

**LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND INTERSEX
CONTENT IN NURSING EDUCATION PROGRAMMES: A MIXED
METHOD SYSTEMATIC REVIEW**

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DECLARATION

I, Tyrone Brett Coetzee herewith declare that this dissertation I submit for the Master of Nursing (MNurs) at the University of the Free State, is my independent work, and that I have not previously submitted it for a qualification at another institution of higher education.

A handwritten signature in black ink, appearing to read 'Tyrone Coetzee', with a small brownish smudge or ink blot on the right side of the signature.

Signature

Date: 31 July 2023

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TABLE OF CONTENTS

DECLARATION.....	i
ACKNOWLEDGEMENTS	ii
TABLE OF CONTENTS	iii
LIST OF TABLES.....	viii
LIST OF FIGURES	ix
CLARIFICATION AND OPERATIONALISING OF CONCEPTS.....	1
LIST OF ACRONYMS	5
ABSTRACT	6
CHAPTER 1	8
OVERVIEW OF STUDY.....	8
1.1 BACKGROUND AND INTRODUCTION.....	8
1.2 SOCIAL JUSTICE AND LGBTI INCLUSIVITY.....	10
1.3 PROBLEM STATEMENT	12
1.4 REVIEW QUESTION	13
1.5 STUDY PURPOSE	13
1.6 RESEARCH PARADIGM	14
1.7 RESEARCH METHODOLOGY	14
1.7.1 RESEARCH DESIGN.....	14
1.7.2 RESEARCH METHOD	15
1.8 RIGOUR OF THE RESEARCH.....	17
1.9 ETHICAL ISSUES	18
1.10 LAYOUT OF THE DISSERTATION.....	20
1.11 CHAPTER SUMMARY	21
CHAPTER 2	22
TOWARDS INCLUSIVITY	22
2.1 CHAPTER OVERVIEW	22

2.2	THE HOMOSEXUAL PATHOLOGY: THE LIGHT OF HOPE.....	23
2.3	PERSPECTIVES ON LGBTI INCLUSIVITY	25
2.3.1	LGBTI INCLUSIVITY: THE INTERNATIONAL PERSPECTIVE.....	25
2.3.2	LGBTI INCLUSIVITY: THE SOUTH AFRICAN PERSPECTIVE	27
2.4	LGBTI REALITIES.....	28
2.4.1	STRIDES IN SOCIAL JUSTICE – OUR LEGISLATIVE REALITIES	28
2.4.2	THE LIVED EXPERIENCES: OUR DAILY REALITIES.....	29
2.4.3	THE NATURE OF EXCLUSION.....	30
2.4.4	STIGMA AND DISCRIMINATION	30
2.4.5	VIOLENCE AND ABUSE	32
2.4.6	RELIGION AND CULTURE	33
2.5	INTERSECTIONS OF THE MANY AVENUES OF OPPRESSION.....	34
2.6	LEFT UNCHECKED: THE CONSEQUENCES.....	35
2.7	NUANCED HEALTHCARE NEEDS OF SEXUAL MINORITIES.....	36
2.8	NURSING EDUCATION	36
2.9	CHAPTER SUMMARY	37
	CHAPTER 3	39
	RESEARCH METHODOLOGY	39
3.1	CHAPTER OVERVIEW	39
3.2	RESEARCH PARADIGM	40
3.3	RESEARCH APPROACH AND METHOD	43
3.4	THE MIXED METHOD SYSTEMATIC REVIEW.....	43
3.4.1	STEP 1 – FORMULATING THE PURPOSE AND REVIEW QUESTIONS.....	46
3.4.2	STEP 2 – SYSTEMATIC SEARCH AND SELECTION OF LITERATURE.....	47
3.4.3	STEP 3 – QUALITY APPRAISAL AND DATA EXTRACTION.....	53
	3.4.3.1 <i>Quality Appraisal</i>	53
	3.4.3.2 <i>The Quality Appraisal Tools</i>	54
	3.4.3.3 <i>Data extraction</i>	56
	3.4.3.4 <i>Extracted data</i>	57
3.4.4	STEP 4 – DATA ANALYSIS.....	58

3.4.4.1	<i>Data transformation</i>	58
3.4.4.2	<i>Thematic analysis</i>	61
3.4.4.3	<i>Data integration</i>	63
3.4.5	STEP 5 – DISCUSSION AND CONCLUSION	65
3.4.6	STEP 6 – DISSEMINATION OF FINDINGS	65
3.5	MEASURES TO ENSURE RIGOUR.....	65
3.6	ETHICAL CONSIDERATIONS	68
3.7	CHAPTER SUMMARY	73
CHAPTER 4		74
DATA ANALYSIS & REVIEW FINDINGS		74
4.1	CHAPTER OVERVIEW	74
4.2	APPLICATION OF THE STEPS OF THE MMSR	75
4.2.1	STEP 2 - SYSTEMATIC SEARCH AND SELECTION OF LITERATURE	76
4.2.2	STEP 3 – QUALITY APPRAISAL AND DATA EXTRACTION	77
4.2.2.1	<i>Quality appraisal</i>	77
4.2.2.2	<i>Quality appraisal process - results</i>	81
4.2.2.3	<i>Data extraction</i>	82
4.2.3	STEP 4 - DATA ANALYSIS	84
4.2.3.1	<i>Data transformation</i>	84
4.2.3.2	<i>Thematic analysis</i>	85
4.2.3.3	<i>Data integration</i>	85
4.2.3.4	<i>Data synthesis</i>	85
4.3	Review findings.....	86
4.3.1	LGBTI CONTENT IN NURSING PROGRAMMES.....	86
4.3.2	CONTEXT SPECIFICITY.....	91
4.3.3	THE ADVANCEMENT OF SOCIAL JUSTICE.....	92
4.3.4	CHALLENGES AND BARRIERS TO LGBTI INCLUSION.....	94
4.3.5	CURRICULAR REVISION.....	96
4.4	CHAPTER SUMMARY	100
CHAPTER 5		102
CONCLUSION.....		102

5.1	CHAPTER OVERVIEW	102
5.2	SUMMARY OF THE MMSR PROCESS	103
5.3	FACTUAL CONCLUSIONS	104
5.3.1	LGBTI CONTENT IN NURSING PROGRAMMES.....	105
5.3.2	CONTEXT-SPECIFICITY.....	105
5.3.3	THE ADVANCEMENT OF SOCIAL JUSTICE.....	105
5.3.4	CHALLENGES AND BARRIERS TO LGBTI INCLUSION.....	106
5.3.5	CURRICULAR REVISION	106
5.4	CONCEPTUAL CONCLUSIONS.....	106
5.5	NURSING EDUCATION: IMPLICATIONS FOR THEORY AND PRACTICE	108
5.5.1	THEORETICAL IMPLICATIONS	108
5.5.2	IMPLICATIONS FOR CLINICAL AND EDUCATIONAL PRACTICE.....	109
5.6	SUGGESTIONS FOR FUTURE RESEARCH.....	110
5.7	LIMITATIONS OF THE STUDY.....	110
5.8	CONCLUSION	111
	SECTION 6.....	113
	POSTSCRIPT REFLECTION - REFLECTIONS ON MY INTELLECTUAL/ACADEMIC JOURNEY	113
6.1	SECTION OVERVIEW: Critical Reflection: The Deal Model.....	113
6.2	DESCRIBE THE EXPERIENCE OBJECTIVELY.....	114
6.4	EXAMINE EXPERIENCES	117
6.4.1	PERSONAL GROWTH	117
6.4.2	CIVIC ENGAGEMENT/SOCIAL CONTRIBUTION.....	118
6.4.3	ACADEMIC ENHANCEMENT	119
6.5	ARTICULATE LEARNING	120
6.6	LIMITATION OF THE REFLECTIVE PROCESS.....	120
6.7	EXIT STATEMENT	121
	REFERENCES	122

ADDENDUM A - NUMBER OF STUDIES ISOLATED IN EACH ELECTRONIC DATABASE	137
ADDENDUM B - QUALITY APPRAISAL TOOL: MIXED METHOD RESEARCH AND MIXED STUDIES REVIEWS	138
ADDENDUM C - JBI CRITICAL APPRAISAL TOOL FOR SYSTEMATIC REVIEWS	149
ADDENDUM D - QUALITY APPRAISAL	153
ADDENDUM E - EXTRACTION TABLE	157
ADDENDUM F - JBI MIXED METHOD DATA EXTRACTION FORM FOLLOWING A CONVERGENT INTEGRATED APPROACH	176
ADDENDUM G - DATA EXTRACTION - REVIEW MATRIX	178
ADDENDUM H - GATEKEEPER APPROVAL – HSREC SUBMISSION ONE	183
ADDENDUM I - HSREC SUBMISSION TWO	184
ADDENDUM J - SUBSEQUENT SUBMISSION	186
ADDENDUM K - TITLE REGISTRATION	187

LIST OF TABLES

Table 1 Layout of Dissertation	20
Table 2 The Pragmatic Paradigm	41
Table 3 Boolean search string and information sources	49
Table 4 Elements to be extracted	57
Table 5 Data Transformation process	59
Table 6 Comparison of Principle Based and Virtue Based approaches to ethics	72
Table 7 Quality appraisal of selected articles	80
Table 8 Publications included for review	81
Table 9 Summary of themes and sub-themes	86
Table 10 LGBTI Inclusivity	87
Table 11 LGBTI content inclusion - ensuring relevance and aptness	90
Table 12 Sources of LGBTI sensitisation programmes and content	99
Table 13 Unpacking the DEAL Model	113

LIST OF FIGURES

Figure 1 Steps in the MMSR Process	15
Figure 2 Chapter 2 Outline	22
Figure 3 Research Methodology	39
Figure 4 Selection of appropriate review design	45
Figure 5 PRISMA Flow Diagram	52
Figure 6 Convergent integrated approach	64
Figure 7 Ethical Decision Making and Trustworthiness	66
Figure 8 Virtue Ethics - Ethical decision making	69
Figure 9 Chapter Four - Location within the MMSR process	75
Figure 10 Data Analysis and MMSR	84
Figure 11 Chapter Five - Location within the MMSR process	102
Figure 12 Factual Conclusions - Interweaving of Data	104
Figure 13 Interweaving - Conceptual Conclusions	107
Figure 14 The DEAL Model	114

“We are not truly free; unless all of us are free. . . As a transgender female, I still face discrimination, even though I am told that I have rights.”

Logan Geswindt (40)

CLARIFICATION AND OPERATIONALISING OF CONCEPTS

Asexual

South African National Aids Council (SANAC) (2017:vii) states that a person who identifies as asexual harbours no desire for sexual intercourse of any kind. The term also refers to someone who lacks sexual attraction to males or females and others. In this review the description remains applicable.

Bisexual

This term defines bisexual person as describes people who are attracted to their own and the opposite gender. As part of this study, this definition is used.

Cisgender

In contemporary literature, this term is used to define or describe when the individual's biological sex and gender identity are aligned (Sutherland *et al.*, 2016:13). Like heteronormativity and heterosexism, it functions on the assumption of being the only dominant experience. It sufficiently encapsulates the hegemonic notions and beliefs that heterosexuality exists alone, in the absence of gender variation, gender fluidity and sexual orientations. The use of this term will be congruent with its original meaning to adequately represent those who may subscribe to this idea.

Gay

The term "gay" refers to same-sex sexual attraction, generally applied to men who are attracted to and have sex with other men (SANAC), 2017:vii). In this study, the term "gay" operates upon the same premise.

Heteronormative

The term postulates that there are only two genders that are reflected by sex assigned at birth. It accepts heterosexuality - sexual attraction between these opposite genders - as the only normal or natural option for human relationships (SANAC, 2017:vii-viii). This describes the premise of *heteronormativity* and highlights the privileged position associated with

heterosexuality. It is closely linked to heterosexism which refers to the system of beliefs that privileges heterosexuality and discriminates against other sexual orientations. Since the terms heteronormative/heteronormativity are so closely related, for the purposes of this study, both terms will be used interchangeably.

Intermediate-level nursing professional

A nursing professional who falls in this category is expected to have 5-10 years of working experience. This professional is capable of conceptualising new approaches, taking ownership of their work and able to make theory – practice integration (Pendegrast & Horst, 2021:8). For review purposes, this term will be incorporated as such.

Intersex

The term intersex refers to cases where persons are born with ambiguous procreative/sex organs which do not fit classic understandings of male or female anatomy (SANAC, 2017:vii; Sutherland *et al.*, 2016:12). In this study, this definition remains the same.

Lesbian

A lesbian is a female who is attracted to and engages in sexual acts with another female (SANAC, 2017:vii). Within this study, the term lesbian will represent the same definition.

LGBTI

This universal acronym refers to lesbian, gay, bisexual, transgender and intersex persons. “LGB” are sexual orientation, while “T” is a gender identity, and “I” is a biological variation. The ‘Q’ represents those who do not identify with LGBTI. They may consider themselves as *queer* and or *questioning*. The acronym *LGBTI* describes individuals who identify as lesbian, gay, bisexual, transgender and intersex. Because most cited research referred to these subpopulations, as opposed to the broader *LGBTIQA+*, which further includes queer/questioning, asexual and other sexual and gender-diverse persons, the researcher considered this acronym the primary one used (Qureshi *et al.*, 2020: 113).

There are currently many forms of this acronym which denotes a broad range of persons who are ostracised because of their sexual practices or who resist heteronormative ideals. These population groups are grouped on similarities in lived experiences related to ostracism, marginalisation, discrimination, and persecution in society (Department of Justice and Constitutional Development, 2014b:15; SANAC, 2017:viii). In this study, the acronym LGBTI will be used interchangeably to include queer/ questioning, asexual, and other sexual and gender-diverse persons.

LGBTI Content

Learning content refers to “*the assemblage of topics, themes, beliefs, behaviours, concepts and facts, clustered within a given subject or learning area under knowledge, skills, values and attitudes, that are expected to be learned*” as part of activities related to of teaching and learning (The United Nations Educational, Scientific and Cultural Organization (UNESCO), International Bureau of Education, 2021). In this study, the term LGBTI content seeks to encompass the same definition. It also includes covering cultural competencies related to working with LGBTI persons, as well as sensitisation training modules for nurses that cover social justice, physical and mental health, and wellbeing.

LGBTI Inclusivity

Dreyer (2017:391) outlines the term within an educational context. It is viewed as a multifaceted concept. Concerning the study, the term represents the active and mindful reflection, not only of content relating to LGBTI health issues but also a comprehensive realisation of the human rights approach to same-sex or LGBTI-related rights. It is about spanning divides between legislative rights and safeguards for LGBTI persons and the actual reality of LGBTI persons (DOJ & CD, 2014a:15).

Mixed method systematic review

The *Joanna Briggs Institute Manual for Evidence Synthesis* describes the mixed method systematic review (MMSR) as a method of inquiry that seeks to integrate quantitative, qualitative, and mixed method evidence to create a comprehensive understanding using available research (Lizarondo & Munn, 2020:15). Unlike the IR the MMSR, allows the researcher to employ a broad review question address the current state of evidence related

to the review question. The MMSR draws on diverse forms of research and allows for wide-ranging assessment of evidence found, the deficits in the collected academic works and aids to pinpoint future research and practice (Lizarondo *et al.*, 2021:248; Toronto & Remington, 2020:6). MMSR findings could be used to confirm or dispute evidence but more importantly, answer the review question/s posed. This type of evidence synthesis is beneficial in healthcare as it attempts to increase the worth and utility of research findings. In the context of this study, this definition remains unchanged.

Nursing education programme

The term nursing education programme refers to the complete academic and practical offering available at an institution of higher education, leading to the bestowal of qualification in the discipline of nursing, recognised by a statutory body (SANC, 2013a:38). In this review, the term nursing education programme/nursing programme refers to the four-year undergraduate university-based, bachelor's degree programmes and all postgraduate programmes (Postgraduate Diploma, Master, and Doctorate studies) in South Africa. Internationally, the basic qualification (*Pre-licensure*) spans three to four years and leads to the conferral of a qualification and registration in the discipline of nursing. Postgraduate programmes may take between one to 4 years to obtain and lead to qualification as a nurse specialist, with or without additional areas of registration.

Transgender

This term describes an individual whose inner gender identity does not match their (external) biological sex (SANAC, 2017:vii; Sutherland *et al.*, 2016:12). This makes it a matter of gender identity rather than sexual orientation. As part of this study the definition remains unchanged.

LIST OF ACRONYMS

- AIDS** Acquired Immunodeficiency syndrome
- HIV** Human Immunodeficiency Virus
- HSREC** Health Sciences Research Ethics Committee
- JBI** Joanna Briggs Institute
- LGBTI** Lesbian, Gay, Bisexual, Transgender and Intersex and all persons who do not categorise themselves within the sexual and gender minorities.
- MMSR** Mixed method systematic review
- SANAC** South African National Aids Council
- SoN** School of Nursing
- SR** Systematic Review
- UFS** University of the Free State

ABSTRACT

Introduction: A prevailing heteronormative approach observed within nursing programmes could perpetuate non-inclusive attitudes amongst nurses. A paucity of published evidence indicated the need to undertake a comprehensive synthesis of evidence regarding LGBTI content in nursing programmes.

Purpose: This MMSR set out to critically synthesise existing evidence in the literature on LGBTI content in nursing programmes in order investigate what evidence exists in the literature on LGBTI content in nursing programmes. The MMSR is provided an updated and comprehensive insight into the presence/inclusion of literature which covers LGBTI-related content in nursing education programmes.

Methods: A mixed method systematic review, conducted according to Joanna Briggs Institute (JBI) Manual for Evidence Synthesis Preferred Reporting Items for Systematic Reviews and Meta-Analyses using the (PRISMA) guidelines, guided the review process. The MMSR followed systematic approach to the search and selection of literature. Data sources were identified within EbscoHost Web, Scopus and Google Scholar. A convergent integrated approach for data integration and synthesis was followed. Data were extracted with the use of two standardised data extraction tools. Through inductive reasoning and MMSR processes of thematic analysis, data transformation, data integration and data synthesis of information from qualitative, quantitative, and mixed method studies. The main search identified 316 publications (n=316) resulting in ten (n=10) articles for quality appraisal. Data of nine (n=9) articles included in this review were extracted. A thematic analysis (manually performed) aided in identification of recurrent themes.

