. Current practice with regards to teaching and learning* *b. Concerns regarding teaching and learning about LGBT topics within the culture of silence and a criminalizing law* *c. Recommendations for effective training and integration of LGBT health into the curriculum*
Table 5: Knowledge of LGBT Related Terminologies	Theme 2 – Faculty and students' perception of same-sex sexual behaviour and LGBT identity *Categories* *a. Knowledge of LGBT terminologies among faculty and students* *b. Curiosity to know more about LGBT people*
Table 6:	

Attitudes towards Gay, Lesbian, Bisexual Women and Bisexual Men Table 7: Attitudes towards Transgender People	Theme 3 – Multilevel and multidirectional influences of attitude towards sexuality related issues and LGBT people *Categories* *a. Hiding, do they exist* *b. Perception of LGBT Identity* *c. Acceptance of LGBT people – The path to transitioning for non-LGBT individuals* *d. Culture of silence and religious beliefs as determinants of African socialization*
Table 8: Attitudes towards LGBT patients	Theme 4 – Ethics, professionalism and personal beliefs in a conflict situation *Categories* *a. Availability of safe spaces in health facilities* *b. Conflicting heart, trying not to feel it, trying not to let it show within the context of service provision to a hidden population* *c. Intersectionality: Faculty and students as healthcare professionals with religious and cultural beliefs* *d. Distrust and perception of rejection from healthcare provider* *e. Access to healthcare services for LGBT people in Nigeria* *f. Recommendations for Healthcare professionals on service provision to LGBT people*
	Theme 5 – Advocacy, Laws and Rights as tools for reducing LGBT health disparity *Categories* *a. Advocating for inclusive training of healthcare professionals and non-discriminatory healthcare* *b. The rights of non-LGBT people*

6.3.4. Theme 1: Teaching and learning about LGBT health topics

One fifth of faculty reported using LGBT examples in class during teaching, while over a third expressed interest in doing so. Faculty who mentioned the topics in class reported that they featured under abnormalities/diseased states. [Table 6.4] A quarter of the students had attended lectures where the following topics were mentioned: definition and theories of sexual

orientation, HIV and sexually transmitted infections in LGBT people. For the students, the least addressed topics were homophobia, sex reassignment surgery and transitioning. The commonest teaching methods were tutorial, seminar and didactic lecture.

Table 6.4: Teaching on LGBT topics

Topic	**Yes Frequency (%)**		**Teaching method**
	Student	**Faculty**	
Definition and theories of sexual orientation	43 (25.0)	6 (57)	Tutorial, seminar, didactic lecture, discussion
Homophobia, heterosexism	16 (9.3)	3 (29)	Tutorial, seminar, didactic lecture, clinic, ward-round
Barriers to access to health care for LGBT people	21 (12.2)	5 (48)	Tutorial, didactic lecture, discussion
Alcohol, tobacco, or other drug use by LGBT people	18 (10.5)	6 (57)	Tutorial, didactic lecture, ward round, group project
Safer sex for LGBT people	20 (11.6)	5 (48)	Tutorial, seminar, didactic lecture
HIV in LGBT people	47 (27.3)	7 (67)	Tutorial, seminar, didactic lecture, ward-round, group project
Other sexually transmitted infections in LGBT people	34 (19.8)	6 (57)	Tutorial, seminar, didactic lecture, discussion, ward-round
Chronic disease risk for LGBT populations	19 (11.0)	5 (48)	Tutorial, seminar, didactic lecture
Disorders of sex development (DSD)/Intersex	26 (15.1)	10 (95)	Tutorial, seminar, didactic lecture, discussion, clinic, ward-round
Transitioning (e.g. male-to-female, female-to-male)	14 (8.1)	5 (48)	Tutorial, seminar, didactic lecture
Sex reassignment surgery / Gender affirming treatment	11 (6.4)	6 (57)	Tutorial, seminar, didactic lecture
LGBT adolescent health	16 (9.3)	3 (29)	Tutorial, seminar, didactic lecture
Mental health in LGBT people	18 (10.5)	3 (29)	Tutorial, seminar, didactic lecture

Current practice with regards to teaching and learning: By providing an opportunity for people to express their feelings about an issue not commonly discussed in Nigeria, data collection in this study generated a buzz among medical and nursing students who reported that it was a novel occurrence.

The questionnaire has opened a lot up because after it was given to us in our hostels, in our rooms there was like there were lots of heated arguments that lasted long periods of time and everybody had their own opinion, everybody had things to say, there were things I found quite outright ridiculous, there were people who said this is okay, why are you disturbing people, there were people who said, no, this is absolutely wrong, we should kill all of them, then there were people who were, well I don't think it's right so it was a lot of back and forth, so I think it's a good time to talk about it.

Respondents at the qualitative interviews opined that teaching and learning of LGBT health related topics in the classroom was inadequate. Faculty reported not teaching LGBT related health topics in class because it was either not relevant to their specialty or because it was not included in the current curriculum for teaching healthcare students in the institution.

In the course of my practice, I do not see anything, that would take me into that and I don't give lectures around cultural issues where we'll be talking about stigma. I've never used it as an example in any of my lectures, so no, I have not had reason to talk about LGBT issues in any of my lectures. (F10)

I teach sexual dysfunction and paraphilias and that is why I have the opportunity of what, mentioning some of these things, okay, yes but it is not as if I'm going to teach them that because it's just an overview in that curriculum and that is not enough. (F6)

The students reported that LGBT topics were never directly addressed as the main focus of teaching, only occasionally mentioned in passing. The topics were mostly mentioned in relation to abnormalities or disease states.

It was just like making reference, talking about the fact that they were more associated with STDs, HIV and then the fact that most of them, maybe a lot of people have not been able to come out to get treated, so that's why there's a recycling of these disease amongst them. (S9)

.....we do sexuality from infant to adulthood. It focus both on the normal and abnormal aspects, not only on abnormality but you have to get to the abnormalities because same sex and all the rest of them, we talk about all of them. (F2)

Student's descriptions of faculty demeanour while talking about LGBT topics in class ranged from professional, to verbal and non-verbal expression of discomfort. Faculty were not explicit, rather they touched on the subject and moved swiftly on in embarrassment. Students expressed concern that some faculty were unable to teach the subject without introducing their cultural and religious beliefs.

She was showing a disgust in her facial expression, she was really angry like if she sees one of them right now she is going to fight the person that was her expression. I was uncomfortable at the beginning of the lecture but during the course of the lecture in my mind I was like me that I'm not even comfortable with it, I'm not as uncomfortable as she is…..why is she is so uncomfortable? (S1)

Despite the deficiency in the teaching, students reported that it was useful. They learned new information in class which has improved their knowledge about LGBT related health issues.

.....I found it useful because I learnt some new things, prior to that lecture, I thought there are just male, female, transgender and intersex but then I got to learn that there are other sexual identities. I also learnt in that lecture that this people are around us, they are not just in the U.S and U.K and all those European countries. It hasn't affected the way I think towards them but it has affected my knowledge. (S10)

Concerns regarding teaching and learning about LGBT health topics within the culture of silence and a criminalizing law: Within the immediate physical and social environment, both faculty and student respondents expressed concern regarding teaching and learning about LGBT health in the classroom because they considered the space unsafe. At the interpersonal level, students concern revolved around parent/guardian objection to the inclusion of the topic

as well as the tone and the energy of the presentation. Faculty however were concerned about the ability to truly teach the topics in a professional manner devoid of beliefs and values while maintaining cultural sensitivity. Knowing that everyone listening to their lectures are trying to form an opinion on whether they are biased or in support of LGBT people is a psychological stressor for the few people who teach LGBT related health topics.

> *……So the onus is going to be on whoever or however the system is going to bring in teachings on LGBT health related topics..... it should be evidence based and knowledge based but you know very well that maybe at the point of the delivery, the beliefs and thoughts would come in, we should not deceive ourselves, it will come out there, it'll come out. (F1)*

> *…….for every lecture he or she delivers concerning LGBT, there will always be this kind of bias, this thing in our mind that oh, you are saying this because you are an LGBT, we won't believe you, that kind of thing but if the person teaches they will misinterpret the person looks and em, non-verbal actions, maybe they'll think oh, he is making a pass at me or that kind of thing. (S1)*

The criminalizing law has heightened the controversy surrounding LGBT identity and made some faculty fearful of arrest by law enforcement officers if they teach LGBT related topics in the classroom. The same law also prevents LGBT individuals from accessing healthcare services to avoid arrest and imprisonment. According to the participants, the resulting invisibility of this population has made it impossible to determine their health related needs or prioritise the development of an inclusive curriculum:

> *I don't know how far I can go in the classroom that I'm discussing such a thing that I would have transgressed the law and the next class I would see police, knocking at my door because I have delivered a lecture. Therefore, I would rather not go in that direction because the law of the land says no I will not because I want to train students for globalisation by so doing incarcerate myself. (F8)*

Some faculty noted that the unaccepting culture in the wider community influenced the institutional culture. The criminalising law strengthens this culture and makes it enforceable within the institution. For faculty the law generates concerns that it might be unsafe to teach LGBT topics in the classroom. The perception of individuals within the college borne out of interpersonal interactions between faculty as colleagues as well as faculty and students was that it is unsafe to delve into LGBT related health issues. This has negatively influenced the development and delivery of an inclusive curriculum. Additionally, participants noted that poor faculty and student acceptance generates concern that the academic institution and even the classroom may not be a safe space to talk about LGBT health.

> *……the teachers themselves come from a background where this was something that was not culturally, socially acceptable…..there are some people that deep down wouldn't mind giving examples on LGBT health but they are afraid of the backlash. Once something is highly controversial like this, people are very careful. (F4)*

> *First of all, before you can be able to teach, it has to pass through various processes, administrative and all that, so that can serve as a barrier at first, and I don't know the orientation of people at the top about these issues too, they can also serve as barriers too, if you have the support of the management, it's going to be easy, you know. (S10)*

Recommendations for effective training and integration of LGBT health into the curriculum: The majority of the participants opined that at the institutional level, an inclusive curriculum is required. Additionally, availability of e-learning platforms and conferences would facilitate the search for knowledge and support development of innovative techniques and methodologies for teaching within the Nigerian context. As individuals, most faculty believed that the right attitude, devoid of religious and cultural bias, is necessary for effective teaching of the topic. The importance of teaching students about ethics and professionalism was also highlighted by faculty. Students' noted that for learning to be effective, teaching must be factual, interesting

and involve the use of engaging methodologies, while exposure to the topic should take place in several departments within the college.

> *I think we need to have conferences where we invite the general faculty to come and engage with current ideas for LGBT, LGBT rights and LGBT issues. Also at faculty conferences, whether it's basic or clinical or dental, there should be a slot addressing current health trends, in which we take global issues, climate change...so it's not just, we should not focus on one issue, there are other issues that are emerging and we need awareness about all these issues, the emerging issues in health……(F10)*

> *I just think we need to try and explain to students and medical people generally that religion and your personal beliefs are different from your profession, and you profess to serve humanity, so as a physician, you are supposed to try and preserve life in any way and you know, religion and beliefs are not to be part of your daily work ethics, I think that that's the key point that needs to be learned. (F7)*

> *Whenever they are giving the lecture, let it be LGBT, let it be known, let the nail be on the head, not on the periphery and the surface kind of lecture we normally have. (S3)*

> *I would love to spend one week in this LGBT Community Health Centre, learning about how to provide care, it will change a lot of things, if you can do that….. (S2)*

> *I feel like an LGBT class should be very interactive because a lot of people have something to say, you are going to have the Christians, the Muslims release their Bible verses and all these, every religious people come up with their own things…….(S9)*

6.3.4. Theme 2: Faculty and Students Perception of Same-sex Sexual Behaviour and LGBT Identity

The pattern of knowledge for LGBT related terms is similar among faculty and students with regards to the terms well known and those that were not familiar. However, the students were more knowledgeable about Trans related terms and a higher proportion had good knowledge overall compared to the faculty (58.7% vs 48.6%). The mean score for knowledge was similar

for students and faculty. Less than a fifth of the faculty had attended training on LGBT health either at conferences/seminar or self-directed online modules. [Table 6.5]

Table 6.5: Knowledge of LGBT Related Terminologies

Terminology	Knows the meaning Student (n = 172)	Knows the meaning Faculty (n = 105)
Bisexual	144 (83.7)	89 (84.8)
Biphobia	48 (27.9)	24 (22.9)
Cisgender	17 (9.9)	15 (14.3)
Cisnormativity	14 (8.1)	11 (10.5)
Gender Identity	91 (52.9)	58 (55.2)
Heterosexual	136 (79.1)	87 (82.9)
Heterosexism	52 (30.2)	34 (32.4)
Heteronormativity	23 (13.4)	14 (13.3)
Homosexual	153 (89.0)	94 (89.5)
Homophobia	114 (66.3)	59 (56.2)
Micro-aggression	20 (11.6)	20 (19.0)
Sexual orientation	119 (69.2)	82 (78.1)
Lesbian	161 (93.6)	99 (94.3)
Gay	162 (94.2)	99 (94.3)
Bisexual men	153 (89.0)	90 (85.7)
Bisexual women	151 (87.8)	88 (83.8)
Trans	130 (75.6)	61 (58.1)
Transgender	150 (87.2)	82 (78.1)
Transphobia	81 (47.1)	28 (26.7)
LGBT	105 (61.0)	71 (67.6)
Queer	45 (26.2)	44 (41.9)
Queerphobia	30 (17.4)	21 (20.0)
Knowledge Score	Student Mean 12.27 $\pm$ 4.19	Faculty mean 12.10 $\pm$ 5.03
Knowledge Grade (scores above the mean are classified as good)	Student Good 101 (58.7) Student Poor 69 (40.1)	Faculty Good 51 (48.6) Faculty Poor 54 (51.4)

Knowledge of LGBT terminologies among faculty and students: Poor knowledge of LGBT related terms by faculty was ascribed to reservations about its inclusion in regular conversation and the curriculum. At the individual level, cultural and religious bias against any form of deviance from heterosexuality inhibits faculty from talking about it, teaching it in class and actively seeking for knowledge improvement. However, faculty felt that a positive attitude promoting knowledge could remove this hindrance to teaching.