Results: LGBTI content in nursing programmes were found to be present but lacking specificity and relevance. The context in which the included studies were conducted linked several social and health related LGBTI aspects, regardless of location. However, location and local belief system dictated extremes to which LGBTI inclusivity was practiced. The review findings further elaborate that curricular revision is necessary in the advancement of social justice, to overcome challenges and barriers to LGBTI inclusion.

Conclusions and Recommendations: In nursing education, a prevailing heteronormative approach creates large gaps in cultural and clinical competencies regarding LGBTI health issues. The concepts of inclusivity, representation, respect, and recognition, according to the review findings, LGBTI content should be included in teaching and learning offerings provide new foci and understandings within the LGBTI research area. Education on LGBTI health disparities could foster a keen appreciation of the impact of stigma and discrimination

experienced by LGBTI persons. To advance a social justice agenda for marginalised and vulnerable populations, LGBTI health-related content in nursing education and healthcare service delivery programmes could enrich and supplement content currently presented.

CHAPTER 1

OVERVIEW OF STUDY

1.1 BACKGROUND AND INTRODUCTION

At South African nursing education institutions, delivering comprehensive, quality education, and developing clinical competencies through practical exposure is important for the registered nurse in preparation for professional practice. Once the basic nursing qualification is completed, the registered nurse is expected to possess a broad range of skills and competencies needed to care for a range of diverse individuals holistically (Henriquez *et al.*, 2019:508; Sommers *et al.*, 2020:126). Nursing education institutions are thus responsible for training and preparation of culturally competent students. However, research suggests that when it comes to sexual minorities, nursing students are poorly educated to meet the health and wellbeing needs of lesbian, gay, bisexual, transgender and intersex (LGBTI) (Müller, 2015:2; Müller, 2018:2). Internationally, there is a re-examination, a refocus towards the realisation of a genuinely inclusive approach to LGBTI inclusivity within healthcare and consequently, health sciences education.

Müller (2013:2) and Müller (2018:2) disseminate data from South Africa and the United States (US) which outlines prevalence of persons identifying as LGBTI in a given population and estimated LGBTI prevalence at just over 10%. Therefore, the likelihood that healthcare professionals may have to deal with LGBTI health issues relating to sexual orientation and gender identity is high yet remains mostly ignored. Given the prevalence of individuals who identify as LGBTI, one can accept that LGBTI persons could be found in every human society, culture, and context (Beyrer, 2012:177).

A recent study across six European Union (EU) member states identified two significant gaps in cultural competencies for nurses regarding LGBTI healthcare provision. These refer to an absence of *knowledge* and *awareness* of the nuanced healthcare needs of LGBTI persons and non-inclusive attitudes healthcare professionals and undergraduate students possess within faculty and the clinical setting (Donisi *et al.*, 2019:979). This sentiment is echoed in similar literature, which identifies the former as the driver of stigma and discrimination of LGBTI individuals within the healthcare setting (Röndahl, 2011:345; Zeeman *et al.*, 2019:974).

In Turkey, a descriptive, cross-sectional study of 2,123 nurses, indicated that 75% of those who participated, revealed an increased prevalence of homophobia towards LGBTI persons. This may be further compounded by the influence of norms and beliefs of this primarily Muslim society (Çakır *et al.*, 2020:617).

Similarly, a Swedish study conducted by Rödahl (2010:245) ten years before Çakır *et al.* (2020), also reported on LGBTI *content* and *representation* within the curriculum. The study concluded that no participating nursing students could recall specific education dealing with LGBTI issues in curricular content. The exclusion of LGBTI content in undergraduate nursing training may, in such instances, exacerbate health inequalities, including discrimination in healthcare settings which, in itself, creates barriers to accessing healthcare and presents major hurdles to LGBTI-inclusive health (Donisi *et al.*, 2019:979).

In Africa, the situation appears worse. In as many as 35 African nations, homosexuality remains illegal. In two countries, Mauritania and Sudan it is punishable by death, and harsh sentences are imposed in areas of Nigeria and Somalia (Moagi *et al.*, 2020:3). In the Republic of Uganda, repressive laws have been passed that LGBTI relationships, according to *The Republic of Uganda Anti Homosexuality Act (2014)*, approved by the Ugandan Parliament on 20 December 2013, effective from December 2014. The law instructs harsh punitive action against LGBT persons. This move effectively classed LGBTI persons in the same category as major crimes (Moagi *et al.*, 2020:8). This repressive piece of legislation discriminates and stigmatises LGBTI persons, resulting in avoidance of pursuing treatment and care for fear of reprisal (Nduna *et al.*, 2017:20; Habib, 2019:1).

Across the African continent, LGBTI persons are open to unrestrained forms of ignorance, hatred, and discrimination, often from their communities and within their own families. Exposure to violence, in all its forms, are damaging to one's safety and well-being of a person (Moagi *et al.*, 2020:5). In Africa, many such outcries against the LGBTI community are relentless. The late president of Zimbabwe, Mr Robert Mugabe's condemnatory remarks have been directed at the LGBTI community for a long time, openly describing gay people as pigs and dogs (Moagi *et al.*, 2020:5). These views further normalise discrimination, violence, and prejudice towards LGBTI persons, and may lead to violent interactions with LGBTI persons.

In South Africa, over half a million people across all populations and age groups categorise themselves as LGBTI, comparable to the population ratio (1 in 10) in other parts of the world (Sutherland *et al.*, 2016:3; Wang *et al.*, 2020:606). South Africa is renowned for its liberal and inclusive constitution, however, there remain inadequacies and shortcomings about implementation of these laws. Globally, the South African Constitution is among the first in the world to outlaw discrimination based on sexual orientation. On an international scale, South Africa was fifth in the world, the first in Africa, to legalise LGBTI marriage (DOJ & CD, 2014a:1; South African National Aids Council (SANAC), 2017:10). These laws exist to protect and safeguard the rights of those who identify as LGBTI. Still, despite these legislative strides on the ground, the reality is that LGBTI individuals experience social exclusion, discrimination, stigma, and violence.

In contrast to their heterosexual counterparts, LGBTI persons are disproportionately predisposed to higher levels of substance abuse, depression, and suicide and at higher risk for sexually transmitted infections and HIV (SANAC, 2017:10). Societal rejection adversely contributes to a sharp decrease in health-seeking behaviours among LGBTI individuals. There appears to be a lack of inclusion of LGBTI health-related issues in rollout plans by National Health, with little to no reference made to clinical care guidelines (Beyrer, 2012:177-178; Department of Health; Jones, 2019:457; Mprah, 2016:18; Müller, 2013:1; Müller, 2015:4; SANAC, 2017:10; Wang *et al.*, 2020:606).

1.2 SOCIAL JUSTICE AND LGBTI INCLUSIVITY

Within the South African context, literature raises four main challenges to LGBTI inclusivity, (1) diversity in culture, (2) religious beliefs, (3) ethnic backgrounds, and (4) a mainstream educational approach that excludes LGBTI individuals from its discourse (Mprah, 2016:18; Müller, 2013:2). It could be argued that the first three challenges may sustain and drive a heteronormative approach. The fourth challenge, related to education, later serves to solidify LGBTI exclusion. 'Heteronormativity' is the concept used to describe the powerful heterosexual paradigm from which education is chiefly dispensed in our schools and universities. The concept of heteronormativity assumes heterosexuality as the universal norm and wrongfully implies heterosexuality as the only assumption around the constructs of sexuality of individuals (Röndahl, 2011:345).

Heteronormativity is deeply rooted and perpetuated by virtue of religious and cultural objection. These misplaced beliefs leaving LGBTI persons to endure unbridled hostility and rejection (Moagi *et al.*, 2020:7). Keeping this in mind, it is not surprising that the overriding teaching approach to LGBTI health at health sciences faculties across South Africa is biomedical and developmental (covering risk, or dysfunction) and not teaching LGBTI healthcare disparities as determinants of health (Juan *et al.*, 2021:80; Müller, 2013:2; Reygan, 2021:114). This consequently leaves little space for questioning around gender and sexuality constructions and propagates and drives societal partiality towards heteronormative standards as a normal cultural and social institution (Müller, 2015:4; Müller, 2013:1). It is here, at institutions.

According to Müller (2015:4) and Reygan (2021:114), this exposes profound gaps in teaching relating to LGBTI identities, with disparities in content within South African and African health education institutions. The care and management of LGBTI individuals, their partners, and families within the context of healthcare varies vastly across social and political landscapes. It is expected, within health sciences, that healthcare professionals provide quality care that is inclusive and non-discriminatory. It is regrettable that the literature states a large portion (ranging around 65%) of healthcare professionals, both internationally and nationally, have demonstrated deep prejudice against LGBTI individuals when it comes to the provision of care (Donisi *et al.*, 2019:979, Wang *et al.*, 2020:606 and Fauer *et al.*, 2020:599).

At nursing education institutions across South Africa, the delivery of the undergraduate nursing programmes takes place from a heteronormative perspective (Donisi *et al.*, 2019:979; Müller, 2013:2). As a learner and an intermediate-level health professional, I am aware that nurses receive varying, sporadic, or negligible training on gender identity in their professional undergraduate tutelage (Fauer *et al.*, 2020:600). The undergraduate training of nurses should not only impart the necessary skills and competencies but should also serve to sensitise students to the realities faced by those who seek their care.

1.3 PROBLEM STATEMENT

Presently, there remains a paucity of content concerning LGBTI health-related issues such as physical health, mental health, and well-being within nursing education curricula (Donisi *et al.*, 2019:979; Müller, 2013:4; Müller, 2015:6; Røndahl, 2011:345; Zeeman *et al.*, 2019:974). There is equally a lack of evidence dealing with LGBTI issues such as social justice and inclusion (Sommers & Bonnel, 2020:126).

The absence of LGBTI inclusivity in nursing programmes could be perceived as being dominated by a prevailing heteronormative milieu driving the non-inclusive attitudes of healthcare professionals, nurse educators and nursing students. Non-inclusive attitudes such as stigma and discrimination drive LGBTI persons to live on the fringes of society, many of whom may not be living openly. However, it is recognised that members of the LGBTI community are situated in all areas of society (Müller *et al.*, 2020:10; Müller, 2013:4). Literature also proposes that the probability that healthcare professionals may encounter LGBTI individuals is high. Clearly, health professionals could encounter LGBTI healthcare users during their careers (Müller, 2015:6).

For LGBTI individuals, disparities in healthcare manifest when these services are aligned to heteronormativity, driven mainly by social and cultural norms. The lack of instructional content in nursing may, in turn, strengthen and entrench stigma and discrimination of sexual minorities, shunning a considerable percentage of the LGBTI community who actively seek essential healthcare. (Donisi *et al.*, 2019:979; Müller, 2013:4; Müller, 2015:6; Røndahl, 2011:345; Zeeman *et al.*, 2019:974). The omission of LGBTI content and instruction in nursing programmes presents critical gaps in training for healthcare professionals. (Donisi *et al.*, 2019:979; Müller, 2013:174; Sommers & Bonnel, 2020:126). These exclusionary practises are rooted in pervasive patriarchal norms and conventions of heteronormativity, and often extend beyond forms of structural discrimination (Sutherland *et al.*, 2016:3-39; Zeeman *et al.*, 2019:974).

It is estimated that 30% of LGBTI persons experience high levels of day-to-day physical violence and discrimination at the hands of their communities and families. This burden of violence and discrimination, ill-tailored preventive health screenings and the high incidence of mental health conditions among youth and adults remains high among LGBTI persons (Fauer *et al.*, 2020:599; SANAC, 2017:13-15).

Therefore, the following question is submitted: *What available evidence exists in literature on LGBTI content in nursing programmes?* This study seeks to identify LGBTI content in nursing programmes to guide and inform educational practice. Ultimately it is hoped that nursing graduates would be better equipped to provide person-centred care to LGBTI persons.

An explorative search of academic literature was conducted with the assistance of a senior librarian (*data specialist*) to validate the need for an inquiry into this topic. The explorative search yielded 192 articles, and after automatic system deduplication, 96 articles were left. A further seven duplicates were removed from this search through manual sorting. The initial search supported the notion regarding the scarcity of literature on the topic. The findings of the explorative search served as a motivation to broaden the scope of the search. Instead of a narrow focus on the undergraduate curriculum, the main search would cover the whole spectrum of nursing training and education.

For the researcher to realise the review question, there was a need to understand the prevalence of LGBTI content inclusion in nursing programmes.

Based on the findings of this review, the researcher anticipates that further study may provide insight into the necessity of truly inclusive clinical instruction within the nursing discipline and contribute implicitly to knowledge advancement within academic spaces.

1.4 REVIEW QUESTION

The question to be answered in this study is: *What evidence exists in the literature on LGBTI content in nursing programmes?*

1.5 STUDY PURPOSE

The purpose of the study was *to synthesise existing evidence in the literature on LGBTI content in nursing programmes.*

1.6 RESEARCH PARADIGM

The researcher needs to elucidate their philosophical and theoretical premise. In this study, the researcher was directed by a pragmatic paradigm, in which “practice and method” receive preference over “reflection and deliberative action” (Denzin & Lincoln, 2018:18). The pragmatic worldview focuses on “what works”, thus granting the researcher the freedom to choose a research design and methodology most appropriate to achieve the purpose of the study (Creswell & Poth, 2018:378; Kivunja & Kuyini, 2017:36). For a more intricate dialogue on the philosophical assumptions of this paradigm, refer to section 3.2.1.

1.7 RESEARCH METHODOLOGY

In this section, the researcher provides a firm foundation for the chosen research design and methodology used while conducting research (De Vos & Strydom, 2011:115; Polit & Beck, 2021:142) to embark on a critical synthesis of available evidence in the literature on LGBTI content in nursing programmes.

1.7.1 Research Design

The researcher believed that a systematic synthesis of the literature, using a mixed method systematic review (MMSR), would provide a sufficient foundation from which to advance new understandings of LGBTI health-related content in nursing programmes. The design was preferred because an MMSR allows for an expansive assessment of a phenomenon of interest. The design, through evidence synthesis, supports the advancement of a comprehensive understanding in relation to the research phenomenon (Dhoulande *et al.*, 2021:428; Toronto & Remington, 2020:2). Furthermore, pragmatism as the chosen paradigm places importance on answering the review question rather than on selecting methods to meet requirements associated with qualitative or quantitative research (Pillay & Morel, 2020:3). As the SR, a MMSR as a design assists the researcher to critique, summarise and draw conclusions objectively. This MMSR follows a systematic approach allowing diligent categorisation of past qualitative and quantitative research studies on the subject (Toronto & Remington, 2020:2).

The researcher seeks to synthesise existing evidence, in literature, on LGBTI content in nursing programmes through the MMSR process and present new understandings in relation to literature (Grove & Gray, 2019:483, Pussegoda *et al.*, 2017:2; Toronto & Remington, 2020:1).

1.7.2 Research Method

The researcher followed an organised and meticulous data collection, sorting and analysis process according to steps applicable to a MMSR. Explanations of the steps of a MMSR in the Joanna Briggs Institute (JBI) Manual for Evidence Synthesis were integrated with those of an integrative review as described by Toronto and Remington (2020:6) for purposes of simplification. The steps of an integrative review are similar to that of a MMSR. The integration of the steps followed in the IR and MMSR provided the researcher with a clear and simplified approach to follow. The steps followed in this MMSR are presented in *Figure 1* and guided by Lizarondo *et al.* (2020), the JBI Manual for Evidence Synthesis and informed by Toronto and Remington (2020) throughout the research process.

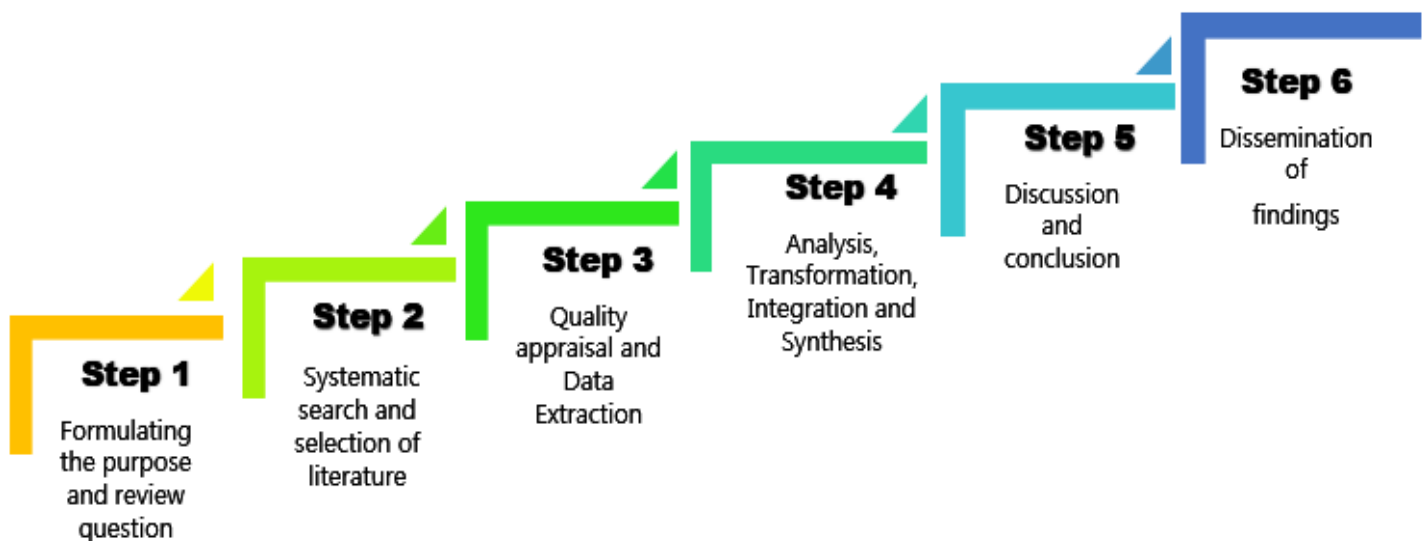


Figure 1 Steps in the MMSR Process

Adapted from Lizarondo *et al.*, (2021) and Toronto and Remington (2020:6)

Step one involves formulating the purpose and review question. During this initial step, the researcher developed and reviewed the significance of the research problem. The background provided sufficient justification for the MMSR.

The review question and purpose were kept broad yet well-defined, to demarcate and inform the search process and data collection. This allowed greater literature search scope, ensuring an array of publications which may inform the review question (Toronto & Remington, 2020:15-17).

Step two encompasses the systematic search and selection of literature. During this step, a broad literature search was sought. The researcher consulted a *data specialist* at the UFS to enhance specificity and completeness. More than one search strategy was employed to identify multiple eligible primary and secondary studies. Grey literature, or evidence not published in commercial publications, has been excluded from the MMSR to preserve rigour.

In step three, the researcher engaged in the quality appraisal of selected documents. The researcher understands that the quality of the studies included determine the strength of a review's findings (Lizarondo *et al.*, 2021: 283). Methodological quality was assessed using the *Mixed methods Research and Mixed-Studies Reviews* developed by the *JBI Appraisal Tool for Systematic Reviews (SR)*. The researcher also incorporated a scoring system to assist in the quality assessment/appraisal process. This served to refine the list of full-text articles selected and is the final stage in organising the group of studies for data analysis and synthesis (Pollock & Berge, 2018:147, Xiao & Watson, 2020:106).

In the fourth step, data extracted from the appraised publications is engaged in analysis, transformation, and synthesis of data. Data were summarised and organised in a data extraction table (Polit & Beck, 2021:592; Toronto & Remington, 2020:58; Xiao & Watson, 2020:107). These data extraction and data table forms then became the dataset from which to synthesise and collate information. Data from qualitative and quantitative studies were transformed or *qualitised*, then analysed using thematic analysis. Recurring and main themes were identified. Due to the qualitative approach taken in this MMSR, the nature of the study may be somewhat emergent because themes at various levels could not be pre-empted. The study purpose and specifiers were used to guide the analysis of identified themes, building, and expanding as new themes emerged. This approach can assist the researcher to depict the observed relationships between themes (Dhollande *et al.*, 2021:435).

During the fifth step, discussion, and conclusion of a MMRS, the researcher unpacked the meaning of the review findings, collated findings, and drew comparisons and contrasts about the background literature and with the work of others (Toronto & Remington, 2020:8). In the final step, step six, dissemination of findings occurred. During this step the researcher communicates research synthesis to a targeted professional community (Toronto & Remington, 2020:9). In the case of this study, in achievement of the master's qualification, dissemination takes place when the study is submitted.

1.8 RIGOUR OF THE RESEARCH

Rigour in a MMSR refers to the thoroughness and detail with which research is carried out (Burns & Grove, 2011:39). It is important that the researcher diligently follows the steps, direction, and references for developing protocols, describing search terms, delineating inclusion, and exclusion criteria, and critically evaluating studies, as these are characteristics of rigour and quality for this method (Botma *et al.*, 2010:233; De Vos., 2012:419-421; Zawacki-Richter *et al.*, 2020:77). To ensure rigour throughout the study process, the researcher sought to embed the framework by Guba and Lincoln (1994) and Lincoln and Guba (1985). The concept of trustworthiness is employed mainly because of the descriptive nature of the MMSR. The framework consists of five strategies to ensure rigour in a study, credibility, dependability, confirmability, transferability, and authenticity.

The five criteria to ensure trustworthiness were adapted from Polit and Beck (2021:559) and are listed below:

1. **Credibility** – conducting the review in a way that enhances the plausibility and outline steps taken to exhibit credible research.
2. **Dependability** – the reliability of data over time and refers to the replicability of the study.
3. **Confirmability** - the impartiality of the data and whether other researchers would independently agree on data relevance and accuracy.
4. **Transferability** - is the extent to which the review findings could apply in other settings.
5. **Authenticity** – the degree to which the researcher can fairly reflect varied realities.

The researcher is mindful that quantitative understandings of minimising bias to ensure rigour cannot be generalised within the context of qualitative research. The qualitative concept of *trustworthiness* was employed due to the descriptive nature of the MMSR and comprises qualitative, quantitative, and mixed method studies.

1.9 ETHICAL ISSUES

As cited, the pragmatic axiological assumption holds that the ethical goal of inquiry is to gain knowledge while answering the review or research question (Mertens, 2017:20). The paradigm, with its epistemological focus on the inquiry process and practicality, lends itself to a virtue-based approach to ethics (Kelly & Codeiro, 2020:2). Literature highlights considerations of ethical issues of traditional qualitative inquiries. Ethical considerations in research take place before, during and after, following a linear fashion, to the point of publishing a study (Botma *et al.*, 2010:5; 26-27; Creswell & Poth, 2018:87).

The researcher agrees that ethics should be applied in all phases of the review process. The researcher chose an augmentation view to ethics where a virtues-based approach supplements adherence to principles, as put forward by Resnik (Resnik, 2012:335). The application of an augmentation view incorporates virtues which may best guide ethical decision-making throughout the study process. As indicated and supported by Banks (2018:10), the virtues chosen by the researcher have been identified as *practical wisdom, respectfulness, trustworthiness, and justice*, (see section Figure 7 Ethical **Decision Making and Trustworthiness**

Credibility refers to how the study was executed and how this enhances the believability of the study. It also speaks truth value of the data and interpretations thereof. The researcher must safeguard the systematic approach of the MMSR. In Step 1, the importance of explicit criteria assisted the researcher in minimising the risk of bias and allowed the reader to judge the validity of the review. An important part of the process is the explorative searches in Step 1, which guides the researcher to formulate a broad research question and purpose. Once that has been achieved, a well-structured review purpose and variables of interest facilitate all other stages of the review. During Step 3, the appraisal of each study was well documented to support the integrity of data analysis in Step 4. Involvement of co-researchers, through Steps 1 to 6, also guided and refined the study, which increases credibility.

Dependability refers to data reliability or stability over time and conditions if the study was replicated within the same parameters. The researcher has ensured that the data used throughout the study are traceable and available as is required for auditing purposes, as in Steps 1 to 4 (De Vos., 2012: 420). The quality of the studies for review was assessed, in Step 3, using a score system for *Mixed Method Research and Mixed Studies Reviews and the Critical Appraisal Skills Programme* (Pluye *et al.*, 2009). Incorporating the PRISMA flow

diagram (*Figure 3.4*) assisted with reporting the literature selection process for the review sample. This improves the reliability of the study while reducing bias (Botma *et al.*, 2010: 233; Toronto & Remington, 2020:7; Xiao & Watson, 2019:105). Identifying and acknowledging limitations of the review, in Step 6, explicitly, is viewed credible and ultimately fortifies impact of the review and speaks to factors which may impact the replicability of the study.

Confirmability speaks to whether two or more people would independently agree on data relevance and accuracy and objectivity of the data. In Steps 1 and 2, a comprehensive search for literature sought to identify the maximum number of eligible primary sources, using more than one strategy. The researcher ensured that there were definite inclusion and exclusion criteria for the review. The researcher, in Step 2, consulted a data specialist at UFS to increase specificity and comprehensiveness (Choi *et al.*, 2019:472; Tawfik *et al.*, 2019:3; Toronto & Remington, 2020:7). In Step 4, the researcher considered it necessary to have more two reviewers peruse abstracts and to do so independently.

Transferability denotes the degree to which research findings could have applicability in other settings. The study should be executed in such a manner as to allow transferability, which means, that it could be duplicated within another social/occupational context, following the same steps. In Steps 1 and 2 the researcher has opted to utilise SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research type), put forth by Cooke *et al.* (2021:1437) used as search method and to refine the research question and purpose. During Steps 1 to 4, the search string and quality of studies have been described as the extent to which the review uses measures to minimise bias in the research design, conduct and analysis.

Authenticity denotes the degree to which the researcher can justly display a range of realities. During Step 4, the researcher collated findings, and drew comparisons and contrasts about the background literature (Toronto & Remington, 2020:8). In Step 2, the MMSR search utilised two search terms or phrases, searching multiple databases. This supports a comprehensive and rigorous review. The researcher ensured that the research process, Steps 1 through 6, were guided by virtue-based ethics to enhance authenticity. In Step 6, references were current, original, and accurate and backed the arguments made in the review. Any conclusions in the MMSR were displayed graphically (table or diagram) to ensure transparency.

1.10 LAYOUT OF THE DISSERTATION

Table 1 (below) represents an outline of the chapters of this dissertation.

Table 1 Layout of Dissertation

Chapters	Brief Description	Addenda
Chapter 1: Background Study Overview	An overview and background of the review, paradigmatic perspectives, and methodology to be employed as well as the problem statement, research question and purpose of the review.	None
Chapter 2: Literature Review	Contextualise the research problem. Locates the study within current discourse around LGBTI persons and content inclusivity in nursing education.	None
Chapter 3: Research Methodology	In the chapter, the research paradigm is described. The research method and design are explained. The six steps of a MMSR are described: Step 1 Formulating the purpose and review question. Step 2 Systematic search and selection of literature. Measures to ensure rigor and ethical considerations are also covered in this Chapter.	Addendum A Addendum B Addendum C Addendum D Addendum E Addendum F
Chapter 4: Data Analysis	Step 2 Systematic search and selection of literature Step 3 Quality Appraisal and Data Extraction Step 4 Analysis, Transformation and Synthesis Step 5 Discussion and conclusion	Addendum G
Chapter 5: Discussion of Findings and Conclusion	Step 5 Discussion & conclusion Step 6 Dissemination of findings	
Section 6: Researchers Reflection	Critical reflection (CR) to guide serious discussion around the researcher's: (a) personal experiences, perceptions, and feelings, (b) considerations on social justice and perceived contributions and recommendations. (c) How did these experiences enhance my knowledge –learning and development.	Addendum H Addendum I Addendum J Addendum K

1.11 CHAPTER SUMMARY

The lack of inclusivity within nursing programmes is dominated by a heteronormative frame, perpetuated by non-inclusive attitudes of healthcare providers, the community, and families (Sommers & Bonnel, 2020:126). The researcher has provided the reader with a *blueprint*, a contextual motivation for the study. A brief explanation was provided regarding the chosen research design as well as the research method and an overview of measures to ensure the study's rigour. Ethical considerations were included. Clinical competencies are important but also proficiencies related to emotional intelligence and cultural competencies. To provide equal and equitable care to LGBTI persons or sexual and gender minorities, we must reflect on our own biases and recall our mandate as nurses. The following chapter elucidates findings from literature on contemporary views around LGBTI inclusivity in nursing. It provides context for the study concerning literature on social justice, legislative application, and the nuanced healthcare needs of LGBTI persons.

CHAPTER 2

TOWARDS INCLUSIVITY

2.1 CHAPTER OVERVIEW

The study’s objectives were placed front and centre - to provide a synthesis of the available evidence in the literature on LGBTI content in nursing programmes. The examination of literature to find proof of the inclusion of LGBTI content may, perhaps, be frank/candid. It is, however, important to provide context as to why it is necessary to include LGBTI in the nursing academic programme, especially in the current discourse on LGBTI inclusivity, representation, and the advancement of social justice.

2.1 Chapter Introduction and Overview					
2.2 The Homosexual Pathology	2.3 Perspectives: On LGBTI Inclusivity	2.4 LGBTI Realities	2.5 Intersections	2.6 Consequences	2.7 Nuanced Health Care - LGBTI
	2.3.1 International Perspectives on LGBTI Inclusivity	2.4.1 Strides in Social Justice	2.5.1 Intersectionality		
	2.3.2 South African Perspectives on LGBTI Inclusivity	2.4.2 LGBTI – Lived Experiences			
		2.4.3 The Nature of Exclusion			
		2.4.4 Stigma & Discrimination			
		2.4.5 Violence and Abuse			
		2.4.6 Religion and Culture			
2.8 Nursing Education					

Figure 2 Chapter 2 Outline

In this chapter, (refer to Figure 2) the researcher has set out a rationale for this inquiry and seeks to contribute to advancing social justice for LGBTI persons. The background not only provides a concise overview of a substantive rationale for the study but also how the research was be conducted,

2.2 THE HOMOSEXUAL PATHOLOGY: THE LIGHT OF HOPE

The terms “*homosexual*” and “*homosexuality*” was popularised by Hungarian journalist Károli Mária Kertbeny, at a political gathering in 1869. The terms were inserted in Prussian law and later codified in the German legal framework, which criminalised male homosexual behaviour (Drecher, 2020:427). Homosexuality and same-sex relationships, between men in particular, had been considered aberrant and criminal for centuries. In late 19th century, psychiatrists and medical practitioners looked to cure LGBTI desire medically and looked for ways to treat this pathology.

Theories of pathology painted homosexuality as an affliction, an unnatural deviation from “*normal*” heterosexual life (Lind *et al.*, 2010:8; Saitta, 2020:1). At the same time across America, the LGBTI community was subjected to a myriad of dubious medical interventions, ranging from electroconvulsive therapy to aversion therapy and trans-orbital lobotomies; a sign that the medical establishment considered homosexuality a disease (Tom & Godwin, 2020:22; Lind *et al.*, 2010:8; Saitta, 2020:5). In Europe various mental health-related disciplines were conceptualising the possible “corrective treatment” of gay men and women, experimenting with many ways in which to *convert* or adjust deviations in sexual orientation. This included psychotherapists, psychiatrists, and psychologists.

Homosexuality was widely considered to be a mental disorder, marking the first notion that “the homosexual” may need some degree of special healthcare. In 1952 the American Psychiatric Association (APA) published edition one of the Diagnostic and Statistical Manual (DSM-I) and classified “*the homosexual*” and the act of “*homosexuality*” as a personality disturbance. The APA revised diagnostic criteria in 1968 were later reclassified in the DSM-II as sexual deviation (Drecher, 2010:47; Drecher, 2020:427).

Gay rights groups mobilised against the classification and in 1973, at a convention, the APA requested it’s attending members to vote on whether to leave homosexuality classified as a mental disorder.

Of 9,664 members, 5,854 psychiatrists voted for the removal of homosexuality from the DSM, with 3,810 psychiatrists voting to retain it. In 1987, homosexuality was removed from the DSM. Meanwhile the new International Classification of Diseases (ICD) were published and saw the World Health Organization (WHO) removed homosexuality from disease classification (Lind *et al.*, 2010:8; Saitta, 2020:1).

The push for equal rights and recognition for LGBTI persons took off in 1969, culminating in the New York City, Stonewall riots in the US, signalling the start of the modern day gay civil rights movement (Drecher, 2020:427). This period was characterised by spontaneous protests by members of the LGBTI community against police. Internationally, the LGBTI community started pushing back systematically, which would later advance the rights and recognition of this marginalised community. One of the most notable points of resistance was the push for de-homogenisation of the LGBTI community, referred to collectively as “*Queer*”, originating around the 1960’s (Lind *et al.*, 2010:8). The Acquired Immunodeficiency syndrome/Human Immunodeficiency Virus (HIV/AIDS) crisis of the ’80s saw countless deaths due to the advanced stage of HIV infection, known as AIDS, occurring when the immunity is compromised because of the virus (Tom & Godwin, 2020:20). In response to this, a chorus of religious fundamentalists and cultural purists, all upholding the traditional ideals of “*the Family*” and “one man – one woman” believed that those infected and affected deserved the suffering brought on by HIV/AIDS. This was God’s divine plan (Tom & Godwin, 2020:20; Lind *et al.*, 2010:8; Saitta, 2020:1).

With the advancement of research new antiretroviral treatments were developed, resulting in HIV/AIDS becoming a treatable chronic condition. Despite the advances in treating HIV/AIDS, fear mongering, misinformation and miseducation continue. Those entrusted with the care of the most vulnerable, the oppressed and persecuted, looked the other way while many succumbed to the disease. The actions presented above have had a profound effect on the collective LGBTI psyche. Despite the horrific events in history the researcher believes it is important to appreciate that there were healthcare workers who resisted prevailing societal prejudices and acted ethically and compassionately to support LGBTI individuals and communities. Clearly it is vital for present-day healthcare workers to consider the unique needs of LGBTI persons presenting for treatment and care.

2.3 PERSPECTIVES ON LGBTI INCLUSIVITY

The American playwright and author Harvey Fierstein, who openly lived his life as a gay male, once exclaimed. *“Never be bullied into silence. Never allow yourself to be made a victim. Accept no one’s definition of your life; define yourself!”* (Sager, 2022:1). These iconic words bring into sharp focus the human socialisation processes religion, school, and family. In most cases, these processes unfold concurrently. Its primary purpose is to serve as an *“education”*, a passage to prevailing heteronormative standards which force compliance from those who cannot, or fail to, comfort. Sadly, LGBTI persons are engaged in a constant battle to be the authors of their own stories. As a heterogeneous group, those who identify as LGBTI are both victims of circumstance and subject matter experts. This is mainly due to the spaces we occupy, the geographical location, culture and many other factors that shape our realities. We are not the ones holding the pen. For a long time, our stories have been written for us by those who wield power and authority. However, advancements in the realisation of equality and freedom for LGBTI persons should result in them defining their lives.

2.3.1 LGBTI Inclusivity: The International Perspective

Internationally, the dawn of the new millennium was marked by sweeping legislative reforms, which resulted in significant advancement in a move towards equality for LGBTI persons.

The need to advocate and promote LGBTI rights are now openly acknowledged and supported within the European Union (EU), LGBTI persons receive broad protection against discrimination based on sexual orientation and identity (Muller *et al.*, 2020:5). The WHO in a Sexual Health Report (2013) recognised that to achieve a better understanding of the healthcare needs of LGBTI persons, more social demographic information was needed, especially from the global south (Muller *et al.*, 2020:5). As task teams set out to scope these needs, the Executive Board Secretariat of the WHO cited the presence and reality of *“social stress, institutional prejudice, social and familial exclusion, anti-homosexual hatred and violence”* as major stumbling blocks to the advancement of social justice for the LGBTI population. The problem of education and sensitisation would have to be considered to make access to healthcare easier for those identifying as LGBTI (Drecher, 2010:47; Drecher, 2020:427; Muller *et al.*, 2020:6).

In response to the WHO recommendations, LGBTI rights and advocacy groups within the economic block of the Association of Southeast Asian Nations (ASEAN) on the Asian continent, Thailand, Philippines, Indonesia Cambodia, Laos, Brunei, Malaysia, Myanmar, Singapore, and Vietnam formed ASEAN Sexual Orientation and Gender Identity and Expression Caucus (ASC). The body functions as a regional human rights organisation, engaging relevant role-players to promote LGBTI rights in Southeast Asia (ASC, 2021:10). Encouraged by the support of the United Nations (UN) and the WHO, its objective is to empower, capacitate and expand safe spaces for LGBTI and gender non-conforming persons in the region. The most important objective of the grouping was to ensure proper education for lay persons and organisations and the provision of healthcare services to marginalised LGBTI persons across the Asian continent to ensure access to healthcare services (ASC, 2021:12).