> *Nigerian, irrespective of your educational level, we are still modulated by our culture and our religion, if you really look at most of those terminologies, it's like a taboo for*

you even to go and check the meaning, they don't even want to let it get integrated in their brain. (F8)

Students reported not receiving enough information in the classroom. They expressed the opinion that training of faculty on LGBT health issues was deficient, which limited their ability to address the topic properly. For this group, the media was an important though sometimes unreliable source of information on LGBT issues.

…….Just one thing, that one statement that you have to care for people equally, aside from that there's no solid knowledge or tangible knowledge that we've learnt concerning LGBT so far…..even way back, when even our lecturers when they were in school, they were not taught this LGBT, so they don't even have a tangible knowledge about this LGBT too ….. (S2)

Most of the knowledge available to us here as medical students is what we see on the internet and by the time it's getting to us, it has been em, you know, I would not say tainted but it has been modified by our cultural beliefs, our religious beliefs and we are interpreting it in the Nigerian sense of the word. (S8)

Some faculty were of the opinion that the students might be more knowledgeable of LGBT terms than their lecturers. This suspicion was confirmed by quantitative data: 58.7% of students compared to 48.6% of faculty had good knowledge.

I wouldn't be surprised even if the student can even have more knowledge of it than the faculty because the faculty is being very careful……(F8)

Curiosity to know more about LGBT people: Faculty and students expressed the desire to know more about LGBT people. The curiosity revolved around their social life and interpersonal relationships and not particularly about health related issues. For respondents who knew an LGBT person personally, they had attempted to acquire more knowledge and understanding by asking questions directly. Completing the study questionnaire was reported to have generated discussion among the students about perceived deficiencies in their

knowledge. In seeking correct information some students highlighted the need for local research to gather evidence and shed more light on the phenomenon.

> *I remember even that day I had to ask one of them who was quite friendly, I remember taking him to one side, even me asking questions to try and understand what is going on, how are you, how is your family responding, I remember him saying his church has kicked him out and things like that, so I was even trying to understand the reason for their choices and what they were experiencing……(F4)*

> *First of all, I'll like to know if possible the basis for it ... the reason and if it is something that cannot be changed how to manage it, how to cope with people around you who are like that. Nothing really about their health, just how the society will cope with having them, the way people can accept them better. (S7)*

> *I think we discussed first of all the terms, a lot of people were like they don't even know this one existed and everything, then I found out that interestingly, some of my own friends really wanted to know more about it…. So maybe if we get to talk about it and then we get to accept it, maybe it would have been better. (S9)*

6.3.4 Theme 3: Multilevel and multidirectional influences of attitudes towards sexuality related issues and LGBT people

The students were more accepting of LGBT people compared to faculty (51.2%; 44.8%). Students were more likely to consider LGBT identity as a lifestyle and be favourably disposed to social equality for LGBT people (47.7%) compared to faculty (33.3%). However, over 60% of faculty and students agreed that LGBT identity was alien to African culture and that LGBT people were engaging in sinful acts. Most of the faculty were against criminalising LGBT individuals. [Table 6.6]

Table 6.6: Attitudes towards Gay, Lesbian, Bisexual Women and Bisexual Men (GLBWBM)

	Agree		Indifferent		Disagree	
Statement (n = students 172, faculty 105)	**Student**	**Faculty**	**Student**	**Faculty**	**Student**	**Faculty**
GLBWBM are criminals and should be treated as such	14 (8.1)	14 (13.3)	36 (20.9)	16 (15.2)	120 (69.8)	74 (70.5)
GLBWBM is alien to the African culture and should not be accepted	105 (61.1)	67 (63.8)	28 (16.3)	18 (17.1)	36 (20.9)	19 (17.1)
GLBWBM need to protest for equal rights	26 (15.1)	10 (9.5)	67 (39.0)	29 (27.6)	76 (44.2)	63 (60.0)
It would be beneficial to society to recognize GLBWBM as normal people.	47 (27.3)	13 (12.4)	47 (27.3)	21 (20.0)	76 (44.2)	68 (64.8)
GLBWBM should have equal opportunity of employment.	100 (57.6)	56 (53.4)	41 (23.8)	27 (25.7)	28 (16.3)	20 (19.1)
GLBWBM should be given social equality.	82 (47.7)	35 (33.3)	44 (25.6)	24 (22.9)	44 (25.6)	39 (37.1)
I would feel comfortable if my close friend is a GLBWBM.	34 (19.8)	16 (15.2)	32 (18.6)	19 (18.1)	104 (60.4)	67 (63.8)
GLBWBM is a different kind of lifestyle.	102 (59.3)	53 (50.5)	34 (19.8)	15 (14.3)	32 (18.7)	36 (34.3)
GLBWBM is a sin	108 (62.8)	69 (65.7)	30 (17.4)	13 (12.4)	25 (14.6)	15 (14.3)
I would avoid GLBWBM whenever possible	62 (36.1)	43 (41.0)	42 (24.4)	24 (22.9)	62 (36.0)	37 (35.2)
Attitude GLBWBM Score	Mean Student 27.93 $\pm$ 7.53 Mean Faculty 25.58 $\pm$ 7.74					
Attitude GLBWBM Grade	Student Positive 88 (51.2) Faculty Positive 47 (44.8) Student Negative 83 (48.3) Faculty Negative 57 (54.3)					

Attitudes towards Transgender People: Faculty and students had negative attitudes (51.4%; 51.7%) towards transgender people. Both groups viewed transgender identity as sinful (60.9%; 60.5%). With regards to the institution of the family, a higher proportion of the faculty compared to students were of the opinion that it is threatened by transgender identity (78.1%;

59.3%) and would be uncomfortable if a close family member became romantically involved with a transgender person (70.4%; 55.8%). [Table 6.7]

Table 6.7: Attitudes towards Transgender People

Statement (n = students 172, faculty 105)	**Agree Student**	**Faculty**	**Indifferent Student**	**Faculty**	**Disagree Student**	**Faculty**
It is a sin to be a Transgendered person	104 (60.5)	64 (60.9)	44 (25.6)	20 (19.0)	18 (10.5)	19 (18.1)
Transgender people endangers the institution of the family	102 (59.3)	82 (78.1)	40 (23.3)	12 (11.4)	25 (14.5)	10 (9.6)
Transgendered individuals should be accepted completely into our society	47 (27.4)	18 (17.1)	55 (32.0)	28 (26.7)	65 (37.7)	57 (54.2)
Transgendered individuals should have equal opportunity of employment.	93 (54.1)	51 (48.6)	51 (29.7)	27 (25.7)	22 (12.8)	26 (24.8)
I will avoid transgendered individuals whenever possible	42 (24.5)	35 (33.4)	58 (33.7)	25 (23.8)	66 (38.4)	44 (41.9)
I would feel comfortable working closely with a transgendered individual	41 (23.9)	28 (26.6)	67 (39.0)	32 (30.5)	58 (33.7)	44 (41.9)
I would feel uncomfortable if I learned that my neighbour is a transgendered individual	65 (37.8)	46 (43.9)	58 (33.7)	37 (35.2)	43 (25.0)	21 (20.0)
Transgendered individuals should not be allowed to cross dress in public	49 (28.5)	50 (47.6)	84 (48.8)	40 (38.1)	32 (18.6)	14 (13.4)
I would like to have friends who are transgendered individuals	18 (10.5)	07 (6.7)	58 (33.7)	25 (23.8)	90 (52.4)	71 (67.6)
I would feel uncomfortable if a close family member became romantically involved with a transgendered individual	96 (55.8)	74 (70.4)	35 (20.3)	15 (14.3)	35 (20.3)	14 (13.4)
Attitude Score NR students = 4, faculty = 0	Mean Student 27.25 $\pm$ 7.17 Mean Faculty 24.03 $\pm$ 8.47					
Attitude Grade	Student Positive 79 (45.9) Faculty Positive 51 (48.6) Student Negative 89 (51.7) Faculty Negative 54 (51.4)					

Hiding, do they exist?: A high proportion of respondents selected the 'indifferent' option in answering the attitude statements. This could be due to the limited exposure of faculty and

students on a personal (family member) and professional (patient) level to LGBT individuals Only a fifth (19.8%) of students know an individual who identifies as an LGBT person while a similar proportion (18.4%) of faculty knew patients who so identified. Respondents described experiences of having physical contact with an LGBT person as a novel experience.

> *Eh, at first it was kind of wow! So this LGBT people actually exist, we have them in Nigeria, you get, most times we tend to watch them in movies and all, … but because it is not legally em, authorised in our community that is why most of them are in hiding or they are hidden and they don't want to come out or they might have the feeling that if they should voice out or get their sexual identity known by others, they will have this em, discriminating looks and attention and all. (S3)*

Perception of LGBT identity: The respondents' narratives of LGBT identity are diverse and revolve around a sinner, a criminal, an individual with a mental health disorder or abnormal lifestyle. A handful were liberal and did not believe that there was anything abnormal about LGBT identity. Declassification of LGBT identity from the list of mental health disorders has not influenced individuals' perceptions. Most respondents firmly believe that it is not normal to engage in same-sex sexual relationships. They argued that procreation is one of the roles of the family unit that is impossible naturally within a same sex setting.

> *.....what I heard actually, the main reason why people become maybe a lesbian or so, the first determinant is peer pressure, … then another thing is poverty, then another thing is depression, those are the things I think make people want to be a lesbian, gay and all, and people want to feel among because they have their own society too. If you want to enter a particular group, a peer group you have to be a lesbian or a gay. (S2)*

> *In the last one and half or so decades we have seen an evolving world, an evolving global space where what used to be a disorder is now been accepted as a norm, again our conservative nature in Africa cum our religious belief … has led it to being criminalized in some African countries including Nigeria. .....depending on which side of the 3 divide you are then you can easily know that it fits into the 3 spheres of being*

a sin, of being a mental health disorder or being a crime. It would actually be a crime beyond being a sin…. (F5)

Acceptance of LGBT people – The path to transitioning for non-LGBT individuals: Fewer than half of the respondents in this study would come to the aid of an LGBT person undergoing harassment while about a third were undecided as to the course of action they will take. Respondents exhibited varying levels of acceptance towards LGBT people ranging from hostile to accommodating. This was influenced by varying factors that included: knowing the person first before knowing their sexual orientation and gender identity; attempting to avoid stigma that comes with associating with an LGBT person; avoiding undue influence from LGBT individuals; influence from social media. Faculty opined that same sex sexual behaviour is known to occur among secondary school students, however taking on the identity as an adult indicated an abnormality. Acceptance of trans people was generally lower than that of gay and lesbian individuals. Among the students, being a lesbian was more acceptable than identifying as a gay individual. Some of the respondents tried to clarify their position about feelings towards the person being different from feelings towards the sexual preference of the individual.

Tolerance to them, yea, especially if the person has been your close associate for a long time before the person becomes a gay or becomes a lesbian and you discover that apart from being a lesbian or being a gay, nothing has changed about that person, the person is still the person you used to know,. (F8)

……I will limit my interaction with the person. If I keep interacting with the person more and more, the person is obviously going to influence my own thoughts and my beliefs also, and I wouldn't want that so I need to distance myself from the person. (S1)

…. Although I'm not comfortable with any of them at all but I think I would be more comfortable with em, lesbian and gays than transgender….. (F11)

….all the guys that I know are fine with lesbianism. They even like it, ah this girl is a lesbian, it's interesting to them but the problem that they have is when it is guy and guy,

they are always like ah! What are you looking for? I don't think they have a problem with the LGBT on its own, it's just the gay that the guys have problem with. I ask girls too, girls also felt not the same per say but they also felt it's more reasonable for a girl to like a girl than for a guy to like a guy. (S7)

Hmmm, for example, some people I've had encounter with and...I think some people are actually against them, the people, some people are actually against the act and the people, while some are just probably against the act and not the people. Yea, I fall under the category like I'm against the act and not the people. (S5)

....you have to take into consideration the age bracket, the academic staff are older and they were brought up in the world of silence about sexual issues, so gay to them is a no go area, then these younger ones are becoming aware of gay and a lot of them are beginning to understand it in its entirety, as a result, they are beginning to accommodate it..... (F6)

……Maybe not so comfortable but then I'm in the transition state of accepting it because I think the media are like, they are putting it in my face, every time I have to see it, so I think if I get irritated, I might not even watch TV again, so I'm learning to hold, I'm learning not to even try to feel irritated. (S9)

Culture of silence and religious beliefs as determinants of African socialization: At the community level, faculty were of the opinion that the culture and religion hold similar views over sexuality related issues that include: keeping it strictly private and secret; firm belief that heterosexuality is normal and the only option; deviant sexual behaviour is wrong and abnormal, should not be tolerated and requires a solution. Sexuality related topics are therefore not topics for discussion or subjects for teaching and learning. Respondents reported that this socio-cultural bias negatively influences faculty attitude and comfort with teaching LGBT related topics in class.

Africa and in particular Nigeria is a place where most often than not, our religious and socio-cultural background form the basis for what we want to discuss openly, form the

basis of what we want to teach in the curricula at all levels of the educational system and also form the basis of human relationships. (F5)

We have a society that doesn't even accept that em it's normal to have different types of sexuality in the first place, and so because that is the case, nobody really talks about issues of sexuality separate from heterosexuality. (F7)

According to the respondents, the stigma associated with LGBT identity and the psychological distress experienced by non-LGBT people is partly responsible for the social distancing from people who identify as LGBT.

It's a cultural shock, it's a religious shock as well because society is used to a certain level of behavior. For the younger generation, it may not be such a cultural shock for them because okay it's something that is already getting rampant but the older generation it's a shock it makes people uncomfortable, it's something they were not used to from when we were children, you are psychologically traumatizing the straight people…… (F9)

6.3.4 Theme 4 – Ethics, professionalism and personal beliefs in a conflict situation

Faculty and students had divergent views on LGBT patients, with the former expressing a higher level of acceptance than the later (55.2%; 41.9%). Respondents felt that healthcare professionals in public health facilities should treat LGBT patients, however, the majority would be discrete about providing healthcare services. [Table 6.8]

Table 6.8: Attitudes towards LGBT Patients

	Agree		Indifferent		Disagree	
Statement (n = students 172, faculty 105)	**Student**	**Faculty**	**Student**	**Faculty**	**Student**	**Faculty**
LGBT patients deserve quality care from doctors and nurses.	146 (84.9)	95 (90.5)	15 (8.7)	7 (6.7)	7 (4.1)	1 (1.0)
LGBT patients should only seek health care from LGBT health clinics.	23 (13.3)	10 (9.5)	29 (16.9)	19 (18.1)	116 (67.5)	73 (69.5)
Doctors and nurses in public health facility should not treat LGBT patients.	6 (3.5)	0 (0.0)	14 (8.1)	10 (9.5)	148 (86.0)	31 (88.5)
I would be comfortable if I became known among my colleagues as a doctor that treats LGBT patients.	70 (40.7)	43 (41.0)	59 (34.3)	42 (40.0)	39 (22.7)	18 (17.1)
I would be comfortable if my heterosexual patients learned that I was treating LGBT patients.	77 (44.8)	49 (46.7)	63 (36.6)	37 (35.2)	27 (15.7)	17 (16.2)
I would be comfortable telling my family that I treat LGBT patients.	85 (49.4)	54 (51.4)	57 (33.1)	34 (32.4)	26 (15.1)	15 (14.3)
I would be comfortable taking history from an LGBT patient	111 (64.5)	74 (70.4)	44 (25.6)	23 (21.9)	13 (7.6)	6 (5.7)
I would be comfortable conducting a physical exam on an LGBT patient.	99 (57.5)	75 (71.4)	44 (25.6)	21 (20.0)	25 (14.5)	7 (6.7)
I would be comfortable conducting a genitourinary or pelvic examination on an LGBT patient.	90 (52.3)	67 (63.8)	52 (30.2)	20 (19.0)	26 (15.1)	15 (14.3)
I would be comfortable discussing sexual behaviour with an LGBT patient	82 (47.7)	60 (57.1)	49 (28.5)	27 (25.7)	36 (20.9)	16 (15.3)
Attitude LGBT patient Score NR students = 4, faculty = 0	Mean Student 37.95 $\pm$ 7.17 Mean Faculty 39.58 $\pm$ 9.75					
Attitude LGBT patient Grade	Student Positive 72 (41.9) Faculty Positive 58 (55.2) Student Negative 96 (55.8) Faculty Negative 47 (44.8)					

Availability of safe spaces in health facilities: With regards to examination and clerking of LGBT patients, faculty were more comfortable than students. Faculty expressed the opinion that LGBT patients/clients should be mindful about the social environment including public health facilities at all times. Coming out to the healthcare provider was not encouraged due to an inability to guarantee safety. Services at private health facilities were considered safer than at public health facility settings for LGBT patients.

> *……they will just come without announcing it to the health setting that they are this or they are that…most of them go to private hospitals and there they receive care and they receive good quality care because they are going to pay. I think if they have em, their money, a private setting will be the best. (F2)*

Conflicting heart, trying not to feel it, trying not to let it show within the context of service provision to a hidden population: Some respondents expressed difficulty in achieving a balance between professionalism and their beliefs. While some believe they will struggle with it, some believe that it is not a problem at all and others are convinced that the resulting conflict will negatively impact on their mental health. Providing general healthcare services constitutes an ethical dilemma while in other instances this will occur only with specialized services.

> *I do have strong beliefs but at the same time I believe that yes, they should have access to care, but I wish that our values are preserved and are not eroded because we want to provide healthcare, so that is where I have a bit of a problem with it. (F1)*

> *I think I will have negative attitude towards LGBT patient because I will always feel guilty, there'll be a sense of guilt while treating them if I have to. I would rather not…. I hope I won't have to take care of them but if I have to, it might affect my mental health but I will deal with it in the place of prayer and faith. (S4)*

> *I will personally not be involved in converting a man to a woman. I will personally not, no matter the amount of money made available because it's against my own religious and let me just say personal belief……if the law made it compulsory that I must do*

transgender surgery that I don't believe in, then it will affect my mental state, I may even possibly resign. (F11)

Intersectionality: Faculty and students as healthcare professionals with religious and cultural beliefs: For students, the perception that an LGBT patient is dangerous plays a critical role in the level of comfort associated with providing care for such patients. Some students were scared of unwanted sexual advances/sexual harassment. Intersection of identities and gender influences perception of danger. A female non-LGBT healthcare student will be highly uncomfortable with a transgender patient. Faculty members also reported being at the intersection of multiple identities which influence what they say and how they react to LGBT related issue. This is a constant stressor to their mental health.

Providing physical care if the person is a em, female, like a lesbian, it will be at the back of my mind that oh! Hope she's not showing some advances to me and all that, so I wouldn't be comfortable at all. If it's a gay man I wouldn't be comfortable but at the back of my mind, I would be like oh! He does not really like females, so I can provide physical care to him I wouldn't really see him as a threat [Smiling] Transgender! Ah! That one, I will not even know what to think, I think I will just find excuse and not care for the person or something. (S1)

One thing I noticed is that when it comes to maybe lesbian, people are actually not as against it as the male situation. ….. so maybe it'll be, in a situation whereby the person feels, he might feel threatened by the person's advances, fear of unwanted advances will make somebody uncomfortable providing care. Yes, that's the truth. So if the patient was to be a lesbian, I might not feel any different about it. (S6)

….it depends on the gathering and what I'm going to talk, as a medical person, I'll tell you that well, I'm indifferent, as a medical person I will say I'm indifferent, but as a Christian, I will tell you it's a sin, as a Christian if I'm going to talk in the church, I will tell you it's a sin and if I'm going to talk in the classroom teaching my students, I'm going to be indifferent about it, I'll just teach it the way it is and talk about it, I will not say it's abnormal but I will say some people have just chosen to take to that aspect of life. (F8)

Distrust and perception of rejection from healthcare provider: Some faculty were of the opinion that LGBT patients are unduly sensitive and biased against non-LGBT healthcare professionals while also noting that some healthcare professionals exhibit verbal and nonverbal acts of discrimination.

> *……automatically you are just going to feel that oh! This person is doing a sinful thing and unconsciously you might just have that reservation against the act, you may not be against the people. Separate that okay somebody is uncomfortable with my sexual preference, not that the person hates me, not that the person wants to harm me. (F9)*

> *I've treated quite a lot of them but there's none of them that will not ask me, are you surprised doctor, some will say I see you didn't even asked me further questions, some will say doctor, ah! Is it that you are not surprised, why do they ask such a question? That means they themselves have seen themselves as a different group from the norm of the community therefore it could be a perceptual disorder from them…… (F8)*

Access to healthcare services for LGBT people in Nigeria: Participants were of the opinion that the criminalizing law in Nigeria has negatively impacted on the willingness of healthcare professionals to learn about LGBT health related issues and service provision for them. This is mostly due to fear of LGBT people, fear of repercussion including courtesy stigma and arrest by law enforcement as well as lack of visibility of the LGBT population. Providers operate within the restriction and limitation of the law which, in effect, is preventing equal access to healthcare. The law also provides an escape route and justification for providers who may prefer not to interact with the population based on individual beliefs and values:

> *Some person may privately be trying to assist people and providing healthcare but I think it still goes back to the laws, the values and policies and in the absence of that, you know, you can not overtly assure those equal right, so you can mouth it, it's just, it can be all talk but they are actually here to ensure that it's not going to see the light of day. (F3)*

> *….people don't want to be associated with what is not openly accepted, meanwhile clandestinely they will provide that service, same thing nobody wants to be given the*

stigma that he or she treats or he or she manages someone who is lesbian, someone who is transgender or someone who is a gay, this carry stigma. (F5)

Recommendations for Healthcare professionals on service provision to LGBT people: Faculty and students were of the opinion that a holistic approach to service provision is the ideal way to ease the stigma associated with LGBT identity and ensure that healthcare facilities become safe spaces for LGBT people.

…….the only way to do it is to put it as part of the holistic comprehensive package, not to single out training for LGBT health. Every health worker should be trained to identify and provide information and care if they want for the LGBT problem, we should not, we cannot separate it because of the stigma associated with it and we have to face that reality. (F10)

I don't really know if you have a place where you label LGBT; nobody would want to go there because they know that okay, anybody that's entering there, this is who you are, you are one of them. So, well, I just feel they should be treated like normal people, if you have any issues, just come around, I don't feel there should be any segregation. (S10)

The respondents were convinced that in service provision, it will be difficult for healthcare professionals to overcome their personal prejudice and the stigma surrounding LGBT identity. At the institutional level, they identified the need to improve the quality of training for healthcare professionals as well as specially designed programs on ethics as the best option to help practitioners achieve professionalism in the presence of conflict.

I think we need to do a lot of education, em and we need to draw a line between the belief and medical profession that we have taken, but I know not many doctors will have this kind of belief, many will carry their religious belief to affect their decision making. (F11)

…….so maybe, they should start programs to help the people that are having problems, to help them to see LGBT people as human beings first and treat them as human beings and not as something...something...abominable or something. I think there should be

programs created to help the doctors see the difference and maintain their professionalism. (S7)

Respondents considered some skills critical for healthcare professionals providing culturally acceptable care to LGBT patients, this includes: ability to maintain confidentiality, friendliness, being knowledgeable about LGBT related health issues and responsive to patient/client needs.

…….the person might have a preconceived notion that they are going to stigmatize me and so they might read meaning into some things that should not be read meaning into, so em, health care workers too should have that at the back of their mind so that if the person is being defensive and all that, you just know that it maybe because of what they've experienced before or what they perceived…. (F9)

I think confidentiality should be of utmost importance in situations whereby you come across them because even within hospital settings, much as we like to pride ourselves on confidentiality, stories of patients with abnormalities always get out and so I feel like confidentiality should be formed that such information won't. S6

6.3.4 Theme 5: Advocacy, Laws and Rights as Tools for Reducing LGBT Health Disparity

Advocating for inclusive training of healthcare professionals and non-discriminatory healthcare: Faculty and students were united in advocating for an inclusive curriculum for training healthcare professionals and access to culturally acceptable healthcare for LGBT people.

…….trying to reorient in the social discourse, we have to address things in a different way and just try and make it clear in the narrative that look yes, we have a certain proportion of population who identify as LGBT, they need access to health care, we need to ensure that we are giving them that access regardless of what we think about, regardless of what laws have been put in place about them, so, advocacy, we need a great deal of advocacy. (F7)

……there must be a compromise, a compromise is for conditions where the peculiarities of this group of people should be mentioned under the different prevailing content of

the curriculum and their peculiarities discussed so that if you show me someone who has that challenge then you know. I know how to start and minimum you know who to call on or how and who to refer to…. I believe that one of the things we should give even in Nigeria despite the prevailing law is we ensure that where relevant issues of LGBT are mentioned even in the current curriculum. (F5)

Doctors should not discriminate but as it is now, that's not how it is, because many people believe that gay, lesbians are an abomination and if it is not build into us in school during our training, we will still carry that into our practise and if you see a case that's related to that, we won't approach it with the same professionalism we would normal cases. (S7)

When the doctors and medical students are able to provide care, it's going to be a lot easier to have a movement to put some pressure on the government to overturn that law, so we can start from doctors, medical students and how they provide care and seeing that this is an issue and then having some more advocacy for improved access to care for the LGBT community but I think that with the doctors and medical students on board it may be a bit easier but the point is at the end of the day that law needs to go for anything to get better. (S8)

The rights of non-LGBT people: Some respondents expressed dissatisfaction with attempts to promote LGBT rights. They opined that the actions carried out to implement LGBT rights was infringing on the rights of non-LGBT people. They perceived that they are being forced to accept LGBT people without a clear understanding of who they are and the risks involved in interacting with them. This is based on the perception that LGBT people are harmful. The need for a balance at all levels to avoid aggressive behavior and violence was emphasized.

The gay and the lesbian, the transgender people, they want to impose their self, their personality into people, you need to accept me and they don't want to tolerate when you say I'm not accepting you, therefore I have the right to say I'm accepting you or not, even if you are not a transgender or if you are a heterosexual individual, I still have my right. (F8)

……em, it's true that in granting gay, LGBT rights, that the rights of straight people should not be infringed upon. If the balance is not struck and the society in trying to give LGBT em, community rights, if that right now infringe on the rights of straight people, straight people too are going to now be hostile because it's going to look as if oh! Is the LGBT community that is making our rights to be infringed upon and trying to change what I believe and trying to force me to take another thing I don't believe and then they will fight back……. (F9)

I feel like we are angry and indifferent because we want to be made to understand a whole lot of things about it or the fact that the media is aggressively throwing it at our faces that you have to accept, LGBT is here to stay, what if I don't want to …… people are angry more because it feels like we are being forced to like it and accept it. The method they went through is like you must accept it but why don't we just let people choose whether to accept it if you want people to accept it then you need to show people that they are probably not even dangerous, they won't hurt you or harm you, this is just their sexual orientation. (S9)

Faculty express the need to protect the mental health of healthcare professionals and reiterated the fact that once it is not an emergency situation providers are free to refer or not to treat patients.

……..you need to realize that as a health care professional you too have a right to treat or not to treat people, so I cannot force someone whose mental health will be affected by treating an LGBT person to treat that LGBT person, that would be wrong. Everybody has a right to em, their mental health… (F10)

I think in medicine too there's a limit to what we can do, it's not all patients that a particular doctor can sort out and that's why there can be referral……I don't know of any law in the country that made it compulsory that as a doctor you have to provide all the services even if you don't believe in it….. (F11)

6.4: Discussion

This sub-Saharan African study showed that in one medical school in Lagos, teaching and learning about LGBT health as a subject for healthcare professionals was inadequate. This has

also been reported in a South African College of Health Sciences.(4, 319) The majority of the faculty do not teach LGBT health related topics in class nor use LGBT examples. Most of the students could not recollect instances when they received lectures on LGBT topics in class. However, the brief exposure was considered useful as students were able to improve their knowledge. Overall, knowledge of LGBT related terminologies was poor, with students more knowledgeable than faculty. Attitudes towards LGBT people were generally negative but students were more accepting of LGBT individuals compared to faculty, while faculty were more accepting of LGBT patients compared to students. With regards to the subpopulations within the LGBT umbrella, our study populations were less accepting of transgender people compared to gay, lesbian and bisexual individuals.