Acting more swiftly, in the US, a US non-profit, non-governmental organisation, the Institute of Medicine (IM), published a study under the mandate of the UN highlighting how LGBTI persons have higher rates of substance use and remain at increased risk of victimisation, harassment, depression and suicide than their heterosexual counterparts (Muller *et al.*, 2020:15). The study elaborated on some lesser known, critical clinical findings. Biological females who may identify as bisexual or lesbian are predisposed to obesity, cardiovascular disease, and breast cancer (IM Joint Commission, 2020:8). Important social determinants of health for LGBTI persons are emphasised linking experiences of stigma and discrimination and poor health outcomes (Muller *et al.*, 2020:15).

Characterised by slow and arduous moves for equal rights and inclusion, African nations remain marred by poor understandings of the gender and sexuality related to LGBTI persons. As a result, these vulnerable populations continue to experience multiple dangers and poor health outcomes (Izugbara *et al.*, 2020:5). The African Population and Health Research Centre, Nairobi, and Amnesty International, Nigeria, published a series of articles which were twofold. They identified limitations to LGBTI inclusion and sought ways to improve continental legal and policy environments to advance LGBTI rights (Izugbara *et al.*, 2020:5). Their findings are damning, identifying large-scale, open homophobia rooted in a misinformation around homosexuality with discriminatory views on AIDS, paedophilia, immorality, and rejection of God, pervasive on the continent.

Evidence of the above are the arbitrary beatings and extrajudicial incarceration of LGBTI persons in Cameroon by police services. Kindzeka (2022:1) documented how Cameroonian Police would use outdated draconian laws to substantiate the persecution of LGBTI persons, then cite that they were doing “*God’s work*”. LGBTI advocacy groups in Cameroon have argued that by taking the religious high road, these officials know that their perceived contribution would be praised by the public who share these sentiments and call for increasingly violent interventions against LGBTI persons. The African continent has seen slow moves towards upholding rights of LGBTI persons. In Malawi legislative changes have been greeted with cautious optimism, while in several African states, most notably in Nigeria and Burundi, the criminalisation of same-sex practices is met with harsh and lethal retributory measures (Kindzeka, 2022:2; Stærfeldt, 2021:5). Such highly stigmatised environments perpetuate unintended health-related consequences which manifests as the reluctance of LGBTI persons to access early diagnostic and treatment services and care programmes (Hunt *et al.*, 2021:2).

2.3.2 LGBTI Inclusivity: The South African Perspective

Post 1994, South Africa was breaking down old barriers to create “*a space for all who live in it*” (Daley, 2022:4). The air of optimism and possibilities inevitably gave way to challenging conversations. The post-apartheid government sought to advance matters related to social justice for all, by formulating an approach that would aid in addressing inequalities and bridging the racial and class divide. Within the South African context, four main challenges to LGBTI inclusivity involved (1) diversity in culture, (2) religious beliefs, (3) ethnic backgrounds, and (4) a mainstream educational approach that excludes LGBTI individuals from its discourse (Mprah, 2016:18; Müller, 2013:2).

The researcher could argue that passing legislation to ensure and safeguard the rights of the marginalised was easy. It is more demanding to change the mindset of society. Anecdotally, experiences ranging from discrimination, to abuse and violence, are commonplace and in the eyes of certain sections of our society, warranted (Daley, 2020:4; OUT LGBT Well-being, 2016:7). Several studies allude to the divide between the legislative imperative and the lived experiences of LGBTI individuals who face discrimination, victimisation, stigmatisation and various forms of abuse and violence (OUT LGBT Well-being, 2016:7; SANAC, 2017:10; Sutherland *et al.*, 2020:10; Wang *et al.*, 2020:606).

2.4 LGBTI REALITIES

Dr Kwame Nkrumah, the first President of Ghana, well-published Pan Africanist, and one of the founding members of the Organisation of African Unity (OAU), once exclaimed in one of his speeches, “*Freedom, is not something that one person or body can bestow upon another as a gift. You claim it! Claim it as your own and no one can keep it from you*” (Asif et al, 2019:1). There is a definite need to navigate the divide between the legislative imperatives and the lived experiences.

2.4.1 Strides In Social Justice – Our Legislative Realities

The Constitution of the Republic of South Africa 1996 is regarded as the absolute *Law of the Land*, and is, by all means, a striking document. This progressive position echoes promise and inclusion throughout its second chapter, The Bill of Rights, for all within its borders (Francis & Webster, 2018:15). It is from this document that we see the promulgation of laws which recognise South Africa as a diverse country and upholds equality and freedom.

Today progressive laws exist geared to safeguard and protect the rights of LGBTI persons which now is considered part of issues related to diversity and the advancement of social justice (Pearson & Reddy, 2021:114). Contemporary South African literature on LGBTI and human rights refers to eleven Acts, which speak to inclusion, acceptance, and the elimination of discrimination (Ellis & Mustasah, 2017:38). However, within the context of this study, it is worth focusing on legislation which is geared to advance LGBTI rights in the pursuit of social justice:

- Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000
- Alteration of Sex Description and Sex Status Act 49 of 2003
- The Prevention and Combating of Hate Crimes and Hate Speech Bill
- Civil Unions Act 17 of 2006

The Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000, aims “to prevent and prohibit unfair discrimination and harassment; to promote equality and eliminate unfair discrimination; to prevent and prohibit hate speech”.

Explicit prescripts are outlined for individuals whose inner experience of gender identity or gender expression do not align with their biological sex or external sexual characteristics (SANAC, 2017:vii; Sutherland *et al.*, 2016:12), thus recognising and outlining this as a matter pertaining to gender identity and not sexual orientation. Furthermore, it allows for (1) Persons born with ambiguous genitalia, such as intersex persons, and have chosen to undergo such alteration and (2) Administrative amendments to the National Births Registry as well as guidance on the prescripts related to gender realignment surgery for those who identify as transgender. These legal provisions and accommodations are enshrined in the *Alteration of Sex Description and Sex Status Act 49 of 2003*. The *Prevention and Combating of Hate Crimes and Hate Speech Bill*, once passed, will build on the foundations laid by the *Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000*. This legislative document will affect offences of hate crimes, hate speech and the prosecution of perpetrators, and impose appropriate sentences on those who commit a hate crime and/or hate speech offences. *The Civil Unions Act 17 of 2006* recognises the union between consenting adults and has legalised the marriage of same-sex couples in South Africa.

2.4.2 The Lived Experiences: Our Daily Realities

The daily realities of LGBTI persons requires us to be pragmatic about the breadth and length to which we subjectively enjoy and experience constitutional protection. Unfortunately, the progressive ideals laid out in the Constitution of South Africa and subsequent acts stand in stark contrast to realities faced by sexual minorities.

Another important aspect to consider is that we should remain cognisant that one cannot assume that lesbian and bisexual women experience similar experiences and psychosocial challenges, nor that two gay men of different social and ethnic backgrounds have similar experiences, merely because of a shared sexual orientation. The researcher, as a member of the LGBTI community, can anecdotally attest to daily acts of open discrimination and victimisation. The effects of discrimination, stigma, and violence are often deliberately downplayed as these acts become accepted as the norm and eventually internalised over time (Department of Women, Youth and Persons with Disabilities, DWYPD, 2020:27).

Studies conducted across the globe support the notion that this degree of complacency and surrender, at developmental ages, later leaves indelible marks on the gender and sexual development of the individual (Cederved *et al.*, 2021:3; Reygan, 2021:114). A mere reflection on our societal status quo exposes a reality in which any deviation from the heteronormative

construct is fanatically opposed and met with hostility. Each person who identifies as LGBTI realises at a young age *I am different*. But through socialisation, we are told to assimilate as part of this larger community, not being able to express oneself or voice your own narrative. Consequently, we are left having to edit, augment and redact parts of our identity to appease societal norms and standards.

2.4.3 The Nature of Exclusion

A patriarchal society taught to uphold constructs and assumptions of heteronormativity systematically ostracises and sanctions those outside this normative sphere through the notion that heterosexuals hold privilege and power and is therefore the norm in society (Cederved *et al.*, 2021:3; Beyrer, 2012:177-178; Department of Health; Jones, 2019:457; Mprah, 2016:18; Müller, 2013:1; Müller, 2015:4; SANAC, 2017:10; Wang *et al.*, 2020:606 Donisi *et al.*, 2019:979; Müller, 2013:2; Müller, 2015:2; Pearson & Reddy, 2021:114). This statement, echoed across the scholarly landscape, provides a window into this social construct, and supports the exclusion of those who do not subscribe to its prescripts.

2.4.4 Stigma and Discrimination

In Africa, LGBTI relations are still outlawed in 35 countries, punishable by execution in Sudan and Mauritania, while extrajudicial killings are commonplace in Somalia and Nigeria. Sexual minorities in South Africa suffer deep antagonism, judgement, and violence within their communities (Moagi *et al.*, 2020:3). Sadly, LGBTI individuals experience multiple incidents of victimisation over their lifetime, which often include stigma, discrimination, and violence from community members where their sexual orientation or gender identity is known (DWYPD, 2020:29).

Discrimination could, perhaps, best be described as the unfair and unwarranted negative verbal and non-verbal reactions that belittle, offend, or undermine another based on a perceived or assumed difference. Stigmatisation takes place within the brackets of discrimination. This stigma is usually associated with a specific trait, often generalised assumed behaviour.

A fictitious example of a mental health care user (below) is used to draw a distinction:

Patient X

Patient X has to collect his follow up medication at the local clinic. He does not like going to the clinic because the people make him feel uncomfortable. The nurses, very hastily, dispense medication. Patient X knows it is because they want him to leave the facility as quickly as possible. As Patient X leaves the facility, he hears a comment, echoed down the passage. One of the nurses say loudly "These mad people are dangerous". Making his way out of the facility, Patient X feels sad and is considering receiving his treatment at a different location.

This fictitious example provides a rudimentary demonstration of discrimination and stigma. In relation to this study, the former – *being treated differently at the clinic*; refers to discrimination and encapsulates the negative treatment of sexual and gender minorities. Discrimination can be personal or relational, such as a refusal of services based on sexual preference or identity, but discrimination may also present structurally, taking forms such as repressive laws or policies that disadvantage LGBTI individuals in employment, education, and the workplace (Izugbara *et al.*, 2020:108; Patterson *et al.*, 2020:25). The latter – *the comment made by the nurse*; represents stigma. We saw the nurse express her disapproval of, an openly discriminate against an individual based on perceived characteristics that serve to distinguish them from other members of a society (Röndahl, 2011:345; Zeeman *et al.*, 2019:974). Sexual minorities experience stigmatisation on multiple fronts, often at various levels of society. This stigma emanates from general populations and communities, the family, religious and cultural organisations and sadly, from nurses and other medical practitioners tasked to care for vulnerable and at-risk people such as the LGBTI community. The extent and degree of stigma and discrimination experienced is often attributed to the pervasive patriarchal norms and entrenched heteronormativity within our respective communities (Kindzeka, 2022:1; SANAC, 2017:15).

Acts of discrimination range from daily rights violations to high levels of violence against LGBTI persons. A study conducted as part of the Love Not Hate (LNH) Campaign, led by OUT LGBT Well-being, reports over 55% of LGBTI people surveyed expressed fear being LGBTI and being at risk of discrimination. A regional breakdown indicated that those in Kwazulu-Natal, Eastern Cape and Free State were more likely to fear discrimination (OUT LGBT Well-being, 2016:9). Open verbal insults, at 39% were found to be the most common form of discrimination. This was followed by 20% of LGBTI persons indicating physical threats of violence, accompanied by threats and verbal abuse.

Family members who perpetrate acts of violence and discrimination were found to be as common as verbal insults. Seventeen percent (17%) of LGBTI respondents reported being chased, followed, and harassed. Sadly, this was more common among gay male respondents. (OUT LGBT Well-being, 2016:9).

2.4.5 Violence and Abuse

These exclusionary practices are rooted in pervasive patriarchal norms and conventions of heteronormativity (Sutherland *et al.*, 2016:3-39; Zeeman *et al.*, 2019:974). It is therefore not surprising to see findings of a survey on attitudes towards LGBTI persons in South Africa highlight that 32% of men in demographic, 45 - 54 years old, disapproved most on LGBTI people. The study also found that about 3% of South Africans mentioned that they caused physical harm to women dressing and behaving like men in public with a further 1% admit to physically harming men who acted and dressed like women (Sutherland *et al.*, 2016:3-39). Given these statistics, it is deplorable that most sexual and gender minorities may experience violence, in any form, within their lifetime. Sadly, literature on the experiences of LGBTI individuals on intimate and sexual violence supports this notion, as does the researcher, who, in this context, speaks to personal, subjective experience, having been violently sexually assaulted, purely based on sexual orientation (OUT LGBT Well-being, 2016:9; SANAC, 2017:5; Sutherland *et al.*, 2016:3-39).

In reality, there are few persons who identify as LGBTI who live lives free of discrimination, abuse, and other forms of violence. The probability of experiencing discrimination, abuse, and other forms of violence in their lifetime is high for those who openly identify as LGBTI (DWYPD, 2020:29; Grieve *et al.*, 20019:157). In certain parts of South Africa, living openly as gay or lesbian may lead to dangerous outcomes. In 2013, McCroy sounded the alarm on the rise of “*corrective rape*” against lesbians in South Africa. The term is associated with the fallacy that the act of rape would somehow “cure” or “correct” the person’s nonconforming sexual identity (Mulaudzi, 2018:5; Gouws, 2021:7). The study, conducted in the Cape Town Metropolitan area, further purports that during 2013 there were on average 10 women, who identified as lesbian, raped per week (McCroy, 2014:1).

Comparing data from the *Out Wellbeing Study* in 2016 to that of *Human Rights Watch* (OUT LGBT Well-being, 2016:9) suggest that homophobic altercations and attacks have shown a 2% increase in the twelve-month cycle, 2016 - 2017. This takes place within communities with those who perpetrate homophobic acts tend to emulate collective beliefs and

behaviours into which they have been socialised (Moagi *et al.*, 2020:3; Mprah, 2016:18; Müller, 2013:1; Müller, 2015:4). Thus, to be able to address the matter we not only need to understand the entrenchment of subservience, dominance, and oppression that many LGBTI individuals experience in their everyday lives, but also how this status quo is continually perpetuated.

2.4.6 Religion and Culture

In their lifetimes, LGBTI persons experience numerous occasions in which they would find resistance from the religious and cultural purists in society. The study conducted by the Human Sciences Research Council and the Other Foundation, found that men most disapproving of LGBTI persons, were aged between 45 - 54 years Africa (Sutherland *et al.*, 2016: 17). Viewed as an important demographic according to the researchers because in terms of policy change it matches the profile of the politically and economically powerful in South Africa (Sutherland *et al.*, 2016: 17). Those who identified as highly religious strongly agreed that homosexuality is “*wrong*” and “*disgusting*”, comparable to the general South African population. “Moderately religious” people tended to be the most tolerant, even when compared with the least religious (Moagi *et al.*, 2020:3; Mprah, 2016:18; Müller, 2013:1; Müller, 2015:4). The common denominator, however, between these responses are that they suggest that principles and values taught in the Bible are advocating a heterosexual life and anyone who does not comply to this is living in sin (Moagi *et al.*, 2020:10). People who identified strongly with their ethnic or cultural ties indicated that they would rather stay away from LGBTI people and, reported roughly proportionate levels of violence and abuse against nonconforming persons (Muller *et al.*, 2020:15).

Across the African continent, the gap between conservative values and equal human rights is widened by the influence of religion and culture (Odell & Udd, 2022:5). The proponents of traditional values often blame those advocating for the advancement of LGBTI rights as eroding African ideals and culture. The view that sex between two men is wrong is reflected equally across all race groups, however, black African and coloured people are twice as likely to express intense disgust about homosexual people leading to physical violence, corrective rape, and murder. Traditionalists, thus, believe that homosexuality is a Western construct foreign to Africa (Madrigal-Borlos, 2021:152).

2.5 INTERSECTIONS OF THE MANY AVENUES OF OPPRESSION

Mental health disproportions among LGBTI persons relative to their heterosexual, cisgender counterparts is increasingly referred to in literature (Donisi *et al.*, 2019:979; Müller, 2013:2; Müller, 2015:2; Pearson & Reddy, 2021:114). The relentless exposure to exclusionary and violent practices towards LGBTI persons results in feelings of isolation, alienation and resignation affecting their mental and social well-being increasing vulnerability (SANAC, 2017:17; Zeeman *et al.*, 2019:974). One cannot assess the lived experiences without giving credence to the intersectionality which exists and is experienced by members of the LGBTI community.

Because the researcher is uniquely positioned as a “*coloured, gay, effeminate male*”, intersectionality can best be summarised by using the researcher’s position or locus as an example.

“It stems from the need for self-preservation leads us to respond in a multitude of maladjusted ways, ways which lead us cower to prevailing societal norms and buckle under the pressures of heteronormative and cisgender hegemony. Growing up, I was socialised to believe that everyone who does not fit that which society deems “normal” are wrong. Thus, in this society, which rejects who I am, tells me the colour of my skin is neither white nor black, that because of this, a set of predetermined characteristics and expectations already exists about me and for me. These assumptions ultimately form a lens through which I am perceived. In this society, these assumptions are inextricably linked to my race, my socioeconomic status and sexual orientation and gender identity. In order for me escape prejudice, rejection and open discrimination, I am forced to misrepresent aspects of my identity. I forsake who I am in order to negate negative societal views.”

A picture is painted of how intersectionality, which refers to the interplay of different categories of one’s identity, race, sexual orientation, gender and socio-economic status, results in variances in subjugation, affecting the individual in interrelated ways (Patterson *et al.*, 2020:4; SANAC, 2017:viii). Over time, the many avenues of the LGBTI person intersect. Cognitive, affective, and psychomotor responses to stigma and discrimination lead to complex psychological difficulties, such as low self-worth, self-stigmatisation, social angst, depression, suicidal thoughts and attempts, increased risk-taking behaviours, self-medicating and substance abuse and ultimately, delayed health-seeking behaviours (DWYPD, 2020:29; SANAC, 2017:xxi; SANAC, 2017:xxi). The idea of intersectionality thus shows how multiple repressions entrench and precipitate each other to generate new areas and dimensions of human distress.

2.6 LEFT UNCHECKED: THE CONSEQUENCES

Notably, one of the recurring themes to emerge from literature is the concept of “*erasing*” anything pertaining to LGBTI content, totally, from the heteronormative discourse (Müller, 2015:2). The consequences of this exclusion and discrimination can have detrimental effects on the LGBTI population, as well as health facilities and the professionals who work there.