The negative attitude towards LGBT people reported in this study is similar to that obtained from previous studies among healthcare professionals.(331-333) For our study participants, religion is a key component of daily life, (more than 95% consider religion an important aspect of their lives). The high proportion of faculty and students with negative attitudes towards LGBT individuals is therefore consistent with reports that identifies religiosity as a determinant of antigay values.(311, 331) Greater acceptance of gay and lesbian individuals has been noted within the general population in recent times, with acceptance of transgender individuals lagging behind.(334) The same inequality was observed among young people, where transgender students still experience more discrimination compared to their gay and lesbian counterparts, sometimes perpetuated by their peers.(335)

Contact with LGBT individuals has been reported to improve acceptance.(336) Among healthcare professionals in this study, the same trend was also observed, with those having a friend, a relative or a patient who is a transgender person being more accepting of transgender individuals. With regards to training of healthcare students and professionals, studies have shown that clinical exposure to LGBT patients during training is associated with development

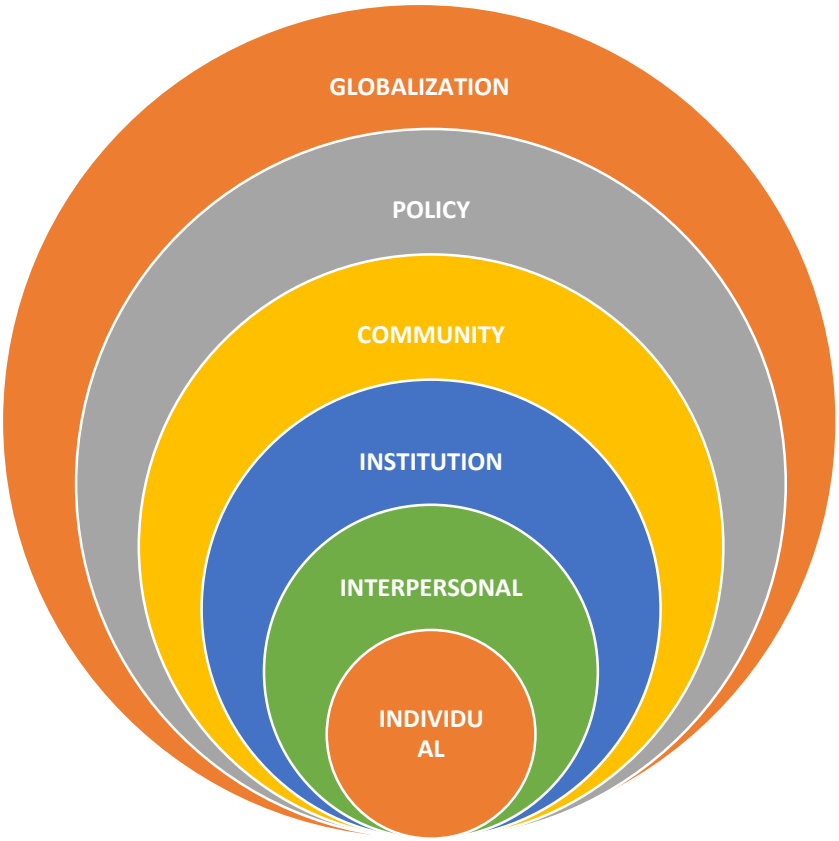
of positive attitudes towards LGBT people.(303, 337) Although it has been argued that clinical exposure and appropriate information on LGBT health have to complement each other before attitudinal change can occur.(338) Positive classroom culture towards LGBT people also promotes student learning. The manner in which faculty handle delivery of LGBT health topics can serve as an indication of comfort with LGBT related issues. Reports of faculty discomfort while mentioning LGBT health in class described in this study falls short of that required for a positive classroom culture. Moreover, healthcare students and faculty in this study reported minimal contact with LGBT individuals and patients, which might contribute to the high proportion that were either indifferent or expressed negative attitudes towards LGBT individuals, as well as the very high proportion that would observe as bystanders if they witness harassment of an LGBT individual.

There has been inconsistent reporting of knowledge of LGBT terminology, with more recent studies reporting good knowledge.(335) However, poor knowledge of LGBT-related terminologies reported by some studies was also observed in our study population.(339, 340) Healthcare professionals have been noted to lack sufficient knowledge and preparation in dealing with transgender patients which sometimes manifests as confusion about terms, lack of comfort and discriminatory acts during encounters.(215, 341) Poor LGBT health-related knowledge has been documented among physicians with a positive attitude,(305) which is similar to that reported in this study. Inadequate representation of teaching on human sexuality in curriculum delivery and evaluation has been observed in schools of nursing and medical schools in other countries.(342) In our study, absence of LGBT content in the curriculum was a deterrent to its delivery in the classroom as reported by other studies where students did not learn about LGBT health issues in the classroom.(343)

Using the modified ecological systems model of socialization (Figure 6.1) I was able to identify concepts operating within six domains (globalization, policy, community, institution,

intrapersonal and individual) that served as facilitators or barriers to inclusive training of healthcare students and subsequently access to non-discriminatory healthcare to LGBT people in Nigeria.

Fig 6.4: Modified Socio-Ecological Model showing Barriers and Facilitators to Teaching and Learning LGBT Health Topics in College of Medicine, University of Lagos.



Legend

- **Globalization**
  Concepts – [Human Rights, Global ideologies, International media, International travels, Laws and policies in High income countries]
- **Policy**
  Concepts – [Criminalising laws, National laws and policies, Legal enforcement, Rights to health]
- **Community**
  Concepts – [Culture, Religion, Attitude, Social media, Training institutions, Local media]
- **Institutional**
  Concepts – [Curriculum, Classroom etiquette, Institutional policy and culture, Attitude of staff, Training opportunities for staff, Access to online resources]
- **Interpersonal**

Concepts – [Interactions faculty/faculty, faculty/students, students/parents, student/student] [Interactions non-LGBT/LGBT family, friend, peer, colleague, patient, role model, celebrity]
[Family culture and cohesion]

- **Individual**
  Concepts – [Knowledge, Beliefs and values, Attitudes, Sexual orientation, Gender identity, Age, Experience, Religion, Skills and training, Local media, Social media]

6.4.1 Discussion of the findings within the context of the six levels of the socio-ecological model

Domain 1 – Individual

Concepts – [Knowledge, Beliefs and values, Attitudes, Sexual orientation, Gender identity, Age, Experience, Religion, Skills and training, Local media, Social media]

Depending on the level of religiosity and cultural beliefs of the individual, speaking about the LGBT topics in class may induce discomfort which can be picked up by the students through verbal and nonverbal communication. At the individual level the main concern is "how do I teach the subject in a way that does not sanction it, approve of the lifestyle, disapprove of it or encourage it in a climate where it is believed that talking about LGBT is a covert attempt to convert individuals to the lifestyle?" The faculty being aware that the students are trying to form an opinion about the presentation and the presenter; homophobic, LGBT ally/suspect or professional. The effort required to balance personal bias and professional expectation is a psychological stressor for the faculty, making the classroom an unsafe space.

In this study, healthcare professionals identified mental health issues as a causation and consequence of LGBT identity. This conviction is not supported by the World Health Organization classification of disorders/diseases, therefore, the construct of LGBT being an abnormality arises from culture and personal beliefs. This perception probably encourages the belief that such people can be harmful and can be violent. De-medicalization was not supported by some members of our scientific community, similar to other studies where LGBT people

were considered abnormal and unhealthy. Hence they would feel more comfortable discussing/ mentioning the subject as disease states. This preference becomes a limitation in teaching the subject and can lead to a state of dissociation “they say it’s not abnormal but I think it’s not normal”. Faculty sometimes find themselves at the intersection of multiple identities with their utterance about LGBT identity shaped by the role they have assumed: a faith based leader/elder preaching at a religious assembly; a faculty teaching in classroom or healthcare provider rendering services.

At the individual level, respondents in this study desired to know more about LGBT related issues, requested for local studies and information leading to understanding of the aetiology and social issues surrounding LGBT identity in Nigeria, to enable them make informed decisions on this subject. Availability of locally generated evidence will also provide guidance in policy formulation.

Conflict arising from incongruent personal and professional values described in previous studies was also mentioned in this study.(332) The operationalization of this dilemma in practice for providers in our study is their willingness to provide only basic general healthcare services to LGBT individuals and not LGBT specific services. The ongoing conflict can manifest as implicit bias which may be picked up by patients. At the same time, continuous discomfort arising at this level may affect job satisfaction and mental health of the provider. It may therefore be necessary to organise programs and training on reflexivity specifically targeting providers working in clinics where LGBT patients will be most likely to access services.

For the healthcare provider, additional stressors are the fear of being accused of promoting/supporting LGBT interest (legal); the emotional disturbance of promoting and abetting a sin during clerking, physical examination and care for an LGBT patient (religious).

Healthcare professionals in this study are therefore worried that providing services to LGBT patients will negatively impact on their mental health. Therefore during this transition period, the mental health of non-LGBT individuals deserves consideration and attention.

Domain 2 – Interpersonal

Concepts – [Interactions faculty/faculty, faculty/students, students/parents, student/student] [Interactions non-LGBT/LGBT family, friend, peer, colleague, patient, role model, celebrity]

[Family culture and cohesion]

Interpersonal relationships and communication within and outside the classroom based on interactions between faculty and faculty, faculty and student, faculty and patient, student and patient, LGBT and non-LGBT individuals and within the community interactions between faculty, students and the general population moderates the perception of safe spaces.(344, 345) In this study, perceptions of character generated during interpersonal interactions is a source of concern as this can lead to stigma extended to people close to/associating with LGBT people. Moreover participants in the quantitative survey, expressed poor knowledge of microaggression which can be partly responsible for the high level of discrimination and poor quality of service experienced by LGBT patients in previous studies in Lagos.(131, 191) Microaggression will contribute to the development of the hidden curriculum. The limited exposure to LGBT patients mentioned in this study will prevent the healthcare students and professionals from generating personal opinions about LGBT people, thereby promoting and maintaining the hidden curriculum through actions that constitute microaggression. Complicating the issue further is the inability of individuals to discern whether negative attitude is due to the "sexual acts", the person or both. At various points during interaction with others individuals also find themselves at the intersection of social identities that is emotionally and psychologically stressful.

Domain 3 – Institutional

Concepts – [Curriculum, Classroom etiquette, Institutional policy and culture, Attitude of staff, Training opportunities for staff, Access to online resources]

At the institutional level, an inclusive climate fosters the perception of safe spaces. This includes but is not limited to educating students, training of staff, and LGBT student groups. The curriculum is the main driver for teaching, learning and training. Some individuals will not use LGBT examples in class, not because they don't have the pre-requisite knowledge (scholarly ignorance), but because they consider it to be a socially unacceptable behaviour (purposeful ignorance). The non-inclusion of LGBT health in the current curriculum also provides an escape route for individuals who would rather not mention it in class. For healthcare students, the explicit curriculum is what is taught. This comprises issues considered important and of great priority. The hidden curriculum is made up of content that is omitted, not taught, excluded and therefore considered unimportant.(346, 347) In this study, the absence of LGBT content in the curriculum institutionalises the culture of silence on LGBT issues that is already existing within the larger community in Nigeria. The hidden curriculum therefore reinforces the culture of heteronormativity. While learning the technical and scientific information required to practice, healthcare students also imbibe the norms, values and beliefs of the profession from their lecturers, academic mentors and role models. This socialization occurs during formal and informal encounters (interpersonal level) with faculty, patients, peers and colleagues.(348) Micro-aggressive behaviours are harmful behaviours. Some harmful behaviours based on heteronormative and cisgender assumption, termed micro aggressive behaviours, are embedded within teaching, learning and service provision.(349) They are unconscious, unintentional and maybe invisible to the perpetuator. Micro-aggression was exhibited at several levels in this study mainly as the omission of LGBT health-related topics in teaching, heteronormative messages during teaching, verbal and non-verbal communication

(behavioural) and environmental conditions.(173) Open display of discriminatory attitudes and behaviours in the classroom as described in this study institutionalises micro-aggression while cascading the culture to the students. The fear and anticipation of these acts at the interpersonal level during clinical encounters might be responsible for perception of the faculty in this study that LGBT patients are unduly sensitive and biased against non-LGBT providers.

Domain 4 – Community

Concepts – [Culture, Religion, Attitude, Social media, Training institutions, Local media]

Culture and religion influences what is acceptable. What is acceptable is considered normal, demand for equal rights equates LGBT identity with heterosexuality which is unacceptable to the majority in this study, and hence the resistance to granting LGBT people equal rights, including health rights. LGBT identity in opinions expressed does not support procreation and the traditional family setup, hence is not popular. The perception of an LGBT person as an individual with mental health issues, abnormal lifestyle and or as a criminal raises great concerns about safety issues and generates fear within the healthcare community. This is expressed during interpersonal relationships. Concern about how people will preserve their faith in the context of changing values and evolving culture were expressed as a source of worry. It is therefore expected that people who are deeply committed to their faith will be less accepting if that is the religious stance. Intergenerational differences exist within the community on knowledge and attitude towards LGBT people which was attributed partly to the effect of social media and the evolving culture.

Domain 5 – Policy

Concepts – [Criminalising laws, National laws and policies, Legal enforcement, Rights to health]

At the policy level, the criminalising law which attracts a 10 year jail sentence is the reference for non-inclusion of LGBT health in the curriculum and not teaching the subject in all the departments. This state of affairs determines attitudes and acceptance of LGBT people by individuals and society as a whole. However, there are three groups of faculty in this study, those who are currently using LGBT examples in teaching, those who are willing to use LGBT examples in teaching and the majority who are not willing to do so. The rights of non-LGBT people is an issue that has been taken for granted considering that they are the majority. However, it appears to be a source of huge concern, as this study shows that people are worried that the fight to establish LGBT rights will actually infringe on their own rights. In countries like Nigeria where the laws and the religious convictions are synonymous, granting or recognising LGBT rights becomes a battle. This raises fears that the law was passed to safeguard cultural and religious values attached to sexual orientation and gender identity. The narrative around laws is that it is a tool used to oppress/intimidate LGBT people or non-LGBT people depending on which part of the globe you reside in. Africans and Nigerians are guided by their belief system which is controlled by the culture, religion and the law. There is always a reference to colonial laws and colonization in the LGBT narrative in Nigeria because the British colonial laws set the stage and serves as the backbone of the Nigerian legal system and laws until now.