If the current milieu is left unchallenged, culturally, and clinically incompetent healthcare professionals may leave LGBTI healthcare users ostracised, leading to an unfortunate increase in health-seeking behaviours (SANAC, 2017: xi). To address this, the South African National LGBTI HIV Plan 2017-2022 (LGBTI HIV Plan) was drafted. An ambitious undertaking by NGO’s, National government and LGBTI advocacy groups drafted plans to address these problems. The *South African National LGBTI HIV Plan 2017-2022 (LGBTI HIV Plan)* makes specific reference to the impact of these consequences, which may lead to (Adapted from SANAC, (2017: XI)):

- Increased exposure to discrimination and exclusion at a young age – leads to increased rates of school dropout and long-term social adjustment issues.
- Absent familial and social support due to rejection or separation from home and family.
- Less stable home lives.
- Turn to sex work and crime.
- Unemployment and less job options.
- Rejection and social isolation
- Ignorance of the entitlement of individual rights leads to a refusal of public services which speak to LGBTI needs.
- Increased prevalence and incidence of mental health issues, low self-esteem, and suicidal ideation and attempts.

The *LGBTI HIV Plan* is an ambitious one. It outlines broad approaches which seek to challenge the prevailing heteronormative, patriarchal hegemony.

2.7 NUANCED HEALTHCARE NEEDS OF SEXUAL MINORITIES

South Africa has a robust and comprehensive health service programme, both public and private. However, health programmes structured heteronormatively may be inappropriately packaged for LGBTI communities (SANAC, 2017:41). Given the unique challenges faced by sexual and gender minorities, healthcare needs of this demographic must be addressed. Within the South African context, previous studies (Donisi *et al.*, 2019:979; Moagi *et al.*, 2020:3; Mprah, 2016:18 Müller, 2013:2; Müller, 2015:2; Muller *et al.*, 2020:15; Pearson & Reddy, 2021:114) have indicated, amongst others, two important congruent findings, (1) the need to advocate for equitable healthcare services which seek to address the unique needs of this demographic and (2) that healthcare professionals lacked cultural and clinical competencies to meet the health needs of LGBTI people (Donisi *et al.*, 2019:979; Moagi *et al.*, 2020:3; Mprah, 2016:18 Müller, 2013:2; Müller, 2015:2; Pearson & Reddy, 2021:114; Zeeman *et al.*, 2018: 978).

In line with the former argument and the work of the authors mentioned, as a secondary outcome in relation to the review purpose, the researcher endeavoured to provide an inclusive breakdown of the nuanced healthcare and support services needed for LGBTI persons.

2.8 NURSING EDUCATION

There is a great need for culturally sensitive trained healthcare professionals who create safe, social, psychological, and medical gender affirmation spaces for sexual minorities to engage openly on health concerns (Patterson *et al.*, 2021:25). The researcher believes that education and training on issues related to LGBTI healthcare, sensitisation and representation are the essential steps in achieving this goal. Since *Nursing* is considered a caring profession, nurses are best located to be effective change agents. To make a valued contribution, safe spaces tailored to free and open dialogue within a participatory approach should be encouraged (Donisi *et al.*, 2019:979).

As an intermediate-level health professional, it has been my experience that nurses receive varying, sporadic, or negligible training on gender identity in their professional undergraduate tutelage (Fauer *et al.*, 2020:600). The undergraduate training of nurses should not only impart the necessary skills and competencies but also serve to sensitise students to the realities faced by those who seek their care.

Foundational training received by nurses should impart the necessary skills and competencies while simultaneously sensitising students to the realities faced by those who seek their care.

Despite calls for a diversified, even decolonised teaching and learning programme, the didactic and pedagogic approaches within nursing programmes appears to be fixed to function within this dichotomous, heteronormative frame (Donisi *et al.*, 2019:979; Müller, 2013:2; Müller, 2015:2). A heteronormative approach which later exposes gaps in cultural and clinical competencies regarding LGBTI health issues. The researcher is of the opinion that the inclusion of LGBTI related content in nursing education programmes is warranted.

2.9 CHAPTER SUMMARY

This chapter has provided a comprehensive background by contextualising the necessity of this enquiry. Firstly, by referring to the time when Homosexuality was deemed a pathology. A delineation of perspectives on LGBTI inclusivity was offered. The researcher located the study within the greater scheme of the current discourse on LGBTI inclusivity, representation, and the advancement of social justice. Consideration was given to the lived realities of LGBTI persons, and the compounding effects of intersectionality. The endeavour to address the gap in nursing training must be met with an active change toward understanding representative and inclusive education and care services. Past and current injustices and all associated challenges can be redressed through collective commitment.

If left unmet, the consequences of inaction may further ostracise LGBTI healthcare users, leading to a further decrease in health-seeking behaviours (SANAC, 2017: xi). Responding effectively to Nuanced Health Care – LGBTI, requires culturally and clinically competent healthcare professionals who (1) have appropriate clinical and cultural competencies regarding the lives and healthcare needs of LGBTI and (2) advocate for equitable healthcare services which seek to address the unique needs of this demographic (Donisi *et al.*, 2019:979; Moagi *et al.*, 2020:3; Mprah, 2016:18 Müller, 2013:2; Müller, 2015:2; Pearson & Reddy, 2021:114; Zeeman *et al.*, 2018: 978). Determining LGBTI inclusion within nursing programmes serves, thus, as a good vantage.

The review of literature on LGBTI inclusivity in nursing programmes also serves to advance of social justice for LGBTI and provided a firm foundation for the chosen research design and methodology (De Vos & Strydom, 2011:115; Polit & Beck, 2021:142). This delineation served to position and contextualise the study in relation to available literature, creating background and rationale for this review. In contributing to the current discourse, this review highlights the importance of ensuring representation, advocating inclusivity, and the advancement of social justice.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 CHAPTER OVERVIEW

To embark on a critical synthesis of available evidence in literature on LGBTI content in nursing programmes, there needs to be clear direction, on the part of the researcher. This chapter serves as means of ensuring that the researcher conveyed a foundation for the chosen research design and methodology used while conducting research (De Vos & Strydom, 2011:115; Polit & Beck, 2021:142). (Refer to Figure 3). In this chapter, the importance of the inquiry in ensuring representation, advocating inclusivity and in so doing advance social justice for all people who identify as LGBT or I is highlighted. The researcher focused on LGBTI content inclusion within nursing programmes. This delineation served to position and contextualised the study in relation to available literature, creating context and reasoning for the study.

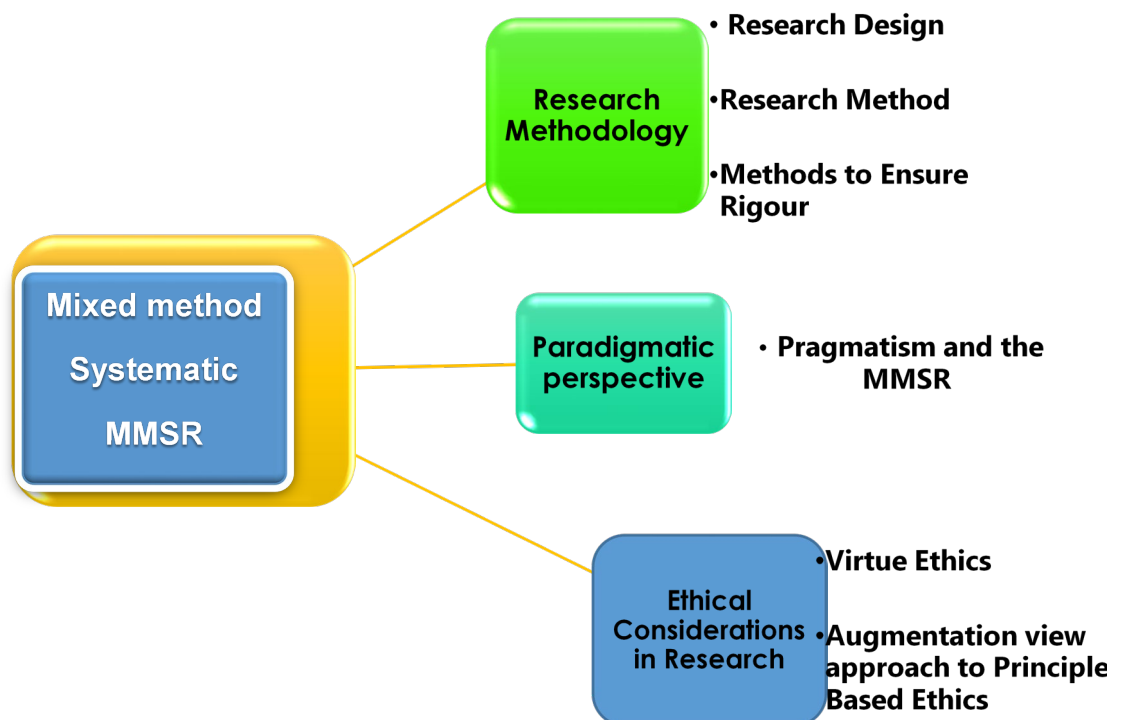


Figure 3 Research Methodology

3.2 RESEARCH PARADIGM

This review was directed by a pragmatic paradigm. Brown and Dueñas (2020:545) describe paradigms as a worldview that also serves as a point of reference for applying theory when observing phenomena. The researcher must clarify their philosophical and theoretical premise. The paradigmatic premise substantiates the employ of certain methods and steps considered appropriate for conducting certain types of research. The paradigm operates as a set of philosophical assumptions, guiding the researcher's methodology to inquiry and definition of the phenomenon in question (Botma *et al.*, 2010:40, Polit & Beck, 2021:738).

John Dewey, one of the fathers of pragmatism, sought to promote pragmatism by steering thinking away from abstract concerns. He described the mandate of science as not working towards a singular truth or reality but guiding and assisting human problem-solving while recognising our different social contexts and positions (Borges & Revez, 2019:180). The researcher sought to connect the basic assumptions of the chosen paradigm and embrace an emphasis on lived experiences (Kelly & Codeiro, 2020:6; Pillay & Morel, 2020:3; Morgan, 2014:1045).

The researcher is aligned with this notion which recognises a single "*real world*" in which all individuals hold unique, subjective interpretations. The "*truth*" is only brought to light when we consider these subjective realities about another. Intersubjectivity is critical to understanding the phenomenon (Morgan, 2014:1045). The researcher understands that within the social sciences, a pragmatic paradigm serves as a philosophical foundation for mixed method research (Morgan, 2014:1045; Mertens, 2015:85; Creswell & Creswell, 2018:47). (Refer to Table 2 which provides a philosophical framework and espouses the philosophical assumptions of this paradigm.)

Table 2 The Pragmatic Paradigm

Basic beliefs	Philosophical assumptions	Application to the study
<p>Axiology <i>What do we value?</i></p>	<p>The ethical goal of research is to understand a phenomenon in the pursuit of benefit to others.</p>	<ul style="list-style-type: none"> · A value-laden axiology - means the researcher is conducting research that benefits people. · Synthesis of available evidence which answers the review question to construct knowledge bringing about positive consequences within the collective value system.
<p>Ontology <i>What's out there to know</i></p>	<p>There is a single "real world" and all individuals have their own unique subjective interpretations of that world.</p>	<ul style="list-style-type: none"> · A non-singular reality ontology. The researcher recognises that there is no single reality, and all individuals have their own, unique interpretations of reality. · Understanding context of each publication, aids in new ways of solving the traditional philosophical problems.
<p>Epistemology <i>What and how can we know about it?</i></p>	<p>Intersubjectivity and relationships in research are best determined by what the researcher deems appropriate to the study.</p>	<ul style="list-style-type: none"> · A relational epistemology means that relationships in research are best determined by what the researcher deems appropriate to that study. Knowledge is created "through lines of action" where the best action is determined from the intersubjective ways in which different persons understand the phenomenon. · Serves as a baseline for further research.
<p>Methodology <i>What precise procedure can be used to acquire it?</i></p>	<p>Qualitative and/or quantitative methods and or Mixed methods which are compatible with the pragmatic paradigm.</p>	<ul style="list-style-type: none"> · A Mixed methods methodology incorporates elements of different research approaches rather than conforming to a traditional approach (qualitative, quantitative. Mixed methods research). · MMSR was conducted, digesting past empirical or theoretical literature and provides a more comprehensive understanding.

Adapted from Botma et al. (2010:39); Kivunja and Kuyini, (2018:35); Morgan (2014:1046-1045) and Mertens, (2015: 85)

The **value-laden axiology** suggests that during the research process, it is important that the researcher reflects on the values which may have shaped the narrative of given publications. A consideration of how these values may be used to assist research which could bring about positive consequences within the collective value system is sought. (Kivunja & Kuyini, 2017:35). The researcher is aligned with the notion of a **non-singular reality ontology** and agrees that our realities are wholly subjective, shaped by our perceptions and position within this world. Understanding the context of each publication, given prevailing norms and beliefs, may assist the researcher in creating a holistic picture of the research problem.

The researcher sought to lessen the perceived distance between the researchers and those being researched. In recognising that **intersubjectivity**, the interconnectedness between experiences, brings us closer, this **relational epistemology** allows a pragmatic approach, which permits enough flexibility to adopt the most workable method to answer research questions (Kivunja & Kuyini, 2017:35). As a result, the researcher generates knowledge, derived from the quantitative, qualitative, and mixed method research in which there will be a singular narrative, which is representative of multiple realities. Pragmatism places the importance on answering the review question rather than on selecting methods to meet requirements associated with qualitative or quantitative research (Pillay & Morel, 2020:3). The **mixed method methodology** of the chosen paradigm aligns well with the design (Kivunja & Kuyini, 2017:35).

The use of systematic steps of a review and the application of a convergent integrated design using a qualitative approach allowed for inductive reasoning in transforming and synthesising information from qualitative, quantitative, and mixed method studies (Lizarondo *et al.*, 2021:89; Kivunja & Kuyini, 2017:36; Morgan, 2014:1049). The researcher could develop an understanding from divergent points of view while being conscious of their own values, attitudes, and biases and acknowledging how these might play out in research (Mertens, 2015: 85; Morgan, 2014:1046-1045). In this mixed methods research, the pragmatic paradigm allowed the researcher to position themselves to dismantle obsolete philosophical problem solving and find practical solutions.

The pragmatic paradigm not only replaces opinions on the nature of reality as the essential condition for discerning approaches to research but also credits the value of those different approaches that may guide choices about conducting inquiry (Morgan, 2014:1046-1045).

Pragmatism calls on different approaches to co-exist within a single inquiry and, in so doing, legitimise multiple approaches. The researcher would argue that in alignment with the pragmatic paradigm, the study could fundamentally be viewed as a form of social action rather than just an abstract philosophical system guiding research (Kivunja & Kuyini, 2017:36; Morgan, 2014:1049). The pragmatic paradigm serves as a lens through which we perceive and comprehend the world, guiding the choice of research method and design, the research question/s, data collection instruments and procedures, and data analysis. The paradigmatic premise of pragmatism, thus, supports the method and design used for the inquiry of the researcher.

3.3 RESEARCH APPROACH AND METHOD

Since the early 2000's researchers have argued the relevance and contribution of mixed method research (Fàbregues *et al.*, 2021:146). A review type, accomplishing sound synthesis of evidence emerged, and has since been labelled with various terms such as integrative review, mixed method review, mixed method research synthesis, mixed research synthesis and mixed studies review, used interchangeably without a clear distinction (Hong *et al.*, 2017:3). MMSR allows for collating diverse findings into a synthesised whole and conversely, exhibits the potential to bridge methodological, paradigmatic, and philosophical divides within the realms of research. Among researchers within the "*caring professions*" the last decade has been characterised by increased appreciation and importance of MMSR and other forms of mixed method research, often a key contributor to decision-making and knowledge generation (Norwell *et al.*, 2022:2).

3.4 THE MIXED METHOD SYSTEMATIC REVIEW

The researcher has chosen to employ the MMSR, convergent integrated design using an inductive approach. The researcher believes that MMSR provides a foundation from which to advance new understandings through the synthesis of the literature. The MMSR, in the context of this study, not only functions to scrutinise the degree of agreement between quantitative and qualitative data but also to validate or triangulate the findings of the study given the sources/publications identified (Lizarondo *et al.*, 2021:271).

Guided by the JBI method to MMSR, the researcher used a *convergent integrated design* that was most appropriate to aid in creating new meaning, using data obtained from qualitative, quantitative, and mixed method studies (Toronto & Remington, 2020:9; Lizarondo *et al.*, 2021:277). To answer the review question, all related existing research studies should be included to present a holistic picture of what is known thus far. This notion is echoed and guided by the chosen paradigm. Pragmatism places importance on answering the review question rather than on selecting methods to meet requirements associated with qualitative or quantitative research (Pillay & Morel, 2020:3). As a design the MMSR allows the researcher to maximise findings through the inclusion of diverse forms of evidence (Pearson *et al.*, 2015:122; Pillay & Morel, 2020:3). Allowing for the synthesis of evidence of qualitative, quantitative, mixed method and review type studies, regardless of methodological diversity (Hong *et al.*, 2017:3; Sandelowski *et al.*, 2006:2). This broad sample created a consistent and comprehensive picture of the research problem (De Souza *et al.*, 2010:1; Hong *et al.*, 2017:2; Lizarondo *et al.*, 2020:271; Sandelowski *et al.*, 2006:1).

The researcher intended to conduct a review which followed thorough research processes supported by scientific knowledge (Souza *et al.*, 2010:1). Choosing the appropriate design and method was a priority. MMSR's together with systematic reviews (SR) and meta-analyses are considered the gold standard for evidence. These studies are used to evaluate the benefits and harms of healthcare interventions and, as a result, have become increasingly important in clinical decision-making and for informing evidence-based practice, clinical guidelines, and health policy (Grove & Gray, 2019:483, Pussegoda *et al.*, 2017:2; Toronto & Remington, 2020:1). *Figure 4* shows six common review types and explains how the researcher was guided by the phenomenon of interest in choosing an appropriate design and method to answer the review question.

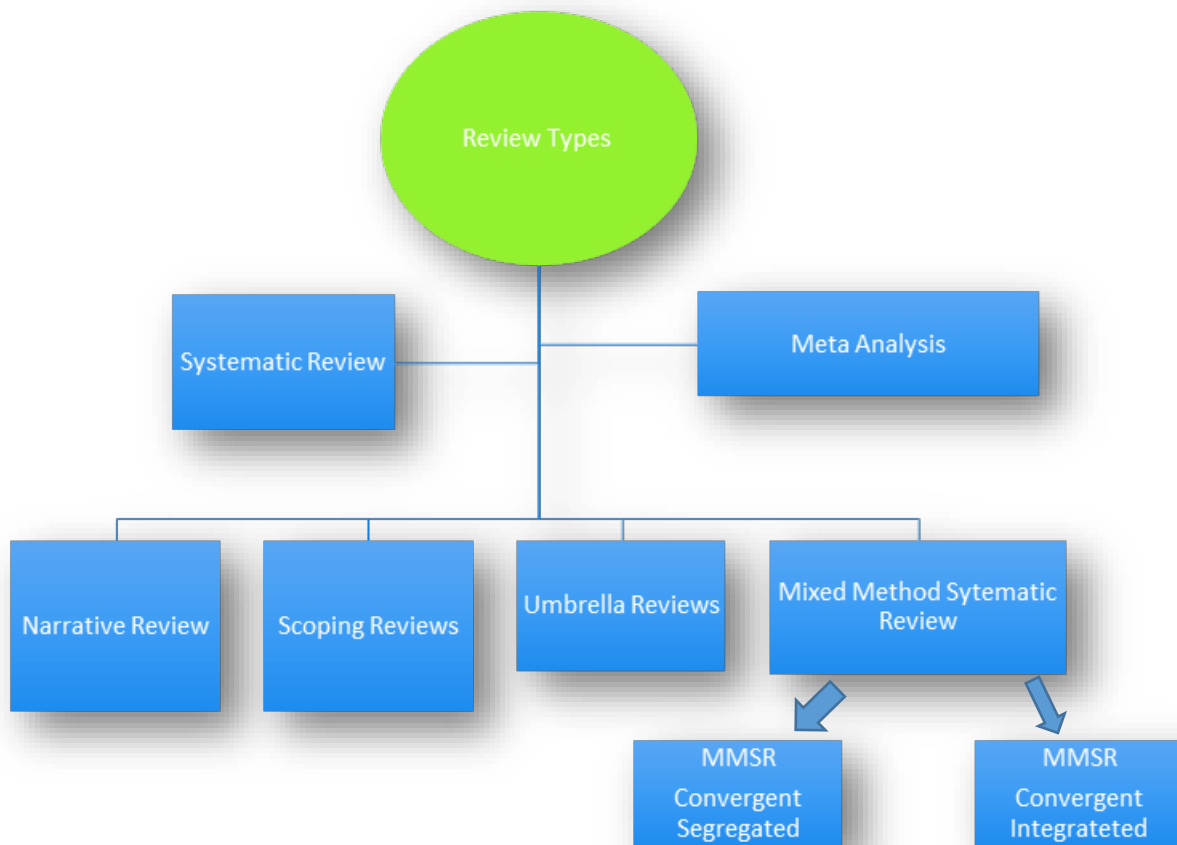


Figure 4 Selection of appropriate review design

Harris M. Cooper (1982), was one of the first to conceptualise a framework for the synthesis of mixed method research, legitimising it as a credible means of inquiry. He initially outlined the process as involving five stages, in Cooper (1982). Since then, the method or approach has been revisited by many of its modern-day proponents. Despite MMSR being an emerging form of enquiry, it is particularly relevant due to the characteristics of methodological inclusiveness and broad conceptualisation of evidence (Lizarondo *et al.*, 2020:271).

In conducting a review of literature, there are variations of the steps involved, espoused in literature. The researcher decided that the best approach to follow, based on the variations of the steps presented in literature by Souza *et al.*, 2010; Dhollande *et al.*, 2021; Ganong, 1987; Russell, 2005; Whitemore & Knafli, 2005, would be the six steps of conducting a review as set out by Toronto and Remington (2020:6), who used Cooper (1982) as foundation. As a novice researcher, it was found that the steps as outlined in Toronto and Remington (2020:6) were the most comprehensive.

3.4.1 Step 1 – Formulating the Purpose and Review Questions

During the initial step, the researcher searched through clearly defined concepts of interest related to the research problem. The researcher then initiated the development of the background and significance of the research problem and provided the rationale for employing an MMSR. For the researcher to gauge what is known about the phenomenon, the review purpose and questions were left broad yet well-defined, as it informs the search process and data collection (Toronto & Remington, 2020:15-17).

As part of this step, the researcher framed the review question and aimed to clearly define the study purpose by scanning the literature to identify gaps in the field by means of a preliminary search (Maku *et al.*, 2020:50). According to Dhoulane *et al.*, (2021:428) and Toronto & Remington (2020:12) the MMSR review question and purpose are more broadly focused, versus narrowly defined, supporting that an MMSR is the way to proceed.

The searching guidelines for an MMSR follow the same systematic process as those outlined in conducting a SR (Toronto & Remington, 2020:24). On reviewing the application of mnemonics to assist with review question formulation, the researcher concluded that the PICO(T) would not be suitable.

Critical reflections around the appropriateness of the PICO(T) format within the mixed method realm had received critical consideration from the authors. The main concern was the difficulties of using PICO(T), which presents a narrow focus, often excluding qualitative studies when searching for literature (Cooke *et al.*, 2012:1437). The SPIDER format was designed due to contemporary literature, which suggests that the SPIDER format allows for a much broader focus of the review question. For this reason, the researcher thought it appropriate to match the research method and design, by supporting it through incorporation into an MMSR search, which is broad in scope (Cooke *et al.*, 2012:1437).

The SPIDER format is less rigid and more specific than the PICOT mnemonic. This format provided a more suitable method for qualitative and mixed method search (Dhollande *et al.*, 2021:430; Tawfik *et al.*, 2019:47).

The SPIDER framework (Sample, Phenomenon of Interest, Design, Evaluation, Research type), put forth by Cooke *et al.*, (2012:1437) was selected as a search method and a means to refine the research question.

S	Sample	Research articles dealing with LGBTI content
PI	Phenomenon of Interest	LGBTI content (social justice and inclusion/physical health/mental health) in nursing education programmes
D	Design	Experimental, non-experimental, and descriptive
E	Evaluation	Review evidence in literature which may indicate the inclusion or paucity of LGBTI content in nursing programmes.
R	Research type	Qualitative, quantitative, and mixed methods

According to the SPIDER model the review question, as stated above, was reformulated as the following: *What available evidence exists in literature on LGBTI content in nursing programmes?*

3.4.2 Step 2 – Systematic Search and Selection of Literature

During this step, a preliminary search was conducted to refine the Boolean search string and gauge the review's feasibility. After amendments were actioned at the behest of the data specialist and study supervisors, the preliminary search commenced. Subsequently, a decision to broaden the scope of the review was taken, in consultation with the study supervisors a decision was taken to include all academic offerings within the nursing programme. The main, broad search for literature to identify the maximum number of eligible primary sources, using at least more than one strategy, was undertaken (Lizarondo *et al.*, 2020:283; Choi *et al.*, 2019:472; Tawfik *et al.*, 2019:3; Toronto & Remington, 2020:7).

Grey literature has been excluded from the MMSR. The term *grey literature* refers to material available outside traditional academic peer-review processes, such as blogs, emails, opinion pieces and social media posts (Adams *et al.*, 2017:433). The researcher appreciated that the search and inclusion of such literature could potentially broaden available evidence, providing a rich, diversified contribution extending beyond the limits of academic journals.

However, to date, few methodological guidelines for scholars exist on including grey literature in reviews (Adams *et al.*, 2017:433). The researcher believes that the quality of these sources may be inconstant due to a lack of peer review, compromising rigour (Toronto & Remington, 2020:7).

In alignment with Lizarondo *et al.* (2020), the researcher undertook a comprehensive search of literature. The researcher made use of multiple electronic databases, ancestry as well as searching through peer-reviewed journals. In so doing, the researcher sought to minimize biased conclusions in publications. A quick search of the literature, which the data specialist at UFS oversaw, was conducted to ascertain the feasibility of the study and to identify any gaps. Consensus reached between the researcher and the data specialist on search terms, acronyms, and synonyms to be used in the explorative search. The explorative search yielded 192 articles after automatic system deduplication (n=96). The data specialist ensured specificity and comprehensiveness (Choi *et al.*, 2019:472; Tawfik *et al.*, 2019:3; Toronto & Remington, 2020:7).

The **1st preliminary search**, overseen by the data specialist at UFS, was conducted using a Boolean search string which included a variation of synonyms and related concepts used as search words. The exploratory search assisted the researcher in testing the SPIDER mnemonic, resulting in refinement of the search. There were 246 articles found, which were reduced to (n=121) after automatic system deduplication.

The researcher and study supervisors agreed upon guiding aspects (inclusion and exclusion criteria) which would guide decision-making during appraisal. Any variances or discrepancies which arose between the reviewers at each stage of the study selection process were resolved through discussion, or with a third reviewer.

Synonyms and international equivalent terms were incorporated into the Boolean Search String to diversify the search. As initially indicated, (Q) queer/questioning, (A) asexual and other (+) did not initially form part of the search focus. Results of the main search are in Table 3. below:

Table 3 Boolean search string and information sources

Main Search	<p>LGBTI</p> <p>A variation of the universally accepted acronym referring to lesbian, gay, bisexual, transgender and intersex persons</p>	<p>(Lesbian* or gay or gays or bisexual* or transgender* or intersex* or lgbt* or "gender fluid*" or nonbinary or "gender divers*" or Two-Spirit* or "Sexual and Gender Minorit*")</p>	Databases and Information Sources	<p>EBSCOHost:</p> <p>Academic Search Ultimate, Africa-Wide Information, APA PsycArticles, APA PsycInfo, CAB Abstracts,</p> <p>CINAHL with Full Text: Communication & Mass Media Complete, ERIC, GreenFILE, Health Source - Consumer Edition, Health Source: Nursing/Academic Edition, Humanities Source Ultimate, MasterFILE Reference eBook Collection,</p> <p>MEDLINE: OpenDissertations, Sociology Source Ultimate, SPORTDiscus</p>	
	<p>NURSING EDUCATION (Collectively)</p> <p>The term nursing education refers to the complete academic and practical programme available at an institution of higher education, undergraduate to postgraduate studies, thus the whole programme.</p>	<p>("nurs* educat*" or "nurs* curricul*" or "nurs* program*" or "nurs* syllab*" or "nurs* student*")</p>			
	<p>NURSING EDUCATION (Specific)</p> <p>The term nursing education refers to the complete academic and practical programme available at an institution of higher education but referred to the programmes in isolation to one another.</p>	<p>(Baccalaureat* or bachelor* or undergraduat* or pre-qualif* or pre-register* or pre-licen* or prequalif* or preregister* or prelicen* or postgraduate* or graduate* or master* or phd or doctoral)</p>			
				<p>SCOPUS</p>	<p>No of Abstracts: 311</p>
				<p>Google Scholar</p>	<p>3</p>
				<p>TOTAL: N=316</p>	<p>2</p>

The **main search** identified 316 publications (n=316) through database searching. The electronic database EBSCOHost rendered (n=311), (Refer to *Addendum A* – Number of studies isolated in each electronic database, for a comprehensive breakdown). A manual search an additional five (n = 5) publications were found via SCOPUS (n=3) and Google Scholar (n=2). The *PRISMA Flow Diagram* (Figure 5) illustrates the workflow and aids in reporting the process of identifying, screening, and determining eligibility of publications for inclusion (Toronto & Remington, 2020:7; Xiao & Watson, 2019:105).

The main search was done for two reasons (1) to broaden the scope of the search and (2) to shift focus to include the range of nursing instructional programmes, from undergraduate to postgraduate.

The total number of results produced was 316, which was reduced after automatic system deduplication to 184. Abstracts were screened by the researcher and the two study supervisors against the inclusion criteria.

Potentially relevant studies were retrieved in full. The full text of selected citations was assessed independently and in detail against the inclusion criteria by the two study supervisors. Exclusion of full-text studies that did not meet the inclusion criteria were listed, discussed, and recorded. The results of the search were reported (Lizarondo *et al.*, 2021:283).

Throughout this process the purpose and/or review question(s) were used as a guide in formulating inclusion and exclusion criteria to identify and manage selected articles.

Studies eligible for inclusion:

- Qualitative, quantitative, and mixed method studies dealing with LGBTI content in nursing programmes.
- Master dissertations, Doctoral theses and studies positioned within the discipline of nursing.
- All studies, regardless of country of origin, race, and gender, as mentioned in article and date.

Studies to be excluded:

- Duplicates
- Abstracts / Publications for which no English translation was found.
- Any studies that introduce a piloted programme into the curriculum.

Studies were selected and screened by the researcher and the two study supervisors per the inclusion/exclusion criteria. The citations from a search were reviewed, and articles deemed relevant for full-text retrieval and critical appraisal were selected. The researcher decided that in cases where clarification or guidance would be required, authors of the selected publications would be contacted. This step was not conducted. Incorporating the *Preferred Reporting Items for Systematic Reviews and Meta-Analyses* (PRISMA) assisted with reporting on the literature selection process for the review sample (Toronto & Remington, 2020:7; Xiao & Watson, 2019:105).

The PRISMA flow diagram (Figure 5) assisted the researcher by focusing on a stepwise approach aimed to improve reporting on *Step 2: Systematic search and selection of literature and Step 3: Data extraction and Quality Appraisal*. The diagram served as a representation to illustrate the actions and decision-making processes taken by the researcher. It shows the number of records identified, included, and excluded, and the reasons for exclusions (Page *et al.*, 2021:4). Following *article identification*, the researcher checked all titles and abstracts for relevance concerning the review question. The removal of 132 system duplicates reduced the number to one hundred and eighty-four (n=184).

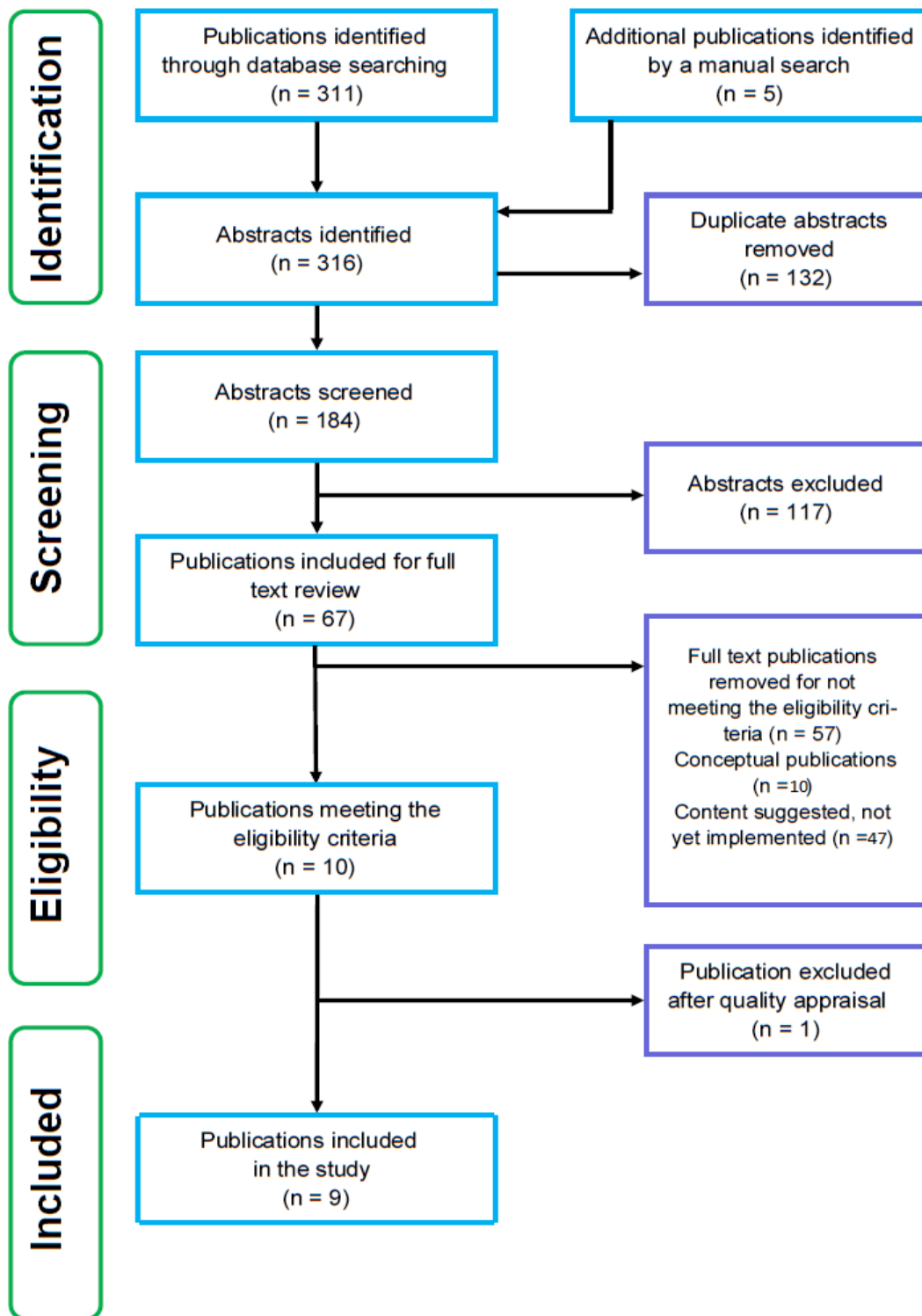


Figure 5 PRISMA Flow Diagram

Abstracts were *screened* in relation to the inclusion and exclusion criteria presented in **section 3.4.1**. A further reduction (n=117). Study supervisors repeated the screening process independently, and discrepancies and decision-making were resolved through discussion (Lizarondo *et al.*, 2021:282; Lizarondo *et al.*, 2020:271). The full-text versions of the remaining sixty-seven (n=67) citations were obtained. These included qualitative, quantitative, and mixed method studies, reviews, master dissertations, and doctoral theses positioned within nursing.

During *eligibility*, the researcher was guided by the review question whilst publications were assessed against the set inclusion and exclusion criteria. There were fifty-seven (n=57) publications either proposing content to be included in response to recommendations or introducing a piloted programme into the curriculum. The fifty-seven (n=57) were excluded, resulting in ten (n=10) articles for quality appraisal.

3.4.3 Step 3 – Quality Appraisal and Data Extraction

The strength of a review's findings relies on the quality of the studies included. It is crucial to assess the quality or internal validity of the studies selected. The relevance of the studies for review was assessed. Those that met the inclusion criteria were retrieved in full, and their details were imported into an independent scoring system to enhance rigour (Lizarondo *et al.*, 2020:271).