This study showed that some healthcare professionals and students believe that they have a right to refuse to take part in activities or events that contravene their beliefs and puts them at risk of violating their religious morals, and the inability to exercise this right will have a negative effect on their mental health. The poor knowledge recorded in this study is a barrier to teaching LGBT health and the fear associated with interacting with an LGBT person but it is surmountable. The main difficulty at the individual level is personal prejudice and at the organization, community and policy level it is the criminalising law, religion and culture.

Domain 6 – Globalization

Concepts – [Human Rights, Global ideologies, International media, International travels, Laws and policies in high income countries]

The influence of primary socialization is moderated by socialization through media, which promotes independent teaching and learning through access to information. Some media in Nigeria, portray LGBT identity as normal, while the culture, religion and the law says otherwise, causing confusion and a sense of unease for some people. Social media is continuously breaking the silence by generating conversation around this issue and showing LGBT individuals locally and in foreign countries in real life situations. This includes ordinary people as well as celebrities and role models. There are therefore two groups of people: those trying to understand, who have been secondarily socialised through social media and will prefer to talk about LGBT issues, and people who will rather prefer the silence and hiding to continue. Participants in this study reported that the older generation are the vast majority in the latter group while the younger generation are the majority in the previous group. However, through international media and travel individuals have been exposed to global ideologies and United Nations human rights laws. Information, communication and technology provide access to information on climes with anti-discriminatory laws, policies, programs and its enforcement. This exposure to media has been shown to increase acceptance of LGBT individuals (media socialization).(350-352) Globalization has contributed to the evolving culture observed in several countries including Nigeria, and plays a role in the generational divide on LGBT acceptance reported in this study.

6.4.2: Strengths and Limitations

This is the first study that used a mixed method approach to examine teaching of LGBT health in a college of medicine in Nigeria, a country with criminalising law targeting LGBT people.

The cross sectional survey and in-depth interviews deployed in this study, complement and enhanced each other's findings. The response rate to the cross sectional survey was good and it provided a quantitative measure thereby making the findings generalizable and representative of faculty and students in the institution. Starting with a quantitative survey generated a discussion around LGBT issues, which loosened up inhibitions and enabled recruitment of people with diverse opinions for the qualitative interviews thereby eliciting rich information. The survey used closed and open ended questions, the responses collected were analysed and used to review and refine the interview guide for the qualitative interviews. By exploring personal stories, subjective experiences within the contextual landscape were examined and analysed resulting in identification of themes and concepts for the modified socio-ecological model.

The response to the attitude questions on LGBT individuals may be exaggerated due in part to the existing criminalising law. The respondents in this study are healthcare professionals and students trained in professionalism, the responses to the attitude statements may therefore not be a true reflection of participant's attitudes There is likely to be some degree of socio-acceptability bias resulting in some respondents providing socially desirable responses to homosexuality while some may provide responses that fits expectations of a healthcare professional. This is a case study of an academic institution in a cosmopolitan city, the findings may not be a true reflection of events in similar institutions in other parts of the country. Also, the assessment of knowledge was not comprehensive, it was restricted solely to LGBT related terminologies and not LGBT health related issues.

6.4.3: Implications for practice

Ongoing local research on LGBT related health issues is required and will provide evidence for planning healthcare service delivery as well as an advocacy tool for civil society organizations.

At the individual level – Training of faculty: Organising training and knowledge improvement programs as well as skills relevant to specialities for faculty and students.

At the institutional level – Replication of this study across the remaining five geo-political zones will allow for comparison of similarities and differences and identification of peculiarities important for program design and future interventions.

Community level: A tested model is available for other institutions within the country to adapt.

Policy level: Ongoing advocacy with policy makers by an intersectoral multidisciplinary team on the right to health for all citizens.

Plans to improve the situation

In present times, considering the arrest of forty four individuals at a party in 2017 in Lagos state on charges of practising homosexuality, changing the institutional climate requires persistence and a gentle approach. Inclusive curriculum: this involves identification of openly and silently supportive allies, and identification of faculty willing to include LGBT topics in their subjects within the various departments. Allies identify more allies within their departments, conduct a detailed mapping of the gaps with regards to teaching, as well as a SWOT analysis with regards to an inclusive curriculum within their departments. This will be compiled and an advocacy team will be constituted to meet with management and the curriculum review committee.

Chapter Seven: Discussion

Each of the empirical and literature based studies reported in chapters 3-6 have discussed the findings of the individual studies in the context of the wider literature. In this chapter, I summarise the key findings of each of the original studies and then place the overall findings in the context of the social determinants of health model, which I modify for the specific context of the LGBT population in Nigeria. I discuss the strengths and limitations of the whole thesis as a body of work and the implications for practice arising from my work. I conclude with recommendations for future research.

7.1 Summary of findings

Access to and delivery of healthcare services to the LGBT population has been reported to be problematic.(189, 353-355) This thesis uses a multipronged approach to examine this issue in Nigeria. Among the general population in Nigeria, represented by educated young people, about a third of the participants in my cross sectional survey carried out after the passage of the same sex marriage prohibition law (in 2014) had a negative attitude towards provision of healthcare services, including HIV related treatment and care, for the LGBT population.(126) Reporting of LGBT patients to law enforcement officers was supported by a high proportion of young people. The health system plays an important role in mediating the differential consequences of illness in people's lives. Failure of this system through differential access to HIV/AIDS services contributed to a high prevalence of the disease within the LGBT population in Nigeria(158, 191) and is a threat to the global goal of ending AIDS by 2030.(356)

In chapter four of this thesis, through interviews with people from the LGBT population in Nigeria, I identified the multilevel, synergistic interaction between religion, power and politics in shaping the health of the LGBT population in Nigeria. My interviews with LGBT people

revealed that an institutional culture of prejudice, hostility and violence occurred within health facilities premised on the criminalising law, the culture and individual prejudice. In this case there were direct and indirect causes of the health inequity reported by the study participants. Participants reported that interactions with healthcare providers were a direct psychological stressor, while unequal access to social resources arising as a result of restricted participation of LGBT individuals in social activities and healthcare services was an indirect cause.

The systematic review in this thesis (chapter five) was the first systematic review to explore the effectiveness of training health care students and professionals about LGBT health issues. The review showed limited heterogeneity of topics and instruments used in measurement of the outcomes, but there was considerable selection bias of participants and no concurrent comparators in many studies; these factors precluded meta-analysis. The systematic review however reported short-term improvements in knowledge, attitude and practise with the various training models. The absence of a best practice model and an integrated curriculum for teaching was identified as a limitation.

The last empirical study in this thesis, a mixed method study of faculty and students in the College of Medicine, University of Lagos and undertaken in 2018, showed that teaching and learning about LGBT health as a subject for healthcare providers was inadequate. Attitudes towards LGBT people were generally negative, although possibly less so than in the cross sectional study undertaken in 2014, albeit the sample in the 2014 survey was not confined to health care students. However the proportion of students who remained indifferent towards social equality for LGBT people remained consistently high across time. Thus I consider this group, people that will easily benefit from appropriate education and information. Because they are not biased against LGBT people, they are potential LGBT allies and can serve as a voice for the LGBT population. Both student and faculty participants were less accepting of

transgender individuals. A generational gap exists in attitudes, with students and young people more accepting of LGBT people, highlighting the role of information and communications technology in societal transformation. At the individual level some healthcare students and professionals reported experiencing conflict and ethical dilemma, which is an indication that their training has not kept pace with addressing emerging issues in the twenty first century. Agitation for a space in the public domain by LGBT people in Nigeria is viewed as a threat to the interest (religion and culture) of the majority and a source of tension by some health workers. Structural changes at the training institution, health facility and community level will therefore be difficult. The wider literature has shown that LGBT people experience minority stress due to social exclusion and marginalization.(357, 358) This phenomenon has been explored including the process that generates it and the consequences on health of individuals.(359) This study has shown that non-LGBT health care students and faculty experience psychological stress (‘majority stress’). This is born out of fear of what will happen to their way of life in the future if the rights of LGBT people in Nigeria are recognised. This will be a barrier to change.

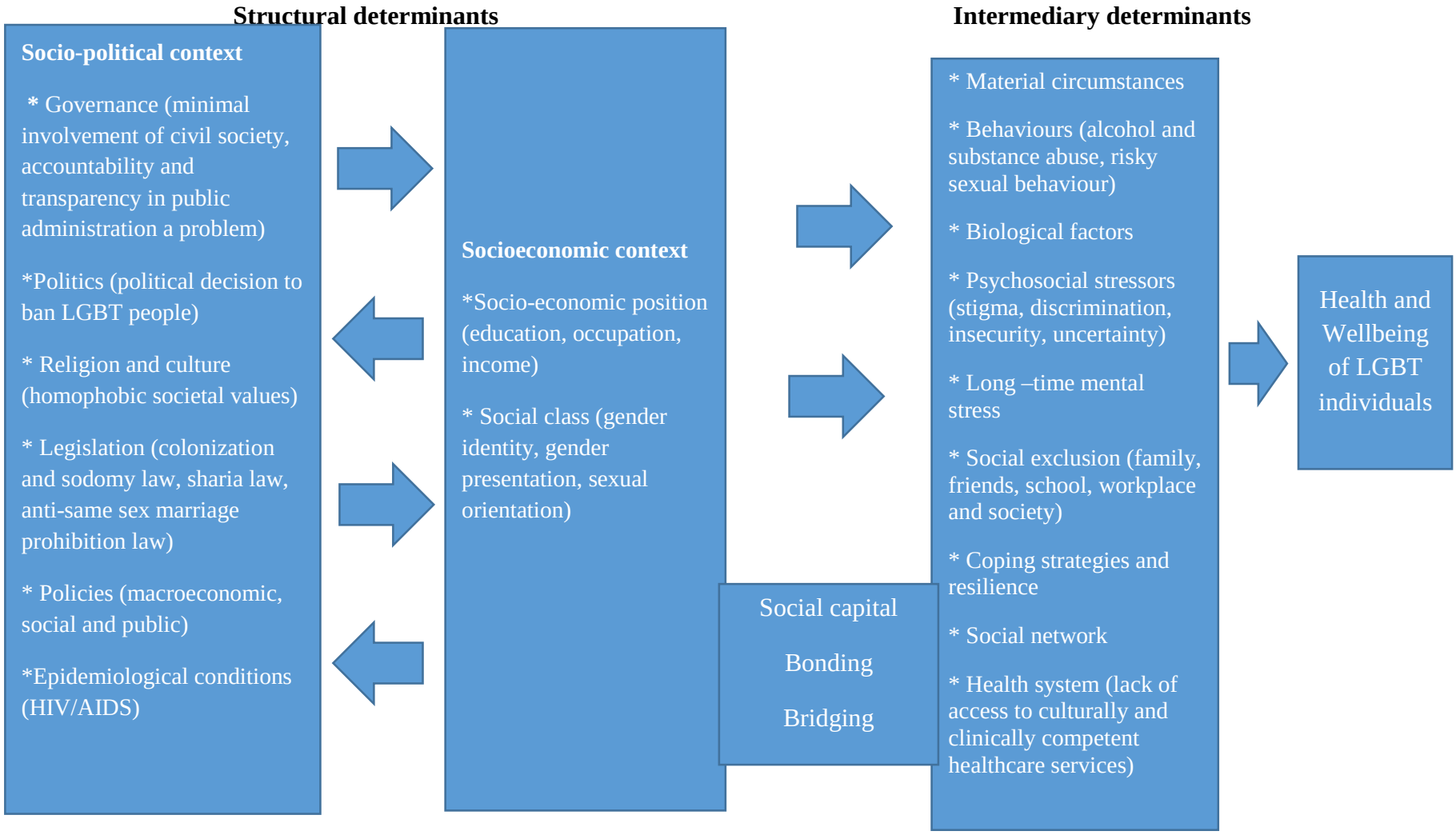
7.2: Interplay between theories in this thesis and the Interpretation of the findings using the social determinants of health model

Using an intersectionality-informed analysis in this thesis ensured that health inequity among the LGBT population in Nigeria was mapped out with more precision, highlighting intragroup differences within the specific social context and social position. By demonstrating the uneven distribution of discrimination and differential risks among LGBT people, shaped by legal categories and social structures including SES and its associated privileges and discrimination, this analysis permitted a context specific adaptation of the WHO social determinants of health framework. The adapted framework expresses the multiple disadvantages and simultaneous

advantages that underpin exclusion of LGBT people identifying why and how they are left behind as an explanation for health inequity reported by researchers. It captures and reflects the dynamic interactions between multiple health influencing factors identified through the intersectional analysis. The ecological framework was used to holistically identify, behavioural, institutional and policy level factors influencing knowledge, attitude and training of healthcare students and professionals which will ultimately determine healthcare service provision for LGBT people in Nigeria. It has provided a platform for systematically categorising barriers and enablers based on the ecological level in which they act as well as identify action points for intervention within the context of medical schools in cosmopolitan Nigeria. This provides a rich explanation for the construct "health system" (lack of access to culturally and clinically competent healthcare services) in the Modified Social Determinants of Health Framework for Health Inequity among LGBT People in Nigeria [see figure 7.1]

I have adapted the World Health Organization multilevel social determinants of health framework to describe the findings of the studies within this thesis in the context of structural and intermediary determinants of health.

Figure 7.1: Modified Social Determinants of Health Framework for Health Inequity among LGBT People in Nigeria



Health inequities have been described as socially produced differences in health status that are unfair and systematically distributed across the population.(360-362) Health inequalities are therefore the creation of the complex relationship between political forces, economic circumstances and social factors. Social stratification results in unequal distribution of power, prestige and resources among groups within a society and is the bedrock on which health differences (inequities) develop, thrive and are maintained. Political will and public policy decisions are often driven by societal values and the political party ideology. A complex relationship therefore exists between health, public policies and politics.(362) Empowering a socially disadvantaged group to exercise control over the factors that influence their health is key in advancing health equity, however the presence of a criminalising law effectively puts a barrier to this in Nigeria.