3.4.3.1 Quality Appraisal

Generally speaking, a MMSR, as a means of conducting an research, presents three distinct challenges: (1) the heterogeneity of the data obtained, (2) the diversity of critical appraisal tools and (3) the lack of consensus on the definition of "*quality*" (Fàbregues *et al.*, 2021:146).

Quality, in this review, quality was dependent on numerous factors, which contributed to the study's strength and rigour. The question of what constitutes quality was addressed by the following three aspects, methodological, conceptual, and reporting quality, postulated by (Fàbregues *et al.*, 2021:146; Pluye, 2015:76; Hong *et al.*, 2018:2; Toronto & Remington, 2020:7; Xiao & Watson, 2019:105). As alluded to, a standardised approach was followed by independently appraising each publication.

The researcher endeavoured to negate challenges presented by the *heterogeneity of data*. Data from qualitative studies were framed within a specific context. Varied epistemological or methodological perspectives would present differently from qualitative studies, for instance. However, this heterogeneity was regarded as a means of data and methodological triangulation, meaning that, regardless of the philosophical, epistemological, or methodological perspectives used in chosen publications for appraisal, congruence in meaning and experiences across quantitative, qualitative, mixed method and review studies enhanced the validity of research findings (Denzin & Lincoln, 2018:779). The data transformation process utilised in the MMSR also served as a means of ensuring congruence and veracity of the research findings.

The issue of the *diversity of critical appraisal tools* was addressed by selecting appraisal tools which assisted in assessing methodological quality. The *MMAT, version 2018 developed by Pluye et al. (2018)*, and the *JBI critical appraisal checklist for systematic reviews and research syntheses* were identified/chosen to evaluate the methodological quality of the chosen publications. (Refer to Addendum B.) Both the *JBI critical appraisal checklist for systematic reviews and research syntheses* and the *MMAT* allow for the evaluation of quality and strength of each study (Hong et al., 2018:2; Toronto & Remington, 2020:50). Since the MMAT Tool was not designed for appraisal of review type studies, the *JBI critical appraisal checklist for systematic reviews and research syntheses* was used (Hong et al., 2018:1).

3.4.3.2 The Quality Appraisal Tools

The *Mixed method Appraisal Tool (MMAT)* developed by Pluye et al. (2009) and the *JBI critical appraisal checklist for systematic reviews and research syntheses* were utilised as quality appraisal tools. (Refer to Addenda C and D.) These tools were chosen as the best tools to evaluate publications, based on the quality of each study, within its methodological domain (Toronto and Remington, 2020:50). Publications included for quality appraisal were listed alphabetically and assigned a number for ease of reference.

The **MMAT** was selected because it was validated through literature reviews, workshops and experts and demonstrates practical and theoretical validity through literature reviews (Pluye, 2015:79).

Since the review undertaken by the researcher used a mixed method approach, the researcher believed the MMAT appropriate as it was specifically designed for mixed method research and contained explicit criteria for assessing methodological quality of studies of diverse designs (Pluye, 2015:79). The *MMAT tool* consists of seven (7) reporting items which guided the researcher in assessing methodological quality of included articles. The reporting items were divided into two sections. The first two items were general screening questions focused on the clarity of the research question and data collection processes which assisted the author in answering the research question. The subsequent five (5) items aimed to describe quality. A section on the MMAT tool allows the researcher to record responses in assessing *quality*. If the publication referred to, espoused, or elaborated on the reporting items, the researcher indicated with “yes”, “*can’t tell*”, or “no”. If the answer to the screening questions was “no” or “*can’t tell*”, further appraisal was not conducted. (Refer to *Addendum B.*)

A systematic review (Number 7/n=1) was included in the study. It should be noted that although SRs are not routinely selected and incorporated into reviews such as a MMSR, the researcher believed that the content and scope of the SR would significantly contribute to the body of work. The SR (and its subtypes) in this case, A7, followed a recognised process, highlighting gaps in the research (Hong et al., 2018:2) and was considered a valuable contribution to the MMSR. Since the MMAT Tool was not designed to appraise SRs, the *JBI critical appraisal checklist for systematic reviews and research syntheses* was used to assess methodological quality (Hong et al., 2018:1). The reporting tool consisted of 13 reporting items.

The JBI tool presented with two similar general screening questions to those used in the MMAT Appraisal tool. Eleven of these were items/descriptors assessing quality. Similarly, the researcher could answer “yes”, “no”, or “unclear”. A “Not applicable” (NA) option was included, which was reserved for unique cases.

To contribute to rigour, the researcher decided to use a scoring system. This was a personal exercise to assist the researcher while engaging in this process. Since the MMAT appraisal tool described the items more concisely, the researcher presented an appraisal summary encompassing aspects of both appraisal tools used in this process. The researcher decided on a cut-off score of 5/five. This would indicate a minimum degree of credibility.

Publications which scored lower than five meant the study would be excluded from the review. Scoring provided insight only and did not compromise, influence, or impact the overall process of quality appraisal. This exercise allowed for all studies included for review to be totalled and graded in the same fashion. (Refer to **Chapter 4 – Quality Appraisal Results**, for a discussion of the appraisal process.)

Following the appraisal, quality assessment/appraisal refined the list of full-text articles selected. It represented the final stage in preparing the pool of studies for data extraction and further data analysis and synthesis (Pollock & Berge, 2018:147, Xiao & Watson, 2020:106). Of the ten articles identified for quality appraisal, nine met the minimum quality threshold for further inclusion in the review. Articles that have not met the quality threshold by scoring sufficiently on the checklists would be excluded.

3.4.3.3 Data extraction

In MMSRs following a convergent integrated approach, data relevant to answering the review question were extracted to allow data preparation for the next stage of the MMSR process (Lizarondo *et al.*, 2020:271).

Data extraction was conducted with the use of two standardised tools. In the case of this MMSR, the researcher utilised the *JBI Mixed method Data Extraction Form* following a Convergent Integrated Approach. The researcher created a tabulated version of the extraction form to assist and supplement the extraction process to include other pertinent information. The JBI extraction form was specifically used because it has been tried and tested within the academic space. Extracted data included quantitative, qualitative, or mixed methods methodology (e.g., randomised control study), number and characteristics of participants; phenomena of interest; setting and other context-related information (e.g., cultural, geographical); outcomes or findings and the significance to the study and the author's conclusion (Lizarondo *et al.*, 2021:307). Please refer to *Table 4 Elements to be extracted* for the additional information extracted (Lizarondo *et al.*, 2021:307). (Refer to *Addendum F* for the data extraction form.)

One extraction form was used per publication, as per JBI guidance. Together with the extraction form, the researcher adapted *mixed method Data Extraction Form* from JBI and created a tabulated version of the extraction form to include additional information (Lizarondo *et al.*, 2021:307).

Table 4 Elements to be extracted

JBI Extraction Form for MMSR	Extraction Elements	Drafted Extraction Table
✓	Biographical information	✓
✓	Type of Study / Methodology	✓
✓	Population and Sampling	✓
	Study aims or Purpose	✓
	Study Limitations	✓
	Data Collection Tool (if applicable)	✓
✓	Authors conclusions / Research Findings	✓
✓	Phenomenon of Interest	✓
✓	Setting/Context	✓
	Recommendations	✓
✓	Comments	✓

The additional items included were the study purpose, study limitations, the type of data collection tool used and the authors' recommendations (Refer to Table 4). The table was circulated to the two study supervisors to assess correctness. The extraction table was then returned to the researcher with comments. This brief comparison, made in Table 4, illustrates the reporting of elements to be extracted, using the drafted extraction table.

3.4.3.4 Extracted data

The characteristics of extracted data included the following: geographical location/where the study was conducted; the presence and nature of LGBTI content; location of LGBTI content within nursing programmes (undergraduate/postgraduate); data collection techniques, population, and sample composition along with recommendations and study limitations. All publications addressed the review question with clear reference to the presence of LGBTI content in undergraduate nursing programmes, postgraduate nursing programmes, and nurses in clinical practice.

Population and sample varied, from nursing education, nurse educators' institutions and student nurses, dealing with perspectives of caring for LGBTI persons. The data collection methods used in the publications included surveys, written and verbal comments, pre/post-test measures, and focus groups with the inclusion of a review type study. One article was excluded failing the two screening questions. There was a paucity of detail related to data collection techniques that were lacking and inappropriate to answer the review question. Further appraisal was not necessary to preserve rigour. A total of nine articles were appraised [N=9] and, participant numbers varied between 30 and 900.

3.4.4 Step 4 – Data Analysis

The *JBI Manual for Evidence Synthesis* outlines concise and systematic steps to adhere to during data analysis up to the point of data synthesis. The manual stated that a convergent integrated approach to synthesis and integration should be undertaken when the review question can be addressed by conducting either quantitative or qualitative studies (Lizarondo *et al.*, 2020:271). *Step 4 – Analysis and synthesis* involved three distinctive processes. The data extraction tool was kept and stored safely. It was stored on the study supervisors' personal computer in an encrypted folder which was password protected and will be kept for a minimum of 5 years, as it may be requested as supplementary material when the results are published.

3.4.4.1 Data transformation

Generally, it is accepted that data transformation involves '*qualitising*' quantitative data. The data are transformed through a process of data transformation before integration (refer to *Table 5*). The process of data transformation involved the transformation of quantitative, systematic review and mixed method studies into textual or narrative descriptions. To answer the review question and maintain the original meaning and context, data from quantitative and mixed method studies were '*qualitised*' through the conversion numerical findings into narrative descriptions (Lizarondo *et al.*, 2021:277).

Table 5 Data Transformation process

Code Applied to Publication	Transformation Process	Pre-transformation – in original text	“Qualitised” data
A1	QUAN TO QUAL	82% of participants would be comfortable teaching sexuality content, 9% said they would not, 9% reported they would possibly be comfortable teaching sexuality content.	On comfortability on teaching LGBTI content, majority of participants expressed a willingness to teach LGBTI content, the minority expressed their refusal to teach such content and some mentioned that they would possibly teach LGBTI content but were uncomfortable with the subject matter.
	QUAN TO QUAL	27% sexuality content is not part of their programme. 16% of nurse educator believe students are prepared to deal with sexuality issues.	Less than half of participating nurse educators mentioned that LGBTI content was not a part of the nursing programme. A smaller number of respondents mentioned, that despite this, they believe that their students can deal with sexuality.
A2	QUAN TO QUAL	53% nursing schools - Content widely taught – focus on LGBTI health disparities, IPV and mental health issues. 65 students (47%) at nursing schools contracted into the study indicated – no sufficient content related LGBTI.	More than half of nursing schools indicated that LGBTI content is present in their nursing programmes and contrary to this statement, participating students indicated no sufficient content related LGBTI,
	QUAN TO QUAL	80 schools agree that there is capacity to expand LGBTI inclusivity. 70 schools indicated that leadership’s reluctance to commit to LGBTI inclusivity.	There is capacity to expand this content area, indicated that Nursing School leadership’s reluctance to commit to LGBTI inclusivity.
A3	QUAL TO QUAL	88% (n/N = 29/33) of participants were able to verbalise increased awareness of health disparities and effective ways of communication.	The majority of participants mentioned an increased awareness of LGBTQ individuals’ health disparities and reframing their communication styles after the session.
A4	QUAN TO QUAL	83% participants were cisgender women (n = 297, 82.73%), 68% White (n = 244, 67.97%) 73% heterosexual (n = 262, 72.98%). The age range 19 to 79 years (M = 27.69, SD = 8.74). 50% graduating from baccalaureate programmes (n = 180, 50.14%). 92% knew someone LGBTQ+ (n = 332, 92.48%).	The majority of respondents identified as heterosexual, white females with an average age of 27 years old, Half of which graduated their first, basic nursing degree qualification. The majority indicated they knew someone in their lives who identifies as LGBTI.
A5	QUAN TO QUAL	41.67% (N = 10) – LGBTI content extremely helpful for their education (M = 8.29, SD= 1.93, Min =3, Max= 10, N = 26). 87.5% (N = 21) had a score of 6 or above 12.5% (N = 3) selecting 5 or below.	Three quarters of participating students agreed that the transgender simulation confidently influenced comfort and confidence in caring for a patient who is transgender.

		Students felt capacitated to render culturally sensitive assessments and deliver support to transgender patients.
A6	<p>QUAN TO QUAL</p> <p>70% Some religious affiliation. 53% Catholic and 13% Christian 30% no religion. A Wilcoxon signed-rank test calculated median GAP scores after the simulation from 114 before to 125 after the simulation.</p>	The majority of participants reported strong affiliation with religion. After the simulation, GAP (Gay Affirmative Practice Survey) Scores, used to assess the health care practitioner's inclusive and respectful care with LGBTI persons improved.
A7	<p>QUAL TO QUAL</p> <p>Four central themes were recognised: (1) Cultural competence and inclusivity. (2) Existing knowledge of LGBT+ health-related issues. (3) Curriculum developments and outcomes. (4) Evidence of best practice in education provision and assessment. Significant gaps in the development of cultural competence in LGBT+ health issues for undergraduate students and practitioners and the restricted accessibility of apt education and training opportunities.</p>	Cultural competency and inclusivity, Existing understandings of LGBTI health-related issues, Curriculum developments and outcomes and Evidence of best practice in education delivery and evaluation were the main themes identified. Main gap identified were the development of cultural competency in LGBT+ health issues for undergraduate students and practitioners and suitable education and training opportunities.
A8	<p>QUAL TO QUAL</p> <p>50% of respondents reported "barriers to accessing medical care for LGBTQI2S+ people" and "chronic diseases relevant to LGBTQI2S+ people" were included in a required course, the other half said they are not in the curriculum at all. Rarely addressed - transitioning, Sex Reassignment Surgery. Some nursing school [40%] leadership acknowledged to not doing it well or avoiding it because of a lack of comfort or knowledge in the area.</p>	Half of the participants reported disparities in accessing healthcare, they also mentioned that LGBTI content in relation to chronic conditions were being taught. The other half mentioned that there was no appropriate LGBTI content at all, especially content related to transitioning and sexual reassignment. Some nursing school leadership self-confessed to not doing it well or avoiding it because of a lack of comfort or knowledge in the area.
A9	<p>QUAN TO QUAL</p> <p>(72%) younger than 30, (88%) white (91% female) (90%) heterosexual Preparedness- At baseline, the majority reported feeling ill prepared (intervention: 2.87 ± 1.17, control: 2.73 ± 1.14). (95%) intervention group - course completion = higher ratings of preparedness on LGBTI healthcare. Knowledge – baseline - (intervention: 94.2%, control: 92.7%). No significant change in post-test/ intervention results. Comfort - discussions about sexual health was moderate for both groups at baseline (intervention: 3.43 ± 1.19,</p>	The majority of participants identified as heterosexual, white females. During protest phase participants described not being prepared. When assessing preparedness post intervention, participants in the intervention group reported meaningfully higher ratings of preparedness to deal with LGBTI healthcare. There was no significant improvement in the intervention group when it came to knowledge in caring for LGBTI persons. Discussions about comfort in LGBTI sexual health was moderate for both groups at baseline with no significant change. At baseline, all participants reported low

	<p>control: 3.50 ± 1.05, N.S.) Intervention group reported significantly higher comfort ratings (general and all sub-categories) on post-test.</p> <p>Confidence - At baseline, all reported low confidence in providing LGBTI care. After completing the course, students in the intervention group were more confident providing care, executing assessments, and describing sexual health disparities for all categories of patients compared to the control group.</p>	<p>confidence in providing sexual healthcare. After completing, students in the intervention group were more confident providing care, performing assessments, and recounting sexual health disparities for all categories of patients compared to the control group.</p>
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Table 5 outlines transformation of quantitative, numerical representation of findings into textual descriptions or narrative descriptions. This facilitated effective data integration and synthesis. The data transformation process allowed for representation of multiple realities based on LGBTI inclusivity in nursing programmes.

3.4.4.2 Thematic analysis

Thematic analysis, in the context of a MMSR, is viewed in three stages that allow the researcher to report beyond the results of the studies (Purssell & Gould, 2021:3). Thematic analysis was utilised as an appropriate method, while seeking deeper understandings of experiences, thoughts, and behaviours (Kiger & Varpio, 2020:2). A thematic analysis was manually performed. Both *qualitised* data and qualitative data were concurrently analysed. The researcher and study supervisors were guided by a three-step approach to thematic analysis, espoused by Purssell and Gould (2021), which is based on the work of Braun and Clarke (2006) and Thomas and Harden (2008).

The processes involved in the three-stage approach are:

- **Stage 1:** The coding of the texts
- **Stage 2:** The generation of descriptive themes
- **Stage 3:** Development of final analytical themes

The thematic analysis process was executed manually. The aim was to identify patterns in the data. An inductive approach was used. These patterns provided an important and interesting insight into identified parallels and inconsistencies in the data. The identification of themes assisted the researcher in representing any parallels and inconsistencies in literature and any observed relationship between themes (Lizarondo *et al.*, 2021:284; Dhollande *et al.*, 2021:435).

Stage 1: Coding of the text – The researcher perused the publications and assigned codes, which are the most basic piece or component of raw data and can be evaluated and explored in relation to the phenomenon of interest (Kiger & Varpio, 2020:3). To avoid extraneous data, only information related directly to the review question was coded. The coded data was transferred word-for-word to a data table or *review matrix*. The review matrix was created using Microsoft Word™. This allowed the researcher to group codes in relation to one another. The review matrix (refer to *Addendum E*) provided a well-structured document which was used during thematic analysis and supported structuring a narrative synthesis (Toronto & Remington, 2021:58).

Stage 2: The generation of descriptive categories – The identification of themes emanating from the preceding stage (Stage 1) was identified by sorting codes into associations or categories. Findings were grouped based on similarity in wording, concepts, and ideas to develop categories (Lizarondo *et al.*, 2021:160). Categorisation was the first step in accumulating conclusions, moving from individual findings to considering all findings for all studies included in the review. Once categories were identified, they were re-read in light of findings, this was a reiterative process (Lizarondo *et al.*, 2021:166).