The ruling class in Nigeria, in conjunction with religious leaders, were able to shape the agenda of public debate and generate a hostile environment for LGBT people, thereby paving the way for a legislation that denies them a voice, space and conditions for their empowerment. This form of oppression and domination when systematically reproduced within institutions, including health facilities, manifests in ways such as omission of gender identity and sexual orientation in client intake forms and constitutes structural oppression.(3, 363) The omission of LGBT health related topics in the curriculum and reluctance of faculty to teach the topics on the basis of the criminalising law (chapter 6) is a form of structural oppression that reinforces the power of political decisions to dominate and oppress LGBT individuals.

Socioeconomic status (SES) is recognised as an important determinant of health and health-related inequity as shown by indicators like life expectancy.(355, 362, 364) It has also been shown by epidemiological studies to influence the prevalence and course of some specific

diseases and self-rated health.(362) Using an intersectionality approach in this thesis I have shown that among the LGBT population in Nigeria, whose intermediary determinants of health are closely related to behavioural and psychosocial factors, SES influences the extent of the health inequity experienced by individuals within the group (chapter four). The placement of individuals within the hierarchy of social stratification defines their economic position and influences their health opportunities. Structural determinants of health therefore reinforce social stratification and promote health inequity.

In grappling with the broad understanding of health disparity among the LGBT populations, recognizing with-in group diversity as opposed to homogeneity is a key strength of this thesis. The dominance of non-LGBT people over sexual and gender minority individuals and lack of acceptance manifest as discrimination, exclusion and marginalization. The framework for social determinants of LGBT health in Nigeria (chapter four) showed that power relations are used to maintain this social context, while the resulting inequality in health, thus created, is also maintained by the same power relations. The resulting unfair treatment received by LGBT individuals as a result of discrimination has been linked to biological and behavioral risk factors for diseases and health problems. It is also a source of physiological and psychological stress with negative mental health implications.

Social position influences health through intermediary factors. SES influences behaviour and life conditions, with a higher prevalence of health problems among people of low SES.(355, 362, 365) Material resources and social advantages are linked with increased access to knowledge, money, power, prestige, social connections and adoption of protective strategies. [SDH framework] The criminalising law places LGBT individuals at a disadvantage and

ensures the quality of intermediary factors is unevenly distributed between the LGBT population and others in society.

Chapter four of this thesis illustrates the negative life events, stressful living conditions and lack of social support from family and the community which manifested as a high occurrence of stigma, discrimination and homophobic acts experienced by the LGBT population living in Nigeria. These are psychosocial factors acting at the intermediary level in the social determinants of health framework.

This thesis did not explore behavioural factors among the LGBT population in Nigeria. However, other research has reported a higher prevalence of unhealthy behaviours in the LGBT population.(355, 362, 366, 367) A study carried out among MSM in Lagos, Nigeria showed a high prevalence of harmful alcohol consumption and cigarette smoking.(368)

In this thesis, the impact of social capital as a determinant of health was established. LGBT individuals involved in bonding social capital [i.e. cooperative relationships between individuals with similar social identity] had access to a community network that provided referral, linkage and guidance to health facilities providing culturally acceptable quality healthcare (chapter four). At the same time the absence of bridging social capital [i.e. respectful relationships between individuals who possess diverse socio-demographic characteristics] was evident from the interviews with healthcare professionals (chapter six). Citizen participation as an LGBT person is not feasible in the presence of a criminalising law which effectively removes this disadvantaged population from participating in any decision making or policy development that will affect their health and well-being. At the same time, LGBT people who go underground in hostile environments (remain 'closeted') can get elected into office but there is a risk that they may act more negatively towards gender and sexually diverse populations

through internalized homophobia/transphobia or to protect their identity. In this way, people from disadvantaged minorities can influence policy but sometimes for worse rather than better.

The health system is a relevant factor as an intermediary determinant of health. Its role in reducing health inequity includes: distribution of health resources based on need, provision of high quality, culturally acceptable services to consumers from diverse social groups, and advocating for healthy public policies grounded in social justice to promote health equity.(362, 369) The individual studies in this thesis have shown that the lack of a physical barrier does not ensure access to care. Healthcare professionals placing limitations and restrictions on the type of service they are willing to render to LGBT individuals is a barrier to availability of healthcare. The outcome is a health system that is unresponsive to the needs of the diverse population they are supposed to cater for and as a result, worse HIV/AIDS statistics, so it is counter-productive.

7.3: Overall methodological strengths and limitations

The strengths and weaknesses of the individual studies have been reported in the discussion sections of chapters 3-6. This thesis has contributed original research to the limited published evidence on access to, and delivery of, healthcare services for LGBT people in a criminalising country in the twenty first century. It is a novel piece of work that featured members of the LGBT community in Nigeria proffering solutions and recommendations towards achieving the right to health. It also provided an insight into the mechanisms that generated and maintain health inequity among the LGBT population in Nigeria. The WHO Director-General in his statement marking the human rights day in 2017 declared discrimination in healthcare as unacceptable and a major barrier to development. The right to health according to the World Health Organization, means that everyone has the right to privacy and to be treated with respect

and dignity. This is in recognition of the important role played by marginalization, stigmatization, experiences of discrimination and violence on the physical and mental health of individuals.

The use of robust methods across the four studies in this thesis enhances the quality of the evidence generated. Different population groups were assessed: chapter three featured educated young adults represented by university undergraduates, chapter four featured lesbians, gay, bisexual men, transwomen and transmen, in chapter six healthcare professionals who were members of the University of Lagos' faculty, and medical and nursing students were included.

The studies dovetailed into each other with the earlier studies informing the later studies. Three theories/models were used: the social determinants of health, the intersectionality theory and the socio-ecological model. The use of intersectionality theory within the African context is novel, providing a deeper insight into inequality within the inequity experienced by individuals within the LGBT community in Nigeria.

The studies were carried out in two major cities in Nigeria, namely Lagos and Abuja, therefore the findings may not be representative of the whole country, especially the rural and less urbanised communities. However, religion as a key theme is a characteristic of Nigerian and SSA populations and thus is likely to be a factor in most settings. Also, LGBT people in low and middle income countries with criminalising laws may have similar experiences. During the four years of the PhD it was noted that attitudes became a bit more liberal, especially in the cities used for the study. The findings therefore have to be interpreted in the context of the time when the data were collected and in the largely urban settings of Lagos and Abuja. In addition, there will have been a degree of selection bias in the recruitment of participants to the individual studies.

7.4: Implications for practice

In conducting this research, I have constantly been self-reflexive, I have considered how my social position as a public health physician and faculty has influenced my approach and examination of my research questions within the broader context of my stance as an advocate of the rights to health for all people and "leaving no one behind" strategy of the Joint United Nations Programme on HIV/Acquired Immune Deficiency Syndrome (UNAIDS). The points mentioned in this section arise from my personal perspective, values and the findings of the research conducted.

The College of Medicine, University of Lagos plans to conduct an audit of the curriculum across departments to identify areas for improvement with regards to teaching and learning about LGBT health. Following the baseline audits, knowledge, attitude and practice in relation to care for people with LGBT will be assessed after training is introduced for medical, nursing and allied health students. For established healthcare professionals and faculty, online modules on LGBT health and inclusive care will be developed and made available on the institutional website. This will serve as a beacon of good practice that can be show cased for other training institutions in Nigeria. It will be necessary for the College of Medicine, University of Lagos to develop a network of LGBT allies across medical schools to support each other in advocating for an inclusive curriculum and policy change for an inclusive climate environment.

However, significant change in practice among the older generation of healthcare professionals is unlikely unless there is societal change, which would be facilitated by the formation of a movement to advocate for LGBT rights. The drive for change may be effective if driven on the platform of rights to health for all by healthcare professionals and the regulatory agencies involved in training and practice. These agencies are crucial in reviewing and revising the

current health related policies and will be essential in negotiating policy changes to support the rights to health for all. The local media in Nigeria, has produced radio and television series depicting the experiences of LGBT people living in Nigeria. This includes the drama series 'Everything in Between" that explores issues of sacrifice, love, sexuality and sexual pressure. Popular Nollywood actors and actresses feature in these TV series making them attractive to the younger generation. This appears to be an effective strategy for engaging the younger generation on issues relating to LGBT people in Nigeria and will be important in the emergence of a social movement for change. Some of the younger faculty and students in the interviews confirmed watching the TV series. Having the majority group (non-LGBT people) at the forefront of advocacy for policy level interventions to ensure adequate access to quality healthcare services for LGBT people in Nigeria will be safer. Apart from policies tackling the structural determinants of health, policies to reduce the social mechanisms that perpetuate inequitable distribution of health (education, income) among population groups are also required.

Civil society organizations are already vocal about issues bordering on human rights and holding political leaders accountable in Nigeria. However the paucity of credible statistics based on local studies remains a hindrance and a limitation to efforts geared towards the campaign for the rights to health for LGBT population in Nigeria. The research evidence generated about inequity by this thesis will bridge this gap and provide the required ammunition required by the civil campaigners. The presence of a criminalising law against LGBT individuals implies that civil society and non-LGBT people will have to represent this group in the design and implementation of policies that address the social determinants of health inequity affecting them.

7.5: Recommendations for future research

Data collection on LGBT health and access to health care in Nigeria

Given the absence of data about the health of LGBT people in Nigeria, locally generated evidence needs to be collected at the population level to guide policy formulation. Information is also required on the type of services currently available and from which sources. Given that my qualitative study identified significant barriers to accessing health care, a more extensive survey of access to health care in the six geo-political zones and examples of discrimination within the health care system is recommended. The lack of evidence outside of large urban settings means that there is a need to reach populations of LGBT people living outside of these settings.

Implementation and evaluation of health related programmes for LGBT people

Some NGOs are providing culturally appropriate care for LGBT individuals in Nigeria. Such programs should be regularly evaluated using mixed methods, and findings published. The outcomes of the NGO-led services can be used as locally available best practices for other health care providers to compare themselves to.

Evaluations of undergraduate programmes for LGBT health teaching

Formal evaluations of undergraduate programmes for LGBT health teaching and inclusive care delivery should be institutionalised. This will generate evidence for program improvement and development of best practices not just in Nigeria, but perhaps across Africa.

Exploration and characterization of the concept "majority stress among non-LGBT individuals"

The emergence of psychological distress (majority stress) among non-LGBT individual's especially healthcare professionals in Nigeria needs to be explored to generate evidence that will throw light on its effect on the mental health, the appropriate direction and specific actions required to address it as a strategy for reducing homophobia and transphobia.

Globalization and cultural transformation

The cultural climate and attitude towards LGBT people is undergoing transformation, albeit at a slow pace compared to the rest of the world, hence there is an urgent need to conduct a well-designed longitudinal study with indicators to monitor, measure and publish the trend overtime. This will serve as a guide for policy formulation on teaching, training and program implementation at all levels. It will also serve as a barometer for advocates to know when the time is ripe for a movement to repel the criminalising law.

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Appendix 1: Ethical Approval for Chapter Three

LAGOS UNIVERSITY TEACHING HOSPITAL

HEALTH RESEARCH AND ETHICS COMMITTEE

PRIVATE MAIL BAG 12003, LAGOS, NIGERIA
e-mail address: luthethics@yahoo.com

Chairman
ASSOC. PROF. N. U. OKUBADEJO
MB. ChB, FMCP

Administrative Secretary
MR. D. J. AKPAN
B.Sc. BUS. ADMIN, MIHSAN

Chief Medical Director:
PROF. AKIN. OSIBOGUN
MBBS (Lagos), MPH (Columbia), FMCPH FWACP

Chairman, Medical Advisory Committee
DR. M. O. OGUNLEWE
BDS, FWACS.

LUTH HREC REGISTRATION NUMBER: NHREC: 19/12/2008a
Office Address: Room 107, 1st floor, LUTH Administrative Block
Telephone: 234-1-5850737, 5852187, 5852209, 5852158, 5852111

2nd June, 2014

NOTICE OF EXPEDITED REVIEW AND APPROVAL

PROJECT TITLE: "KNOWLEDGE AND ATTITUDE TOWARDS SAME SEX MARRIAGE PROHIBITION LAW AMONG UNIVERSITY UNDERGRADUATES IN LAGOS STATE".
HEALTH RESEARCH COMMITTEE ASSIGNED NO.: ADM/DCST/HREC/APP/1887
NAME OF PRINCIPAL INVESTIGATOR: DR. A. O. SEKONI
ADDRESS OF PRINCIPAL INVESTIGATOR: DEPT. OF COMMUNITY HEALTH AND PRIMARY CARE, CMUL.
DATE OF RECEIPT OF VALID APPLICATION: 28-05-14

This is to inform you that the research described in the submitted protocol, the consent forms, and all other related materials where relevant have been reviewed and given full approval by the Lagos University Teaching Hospital Health Research Ethics Committee (LUTHHREC).

This approval dates from 02-06-2014 to 02-06-2015. If there is delay in starting the research, please inform the HREC so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of this dates. All informed consent forms used in this study must carry the HREC assigned number and duration of HREC approval of the study. In multiyear research, endeavor to submit your annual report to the HREC early in order to obtain renewal of your approval and avoid disruption of your research.

The National code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the code including ensuring that all adverse events are reported promptly to the HREC. No changes are permitted in the research without prior approval by the HREC except in circumstances outlined in the code. The HREC reserves the right to conduct compliance visits to your research site without previous notification.

HEALTH RESEARCH & ETHICS COMMITTEE
CHAIRMAN

PROF. N. U. OKUBADEJO
CHAIRMAN, LUTH HEALTH RESEARCH ETHICS COMMITTEE

Appendix 2: Questionnaire Cross sectional Survey (Chapter three)

QUESTIONNAIRE TO ASSESS KNOWLEDGE AND ATTITUDE TOWARDS SAME SEX MARRIAGE PROHIBITION LAW AMONG UNIVERSITY UNDERGRADUATES IN LAGOS STATE.

INSTRUCTION: Please mark the correct answer by ticking the appropriate column and or fill in the blank spaces.

Name of Institution: (a) LASU (b) UNILAG

Section A - Socio-demographic information.

1. Gender a. ( ) Male b. ( ) Female
2. Age (years) ----------
3. Religion (a) ( ) Christianity (b) ( ) Islam (c) Others (please specify) ----------
4. Ethnicity (a) ( ) Igbo (b) ( ) Hausa (c) ( ) Yoruba (d) ( ) Others (please specify) ----------
5. Name of your faculty ----------
6. What is your department ----------
7. What is your level ----------
8. Marital status (a) ( ) Never married (b) ( ) Currently married

Section B – Knowledge of same-sex prohibition law

9. Have you heard about the Same Sex Marriage Prohibition Law that President Goodluck Jonathan passed in 2013? (a) ( ) Yes (b) ( ) No
10. If yes, what are your sources for the information? (**Tick as many as applies)**

    (a) ( ) Radio/Television (b) ( ) Newspaper/Magazine (c) ( ) Friends and family (d) ( ) Journals (e) ( ) Others (Please specify) ----------

11. Do you know that it is illegal for same sex couple to get married in any place of worship in Nigeria? (a) ( ) Yes (b) ( ) No

12. Do you know that same sex marriage contracts issued in other countries are invalid in Nigeria? (a) ( )Yes (b) ( ) No

13. Do you know that penalty for getting married to the same sex is fourteen (14) years imprisonment, upon conviction? (a) ( )Yes (b) ( ) No

14. Do you know that the penalty for solemnizing same sex marriage is ten (10) years imprisonment, upon conviction? (a) ( )Yes (b) ( )No

15. Do you know that the penalty for aiding or abetting the solemnization of same sex marriage is ten (10) years imprisonment, upon conviction? (a) ( )Yes (b) ( )No

16. Do you know that the penalty for witnessing same sex marriage is ten (10) years imprisonment, upon conviction? (a) ( )Yes (b) ( )No

17. Do you know that anybody who witnesses a civil union organized by gay organizations, if convicted, will go to prison for ten (10) years? (a) ( ) Yes (b) ( ) No

18. Do you know that anybody who makes direct or indirect public show of same-sex relations indicative of love, if convicted, will go to prison for ten (10) years?
(a) ( ) Yes (b) ( ) No

19. Do you know that anybody who registers gay clubs, societies, organizations, processions or meetings in Nigeria, if convicted, will go to prison for ten (10) years ?
(a) ( ) Yes (b) ( ) No

20. Do you know that anybody who operates gay clubs, societies, organizations, processions or meetings in Nigeria, if convicted, will go to prison for ten (10) years
(a) ( ) Yes (b) ( ) No

21. Do you know that anybody who supports gay clubs, societies, organizations, processions or meetings in Nigeria, if convicted, will go to prison for ten (10) years?
(a) ( ) Yes (b) ( ) No

22. Do you know that entering into a same-sex civil partnership can be regarded as a crime on conviction and is punishable by imprisonment for fourteen (14) years? (a) ( ) Yes (b) ( ) No

23. Do you know that witnessing meetings involving same-sex partners is a crime liable on conviction to a prison term of ten (10) years?

(a) ( ) Yes (b) ( ) No

24. Do you know that any healthcare service provider found guilty of sponsoring or giving health-related services or information to any gay-registered community will go to prison for ten (10) years? (a) ( ) Yes (b) ( ) No

Section C - Attitudes towards MSM and provision of healthcare services to MSM

Please tick one for each of the following

Item	**Agree (Yes)**	**Indifferent (I Don't Care)**	**Disagree (No)**
25. Do you think that homosexuality is alien to our culture and so should not be accepted?			
26. Do you think that homosexuals should not have access to HIV prevention services?			
27. Do you think that homosexual acts are unnatural and should be prevented?			
28. Do you think that homosexuals should submit themselves for correctional therapy or rehabilitation?			
29. Do you think that health care service providers should not provide services to homosexuals?			
30. Do you think that doctors and other health workers should be compelled to give priority to others groups before homosexuals are considered if resources (drugs) are insufficient?			
31. Do you think that homosexuals should be raped to cure them of their homosexuality?			
32. Do you think that homosexuals should be abused verbally?			
33. Do you think that homosexuals should be abused physically?			
34. Do you think that homosexuals should be rejected by family and friends because of their sexual orientation?			

35. Do you think that homosexuals should be expelled from school because of their sexual orientation?			
36. Do you think that workplaces should not employ homosexuals?			
37. Do you think that homosexuals should be sacked from their places of work?			
38. Do you think that homosexuals should be thrown out of their houses?			
39. Do you think that homosexuals should be given housing accommodation?			
40. Do you think that homosexuals should be treated with less priority compared to heterosexuals?			
41. Do you think that doctors and other health workers should be compelled to report homosexuals who come in for treatment?			
42. Do you think that public show of love between persons of the same sex is unpleasant?			

Thank you for participating in this study

Appendix 3: Ethical Approval for Chapter Four

LAGOS UNIVERSITY TEACHING HOSPITAL
HEALTH RESEARCH AND ETHICS COMMITEE

PRIVATE MAIL BAG 12003, LAGOS, NIGERIA.
e-mail address: luthethics@yahoo.com

Chairman
ASSOC. PROF. N.U. OKUBADEJO
MB. ChB, FMCP

Administrative Secretary
MR. O.J. AKPAN
B.Sc. BUS. ADMIN, MIHSAN

Chief Medical Director:
PROF. AKIN. OSIBOGUN
MBBS (Lagos), MPH (Columbia), FMCPH FWACP

Chairman, Medical Advisory Commitee
PROF. CHRIS BODE FMCS (Nig.) FWACS

LUTH HREC REGISTRATION NUMBER: NHREC: 19/12/2008a
Office Address: Room 107, 1st floor, LUTH Administrative Block
Telephone: 234-1-5850737, 5852187, 5852209, 5852158, 5852111

4th December, 2015

NOTICE OF EXPEDITED REVIEW AND APPROVAL

PROJECT TITLE: "HEALTH CARE UTILIZATION AND NEEDS OF LGBT PEOPLE IN LAGOS, NIGERIA – AN EVALUATION OF THE PROVIDER AND THE CLIENTS".
HEALTH RESEARCH COMMITTEE ASSIGNED NO.: ADM/DCST/HREC/APP/625
NAME OF PRINCIPAL INVESTIGATOR: DR. A. O. SEKONI
ADDRESS OF PRINCIPAL INVESTIGATOR: DEPT. OF COMMUNITY HEALTH AND PRIMARY CARE, CMUL.
DATE OF RECEIPT OF VALID APPLICATION: 02-12-15

This is to inform you that the research described in the submitted protocol, the consent forms, and all other related materials where relevant have been reviewed and given full approval by the Lagos University Teaching Hospital Health Research Ethics Committee (LUTHHREC).

This approval dates from 04-12-2015 to 04-12-2016. If there is delay in starting the research, please inform the HREC so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of this dates. All informed consent forms used in this study must carry the HREC assigned number and duration of HREC approval of the study. In multiyear research, endeavor to submit your annual report to the HREC early in order to obtain renewal of your approval and avoid disruption of your research.

The National code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the code including ensuring that all adverse events are reported promptly to the HREC. No changes are permitted in the research without prior approval by the HREC except in circumstances outlined in the code. The HREC reserves the right to conduct compliance visits to your research site without previous notification.

CHAIRMAN

PROF. N. U. OKUBADEJO
CHAIRMAN, LUTH HEALTH RESEARCH ETHICS COMMITTEE

Appendix 4: Interview Guide for Chapter Four

Experience of identifying as LGBT in Lagos

What can you tell me about LGBT people living in Lagos?

What effect has the experience of identifying as LGBT had on your family, relationships, friends, accommodation, occupation/ability to work, education and social life?

In what ways are you involved in LGBT social networks

Can you tell me about the effect on your health?

Views on health system in Lagos

What can you tell me about the health of people living in Lagos?

What are the things people living in Lagos do to maintain their health

Can you tell me what people living in Lagos do when they have health problems or fall sick?

What can you tell me about healthcare providers in Lagos (formal and informal)

Your own health

How do LGBT people living in Lagos manage their health?

Can you describe what you do to maintain your health?

What do you do when you feel disturbed, down or stressed out, unhappy or agitated?

How do you cope and manage such feelings

Where do you seek help for emotional disturbance?

Your experience as LGBT person seeking healthcare

Are there health facilities where LGBT people living in Lagos go for treatment?

Is there any difference between the ways healthcare providers treat LGBT people compared to other people?

How do you get information on health issues?

What types of healthcare have you had in the past two years? (Physical, sexual, mental, HIV)

Your interactions with healthcare worker

Have you disclosed your sexual orientation to a healthcare provider? Can you tell me what happened before and immediately afterwards?

Can you tell me about a time when you received good care and poor care from a healthcare worker? Why do you think it was a good/bad care?

In your opinion what effect has disclosure of your sexual orientation/gender identity had on the care you received from a healthcare worker. (Provider insensitivity)

What type of health services have you accessed in the past two years?

Tell me about the last time you went to a health facility for treatment.

What are the things that will make you go to a health facility for treatment?

Impact of the antigay law

What effect did the antigay law have on LGBT people in Lagos?

What effect did the antigay law had on your family, relationships, friends, accommodation, occupation/ability to work, education and social life?

What has been the effect of the law on your health and ability to access healthcare services?

Suggestions for improvement to health services in Lagos and how they think that might be achieved

What are ways by which health service provision to LGBT people in Lagos can be improved?

Do you have anything else you want to mention or remembered that you want to say?

Socio-demographic information

Age

Duration of living in Lagos

Highest level of education

Religion

Ethnicity

Employment

Occupation

Marital status

Sexual orientation and gender identity

Appendix 5: Student Questionnaire for Chapter Six

Questionnaire to Assess Educational Knowledge, Attitude and Delivery of Inclusive Healthcare in an Academic Setting: A Mixed Method Case Study of Faculty and Healthcare Students in Lagos, Nigeria.

Questionnaire ID: ----------

Instructions: Please answer all the questions

Section A – Socio-demographic Section

1. Age (years) at last birthday: _____

2. Which religion do you practice?

A. Christianity [ ] B. Islam [ ] C. Others (Please specify) _____

3. How important is religion in your life?

A. Very important [ ] B. Important [ ] C Not important [ ]

4. How often do you attend religious services?

A. Every day [ ] B. At least once a week [ ] C. At least once a month [ ]

D. At least once a year [ ] E. Never [ ]

5. Which ethnic group do you belong to?

A. Yoruba [ ] B. Igbo [ ] C. Hausa [ ] D. Others (Please specify) _____

6. Marital status? A. Single [ ] B. Married [ ] C. Divorced/Separated [ ]

D. Widow/Widower [ ]

Section B – Knowledge about lesbian, gay, bisexual and transgender (LGBT) people

How familiar are you with the following terminologies? Please tick the appropriate box.

Terminology	**Never heard of it**	**Heard of it but not sure of the meaning**	**Familiar with the word(s)**	**I know the meaning**
Bisexual				
Biphobia				
Cisgender				
Cisnormativity				
Gender Identity				
Heterosexual				
Heterosexism				
Heteronormativity				
Homosexual				
Homophobia				
Micro-aggression				
Sexual orientation				
Lesbian				
Gay				
Bisexual men				
Bisexual women				
Trans				
Transgender				
Transphobia				
LGBT				
Queer				
Queerphobia				

Section C:Attitudes towards Gay, Lesbians, Bisexual Women and Bisexual Men (GLBWBM)

The response to the following statements should be based entirely on your personal opinion.

Statement	**Strongly Agree**	**Partially Agree**	**Indifferent**	**Partially Disagree**	**Strongly Disagree**
GLBWBM are criminals and should be treated as such					
GLBWBM is alien to the African culture and should not be accepted					
GLBWBM need to protest for equal rights					
It would be beneficial to society to recognize GLBWBM as normal people.					
GLBWBM should have equal opportunity of employment.					
GLBWBM should be given social equality.					
I would feel comfortable if my close friend is a GLBWBM.					
GLBWBM is a different kind of lifestyle.					
GLBWBM is a sin					
I would avoid GLBWBM whenever possible					

If you responded very strongly to either agree or disagree with the issues above please expand on your answer

Section D – Attitudes towards Transgender People
The response to the following statements should be based entirely on your personal opinion.

Statement	Strongly Agree	Partially Agree	Indifferent	Partially Disagree	Strongly Disagree
It is a sin to be a Transgendered person					
Transgender people endangers the institution of the family					
Transgendered individuals should be accepted completely into our society					
Transgendered individuals should have equal opportunity of employment.					
I will avoid transgendered individuals whenever possible					
I would feel comfortable working closely with a transgendered individual					
I would feel uncomfortable if I learned that my neighbour is a transgendered individual					
Transgendered individuals should not be allowed to cross dress in public					
I would like to have friends who are transgendered individuals					
I would feel uncomfortable if a close family member became romantically involved with a transgendered individual					

If you responded very strongly to either agree or disagree with the issues above please expand on your answer: ----------
---

Section E – Attitudes towards Lesbian, gay, bisexual and transgender (LGBT) patient

The response to the following statements should be based entirely on your professional opinion as a medical doctor/nurse.

Statement	**Strongly Agree**	**Partially Agree**	**Indifferent**	**Partially Disagree**	**Strongly Disagree**
LGBT patients deserve quality care from doctors and nurses.					
LGBT patients should only seek health care from LGBT health clinics.					
Doctors and nurses in public health facility should not treat LGBT patients.					
I would be comfortable if I became known among my colleagues as a doctor that treats LGBT patients.					
I would be comfortable if my heterosexual patients learned that I was treating LGBT patients.					
I would be comfortable telling my family that I treat LGBT patients.					
I would be comfortable taking history from an LGBT patient					
I would be comfortable conducting a physical exam on an LGBT patient.					
I would be comfortable conducting a genitourinary or pelvic examination on an LGBT patient.					
I would be comfortable discussing sexual behaviour with an LGBT patient					

If you responded very strongly to either agree or disagree with the issues above please expand on your answer: ----------

Section F – Topics

Did lecturers in CMUL teach you any of the following topics? Please indicate the number of hours spent teaching the topic and the method used

Topic	How many hours	Teaching method (Tutorial, seminar, didactic lecture, clinic, ward round, panel sessions, group projects, internship) **Tick as many method as applies for each topic**
Definition and theories of sexual orientation		
Homophobia, heterosexism		
Barriers to access to health care for LGBT people		
Alcohol, tobacco, or other drug use by LGBT people		
Safer sex for LGBT people		
HIV in LGBT people		
Sexually transmitted infections (not HIV) in LGBT people		
Chronic disease risk for LGBT populations		
Disorders of sex development (DSD)/Intersex		
Transitioning (e.g. male-to-female, female-to-male)		
Sex reassignment surgery (SRS)/Gender affirming treatment		
LGBT adolescent health		

Mental health in LGBT people		

If you have been taught about any of these, please comment on how useful the teaching was: ----------

If you have been taught about any of these, please comment on how you felt about it: -

----

If you were not taught about any of the issues please comment on how useful you think the teaching would be: ----------

----

If you were not taught about any of the issues please comment on how you would feel about being taught about it ----------

----

Section G – Barriers and Facilitators

Do you know any student who is an LGBT person? **Yes [ ]** **No [ ]**

Do you know any lecturer who is an LGBT person? **Yes [ ]** **No [ ]**

Do you have friends/family member who is an LGBT person? **Yes [ ]** **No [ ]**

Do you know any patient who is an LGBT person? **Yes [ ]** **No [ ]**

Have you ever used the word gay/homosexual as an abuse to refer to an individual in a clinical or professional situation? **Yes [ ]** **No [ ]**

Have you witnessed anybody been verbally abused in a clinical setting in Nigeria because they are suspected to be an LGBT person/they identify as an LGBT person? **Yes [ ] No [ ]**

What word was used to abuse the person (please specify) ----------

In the most extreme case of this, could you please describe the incident ----------

---

Have you witnessed anybody been physically abused because they are suspected to be an LGBT person/they identify as an LGBT person in Nigeria? **Yes [ ] No [ ]**

What type of physical abuse was used (please specify) ----------

Have you witnessed anybody been discriminated against in a clinical setting in Nigeria because they are suspected to be an LGBT person/they identify as an LGBT person? **Yes [ ] No [ ]**

If yes, in what way (please specify) ----------

In the most extreme case of this, please could you describe the incident ----------

---

What will you do if your classmate is harassed on the basis of sexual orientation/gender identity?

A. Walk away [ ] B. Watch while feeling pity [ ] C. Report [ ] D. Come to the aid of the person [ ] E. Not sure what I will do [ ]

Have you received training specifically on LGBT health? **Yes [ ] No [ ]**

If yes, How? A. Online course [ ] B. Self-directed learning [ ] C. Workshops [ ]
D. Conferences [ ] E. CMUL [ ] F. Others (please specify) ----------

Appendix 6: Faculty Questionnaire for Chapter Six

Questionnaire to Assess Educational Knowledge, Attitude and Delivery of Inclusive Healthcare in an Academic Setting: A Mixed Method Case Study of Faculty and Healthcare Students in Lagos, Nigeria

Questionnaire ID: ----------

No of years in service as faculty: ----------

Instructions: Please answer all the questions

Section A – Socio-demographic Section

1. Age (years) at last birthday: _____

2. Which religion do you practice?

A. Christianity [ ] B. Islam [ ] C. Others (Please specify) _____

3. How important is religion in your life?

A. Very important [ ] B. Important [ ] C Not important [ ]

4. How often do you attend religious services?

A. Every day [ ] B. At least once a week [ ] C. At least once a month [ ]

D. At least once a year [ ] E. Never [ ]

5. Which ethnic group do you belong to?

A. Yoruba [ ] B. Igbo [ ] C. Hausa [ ] D. Others (Please specify) _____

6. Marital status? A. Single [ ] B. Married [ ] C. Divorced/Separated [ ]

D. Widow/Widower [ ]

Section B – Knowledge about lesbian, gay, bisexual and transgender (LGBT) people

How familiar are you with the following terminologies? Please tick the appropriate box.

Terminology	**Never heard of it**	**Heard of it but not sure of the meaning**	**Familiar with the word(s)**	**I know the meaning**
Bisexual				
Biphobia				
Cisgender				
Cisnormativity				
Gender Identity				
Heterosexual				
Heterosexism				
Heteronormativity				
Homosexual				
Homophobia				
Micro-aggression				
Sexual orientation				
Lesbian				
Gay				
Bisexual men				
Bisexual women				
Trans				
Transgender				
Transphobia				
LGBT				
Queer				
Queerphobia				

Section C:

Attitudes towards Gay, Lesbians, Bisexual Women and Bisexual Men (GLBWBM)
The response to the following statements should be based entirely on your personal opinion.

Statement	**Strongly Agree**	**Partially Agree**	**Indifferent**	**Partially Disagree**	**Strongly Disagree**
GLBWBM are criminals and should be treated as such					
GLBWBM is alien to the African culture and should not be accepted					
GLBWBM need to protest for equal rights					
It would be beneficial to society to recognize GLBWBM as normal people.					
GLBWBM should have equal opportunity of employment.					
GLBWBM should be given social equality.					
I would feel comfortable if my close friend is a GLBWBM.					
GLBWBM is a different kind of lifestyle.					
GLBWBM is a sin					
I would avoid GLBWBM whenever possible					

If you responded very strongly to either agree or disagree with the issues above please expand on your answer

Section D – Attitudes towards Transgender People
The response to the following statements should be based entirely on your personal opinion.

Statement	Strongly Agree	Partially Agree	Indifferent	Partially Disagree	Strongly Disagree
It is a sin to be a Transgendered person					
Transgender people endangers the institution of the family					
Transgendered individuals should be accepted completely into our society					
Transgendered individuals should have equal opportunity of employment.					
I will avoid transgendered individuals whenever possible					
I would feel comfortable working closely with a transgendered individual					
I would feel uncomfortable if I learned that my neighbour is a transgendered individual					
Transgendered individuals should not be allowed to cross dress in public					
I would like to have friends who are transgendered individuals					
I would feel uncomfortable if a close family member became romantically involved with a transgendered individual					

If you responded very strongly to either agree or disagree with the issues above please expand on your answer: ----------
---

Section E – Attitudes towards Lesbian, gay, bisexual and transgender (LGBT) patient
The response to the following statements should be based entirely on your professional opinion as a medical doctor/nurse.

Statement	Strongly Agree	Partially Agree	Indifferent	Partially Disagree	Strongly Disagree
LGBT patients deserve quality care from doctors and nurses.					
LGBT patients should only seek health care from LGBT health clinics.					
Doctors and nurses in public health facility should not treat LGBT patients.					
I would be comfortable if I became known among my colleagues as a doctor that treats LGBT patients.					
I would be comfortable if my heterosexual patients learned that I was treating LGBT patients.					
I would be comfortable telling my family that I treat LGBT patients.					
I would be comfortable taking history from an LGBT patient					
I would be comfortable conducting a physical exam on an LGBT patient.					
I would be comfortable conducting a genitourinary or pelvic examination on an LGBT patient.					
I would be comfortable discussing sexual behaviour with an LGBT patient					

If you responded very strongly to either agree or disagree with the issues above please expand on your answer: ----------

Section F – Topics

Did lecturers in CMUL teach you any of the following topics? Please indicate the number of hours spent teaching the topic and the method used

Topic	How many hours	Teaching method (Tutorial, seminar, didactic lecture, clinic, ward round, panel sessions, group projects, internship) **Tick as many method as applies for each topic**
Definition and theories of sexual orientation		
Homophobia, heterosexism		
Barriers to access to health care for LGBT people		
Alcohol, tobacco, or other drug use by LGBT people		
Safer sex for LGBT people		
HIV in LGBT people		
Sexually transmitted infections (not HIV) in LGBT people		
Chronic disease risk for LGBT populations		
Disorders of sex development (DSD)/Intersex		
Transitioning (e.g. male-to-female, female-to-male)		
Sex reassignment surgery (SRS)/Gender affirming treatment		
LGBT adolescent health		
Mental health in LGBT people		

Have you ever used LGBT examples in teaching students? **Yes [ ]** **No [ ]**

If yes, please give examples/cite instances

Are you willing to teach any of the topics? Yes [ ] No [ ]

If you didn't teach any of the topics, what are the reasons? Kindly fill in the table below

A. Not comfortable teaching the topic B. Topics not in the curriculum

C. Topics not considered important D. Topics not considered necessary

E. I am not familiar with the topics F. Not relevant to my discipline

G. Others (kindly specify) ----------

Topic	**Kindly Insert of any reasons mentioned above using the alphabet A, B, C, D, E, F, G. IF THE OPTION PICKED IS G kindly specify. Multiple options are allowed for each topic**
Definition and theories of sexual orientation	
Homophobia, heterosexism	
Barriers to access to health care for LGBT people	
Alcohol, tobacco, or other drug use by LGBT people	
Safer sex for LGBT people	
HIV in LGBT people	
Sexually transmitted infections (not HIV) in LGBT people	
Chronic disease risk for LGBT populations	
Disorders of sex development (DSD)/Intersex	
Transitioning (e.g. male-to-female, female-to-male)	
Sex reassignment surgery (SRS)/Gender affirming treatment	
LGBT adolescent health	

Mental health in LGBT people	
Use in teaching examples of people who are LGBT when teaching about non-sexual health related conditions	

Section G – Barriers and Facilitators

Do you know any student who is an LGBT person? **Yes [ ] No [ ]**

Do you know any lecturer who is an LGBT person? **Yes [ ] No [ ]**

Do you have friends/family member who is an LGBT person? **Yes [ ] No [ ]**

Do you know any patient who is an LGBT person? **Yes [ ] No [ ]**

Have you ever used the word gay/homosexual as an abuse to refer to an individual in a clinical or professional situation? **Yes [ ] No [ ]**

Have you witnessed anybody been verbally abused in a clinical setting in Nigeria because they are suspected to be an LGBT person/they identify as an LGBT person? **Yes [ ] No [ ]**

What word was used to abuse the person (please specify ----------?

In the most extreme case of this, could you please describe the incident ----------

----------?

Have you witnessed anybody been physically abused because they are suspected to be an LGBT person/they identify as an LGBT person in Nigeria. **Yes [ ] No [ ]**

What type of physical abuse was used (please specify) ----------

Have you witnessed anybody been discriminated against in a clinical setting in Nigeria because they are suspected to be an LGBT person/they identify as an LGBT person. Y**es [ ] No [ ]**

If yes, in what way (please specify) ----------

In the most extreme case of this, could you please describe the incident ----------

----------?

Have you witnessed a patient in the hospital/clinic been discriminated against by a Doctor/Nurse in Nigeria because they are suspected to be an LGBT person/they identify as an LGBT person. **Yes [ ] No [ ]**

Have you witnessed any patient denied treatment in Nigeria because they are suspected to be an LGBT person/they identify as an LGBT person. **Yes [ ] No [ ]**

What will you do if you see someone you know harassed/abused on the basis of sexual orientation/gender identity?

A. Walk away [ ] B. Watch while feeling pity [ ] C. Report [ ]

D. Come to the aid of the person [ ] E. Not sure what I will do [ ]

Have you received training on LGBT health? **Yes [ ] No [ ]**

If yes, How? A. Online course [ ] B. Self-directed learning [ ] C. Workshops [ ]

D. Conferences [ ] E. CMUL F. Others (please specify) ----------

Have you studied outside Nigeria? **Yes [ ] No [ ]**

If yes, is it at **A. Undergraduate [ ] B. Postgraduate [ ]**

Which country did you study? ----------

Have you ever worked outside the country as faculty? **Yes [ ] No [ ]**

Appendix 7: Ethical Approval for Chapter Six

COLLEGE OF MEDICINE, UNIVERSITY OF LAGOS
HEALTH RESEARCH ETHICS COMMITTEE
CMUL HREC Registration Number: HREC/15/04/2015
Office Address: 2nd Floor, Biomedical Engineering Block,
College of Medicine, University of Lagos
P.M.B. 12003, Lagos, Nigeria
Telephone: 012932526 *E-mail:* hrec@cmul.edu.ng *Website:* cmul.unilag.edu.ng

Chairman:
Prof. Sunday A. Omilabu
B.Sc. (Hons.) (Ife), M.Sc. (Ibadan), Ph.D. (Ibadan)

Vice-Chairman:
Dr. Kolawole S. Oyedeji
B.Sc. (Uniport), M.Sc. (Ife), MHRE (South Africa), Ph.D, (Lagos), AIMLS (Nig.), CPHPM (Ilorin)

31th October, 2017

Re: Educational Knowledge, Attitude and Delivery of Inclusive Healthcare in an Academic Setting: A Mixed Method Case Study of Faculty and Healthcare Students in Lagos, Nigeria

CMULHREC Number: CMUL/HREC/08/17/240
Name of Principal Investigators: Dr. Sekoni Adekemi
Date of receipt of valid application: 21st August, 2017
Date of meeting when final determination of research was made: 26th October, 2017

APPROVAL LETTER

The above named proposal has been adequately reviewed; the protocol and safety guidelines satisfy the conditions of **CMULHREC** policies regarding experiments involving human and or animal participants.

Therefore, the study under its reviewed state is hereby **approved by the Health Research Ethics committee of College of Medicine of the University of Lagos.**

PROF. S.A. OMILABU
Name of CMULHREC Chairman

PP 31-10-17
Signature & Date

DR. M.O. Akinleye
Name of CMULHREC Member

..... 31/10/17
Signature & Date

This approval is given with the investigator's responsibility declaration as attached and that;

i) You will submit in CMULHREC prescribed forms, annual progress report during the course of this study, if it is more than one year and final report as the case may be if less than one year and after completion of the study.
ii) The CMULHREC reserves the right to monitor and review this approval; even after the commencement of your study and inform you of any further changes or amendments that may be required for your compliance.

This approval dates from **31/10/2017 to 30/10/2018.** If there is delay in starting the research, please inform the HREC so that the dates of approval can be adjusted accordingly