The following broad *descriptive categories* were identified:

- Research Question (Review objectives and congruence in relation to this study)
- Study sample (*Nursing Programme: Undergraduate / Postgraduate*)
- The nurse and patient care
- Where (*in the nursing curriculum*) is LGBTI Content included
- Time spent | Type of Content
- Barriers to LGBTI Inclusion
- Nurse / Nurse Educator
- Student voices: Exclusion, Omission, neglect of LGTI (*Health Content*)
- Explicit Study Recommendations
- LGBTI Specific Healthcare needs
- Knowledge generation and improvement
- Culturally sensitive and/or culturally competent care

The iteration and reiteration assisted in grouping and the identification of categories. Categories were sorted and allocated an appropriate heading. During Stage 3, these would later be sorted into themes. To confirm the accurate representation and validity of the data, the researcher requested the two study supervisors to check and confirm the information.

At the end of the second stage of thematic analysis, data from the articles included for review were reread and prepared to develop the final analytical themes.

Stage 3: Development of final analytical themes – Working past the outcomes of the studies, the researcher identified analytical themes. Data that were pooled in the previous stage were then arranged into themes. The data was copied from the original textual context and tabulated with headings and subheadings drawn during the previous stage. To summarise and explain the findings with reference to the study contexts and findings, all data considered were evaluated against the review question and confirmed with study supervisors. The thematic analysis allowed for large volumes of data to be analysed, easily aligned with choice of paradigmatic perspective, and afforded the researcher the ability to scrutinise data with an inductive approach (Kiger & Varpio, 2020:5). Through repeated reading (*of the text*) and subsequent selection of headings which adequately described the themes, data which would assist the researcher in answering the review question were identified (Lizarondo *et al.*, 2021:60; Dhollande *et al.*, 2021:435).

The following recurring themes were identified:

- LGBTI content in nursing programmes
- Study characteristics/content specificity
- The advancement of social justice
- Challenges and barriers to LGBTI inclusion
- Curricular revision

As an analysis method, the researcher found it useful in developing insights based on common elements or patterns across the studies included for review, thus shedding light on a complex phenomenon (Lizarondo *et al.*, 2021:244; Kiger & Varpio, 2020:4).

3.4.4.3 Data integration

The methodology for MMSR, a convergent integrated approach to data transformation, integration, and synthesis, as set out in the JBI manual was followed. Quantitative data were transformed into qualitative, narrative interpretations (Lizarondo *et al.*, 2020:294). Data transformation and thematic analysis served to prepare portions of the data set. The process was facilitated by using a framework (Lizarondo *et al.*, 2020:284). *See Addenda F and G.* The codes ascribed to the texts, identified during the analysis of extracted data, were used to assist the researcher. Data could be integrated, while data were categorised and

combined based on resemblance to develop a set of themes. The integrated findings were presented later (*data synthesis*) and formed the basis of *line of action* statements.

3.4.4.4 Data synthesis

The data synthesis process involved the combination or synthesis of findings to produce a set of statements representative of that combination. The findings were assembled and categorised based on similarity in meaning and further synthesised to offer comprehensive findings used to inform nursing educational practice (Lizarondo *et al.*, 2020:284). (Refer to Figure 6).

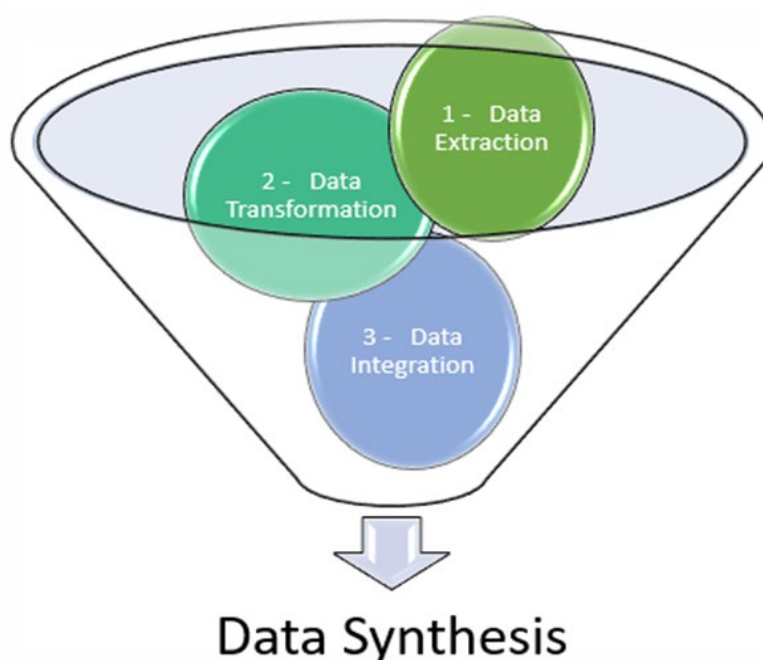


Figure 6 Convergent integrated approach

After reviewing the included studies, the analysed data were organised into five themes and sub-themes, are discussed: *LGBTI content in nursing programmes; context specificity; the role of the nurse in the advancement of social justice; challenges and barriers to LGBTI inclusion, and curricular revision*. The data were assembled, categorised, and grouped on similarity and organised to produce a set of relational findings (Polit & Beck, 2021:671, Toronto & Remington, 2020:58; Xiao & Watson, 2020:107). Findings were integrated and synthesised using qualitative synthesis.

3.4.5 Step 5 – Discussion and Conclusion

In this step of a MMSR, the researcher documented their review findings. The researcher collated findings and drew comparisons and contrasts in relation to the background literature and work of others (Toronto & Remington, 2020:8). Any conclusions in the MMSR were displayed graphically (be it a table or diagram) to ensure transparency and that the reader can follow the research's steps. The MMSR should also point out prospects and directions for future research (Xiao & Watson, 2020:107).

3.4.6 Step 6 – Dissemination of Findings

Dissemination occurs once the researcher communicates their research synthesis to a professional community or institution of higher learning (Toronto & Remington, 2020:9). In the case of this study, dissemination will take place at the publication of the research at which the study is submitted for qualification. It will be published after completing the master's degree, and content will be shared with peers.

3.5 MEASURES TO ENSURE RIGOUR

The researcher sought to embed the framework by Lincoln and Guba (1985) and Guba and Lincoln (1994) to ensure rigour throughout the review process. Rigour in MMSR refers to the thoroughness and detail with which research is carried out (Burns & Grove, 2011:39). The researcher, thus, remained vigilant of the influence and presence of bias, which may distort the results adversely influencing the believability or trustworthiness of the results of the study (Toronto and Remington, 2020:45). As part of ensuring rigour and quality for this MMSR, it is important that the researcher diligently follow the steps and recommendations for the MMSR as these may ensure rigour (Botma *et al.*, 2010:233; De Vos., 2012:421; Zawacki-Richter *et al.*, 2020:77).

The researcher remained cognisant that quantitative understandings of minimising bias to ensure rigour cannot be generalised within the context of qualitative research. The qualitative concept of trustworthiness was employed because of the descriptive nature of the MMSR and the fact that this integration comprised of quantitative, qualitative, and mixed method studies. The *trustworthiness* framework consisted of five strategies to ensure rigour in a study, credibility, dependability, confirmability, transferability, and authenticity (Toronto & Remington, 2020:46).

The five strategies identified and the application thereof, before, during and after the study are discussed in relation to *Figure 7*.

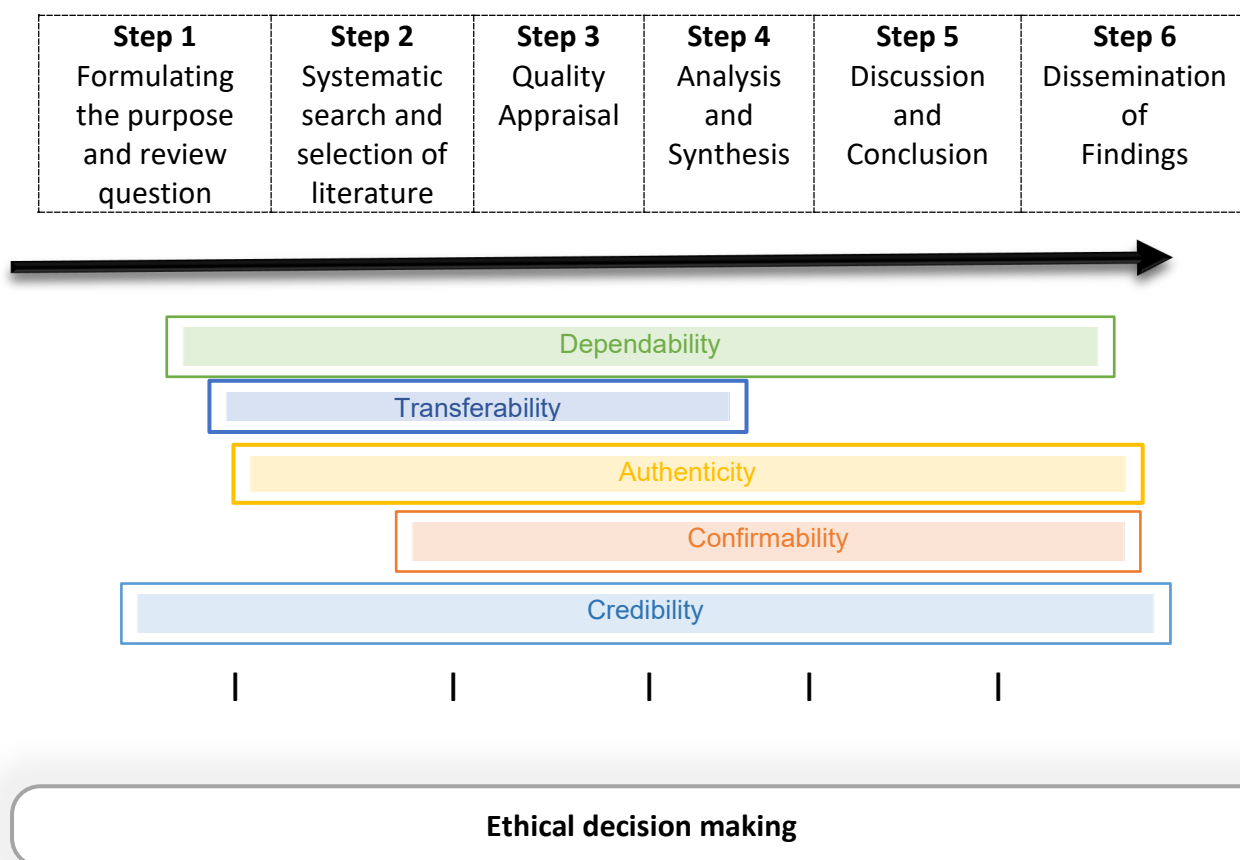


Figure 7 Ethical Decision Making and Trustworthiness

Credibility refers to how the study was executed and how this enhances the believability of the study. It also speaks truth value of the data and interpretations thereof. The researcher must safeguard the systematic approach of the MMSR. In Step 1, the importance of explicit criteria (inclusion and exclusion criteria) assisted the researcher in minimising the risk of bias and allowed objective adjudication of the validity of the review.

An important part of the process is the explorative searches in Step 1, which guides the researcher to formulate a broad research question and purpose. Once that has been achieved, a well-structured review purpose and variables of interest facilitate all other stages of the review. During Step 3, the appraisal of each study was well documented to support the integrity of data analysis in Step 4. The involvement of study supervisors, through Steps 1 to 6, also guided and refined the study, which increases credibility.

Dependability refers to data reliability or stability over time and conditions if the study was replicated within the same parameters. The researcher has ensured that the data used throughout the study are traceable and available as is required for auditing purposes, as in Steps 1 to 4 (De Vos., 2012: 420). The quality of the studies for review was assessed, in Step 4, using a score system for *Mixed Method Research and Mixed Studies Reviews and the Critical Appraisal Skills Programme* (Pluye et al., 2009). Incorporating the PRISMA flow diagram (*Figure 5*) assisted with reporting the literature selection process for the review sample. This improves the reliability of the study while reducing bias (Botma et al., 2010: 233; Toronto & Remington, 2020:7; Xiao & Watson, 2019:105). Identifying and acknowledging limitations of the review, in Step 6, explicitly, is viewed credible and ultimately fortifies impact of the review and speaks to factors which may impact the replicability of the study.

Confirmability speaks to whether two or more people would independently agree on data relevance and accuracy and objectivity of the data. In Steps 1 and 2, a comprehensive search for literature sought to identify the maximum number of eligible primary sources, using more than one strategy. The researcher ensured that there were definite inclusion and exclusion criteria for the review. The researcher, in Step 2, consulted a data specialist at UFS to increase specificity and comprehensiveness (Choi et al., 2019:472; Tawfik et al., 2019:3; Toronto & Remington, 2020:7). In Step 4, the researcher utilised study supervisors as two independent reviewers, to peruse abstracts.

Transferability denotes the degree to which research findings could have applicability in other settings. The study should be executed in such a manner as to allow transferability, which means, that it could be duplicated within another social/occupational context, following the same steps. In Steps 1 and 2 the researcher has opted to utilise SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research type), put forth by Cooke et al. (2021:1437) used as search method and to refine the research question and purpose. During Steps 1 to 4, the search string and quality of studies have been described as the extent to which the review uses measures to minimise bias in the research design, conduct and analysis.

Authenticity denotes the degree to which the researcher can justly display a range of realities. During Step 4, the researcher collated findings, and drew comparisons and contrasts about the background literature (Toronto & Remington, 2020:8). In Step 3, the

MMSR search utilised two search terms or phrases, searching multiple databases. This supports a comprehensive and rigorous review. The researcher ensured the research process, Steps 1 through 6, were guided by virtue-based ethics to enhance authenticity. In Step 6, references were current, original, and accurate and backed the arguments made in the review. Any conclusions in the MMSR were displayed graphically (table or diagram) to ensure transparency.

3.6 ETHICAL CONSIDERATIONS

The paradigm, with its *relational epistemology*, focuses on the inquiry process and practicality, and lends itself to a virtue-based approach to ethical considerations (Kelly & Codeiro, 2020:2; Kivunja & Kuyini, 2017:35). The axiological assumption outlines that the ethical objective of inquiry is to know a phenomenon in the search of benefit to others. (Mertens, 2020:20).

Research regulations are explicit rules that guide the health sciences research and ethics committees' determinations (Morris & Morris, 2016:204). It is generally accepted and understood that a principle-based approach may provide a guide for action to promote integrity in research. Ethical conduct grounded in a principle-based ethics approach was understood or portrayed as compliance to ethical rules (Resnik, 2012:1). Virtue ethics, by contrast, focuses on the growth of one's character when being confronted by ethical dilemmas and assist in illuminating the relationship between individual impetus and ethical conduct (Morris & Morris, 2016:202; Resnik, 2012:5). In traditional inquiries the study follows a linear fashion but the consideration of ethical issues in research can be described as occurring before conducting the study, during and at the end (Botma *et al.*, 2010:5; 26-27; Creswell & Poth, 2018:87).

The researcher agrees that ethics are applicable at all phases of the research process. Figure 7 illustrates how ethical decision-making drove and strengthened rigour throughout the study. The researcher has identified chosen virtues (refer to *Figure 8*) which best guided ethical decision-making throughout the study process as indicated in Banks (2018:10). The virtues are *practical wisdom, respectfulness, trustworthiness, and justice*.

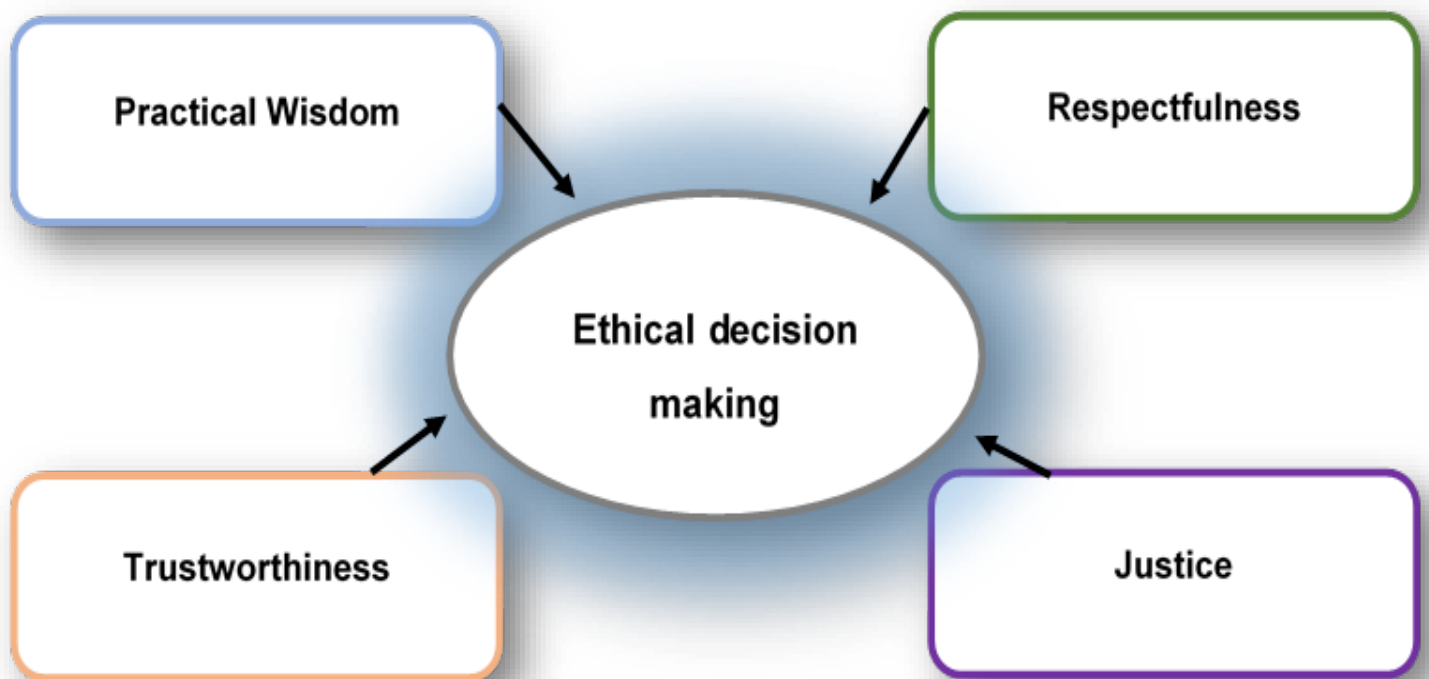


Figure 8 Virtue Ethics - Ethical decision making

Practical wisdom refers to the quality by which researchers carefully plan what to do in research processes. A person of practical wisdom is viewed to be able to engage in applied reasoning, essential for good judgment. Practical wisdom enables one to discover the difference and similarities between extremes. Practical wisdom, thus, is used to make the suitable choices that create worthy research (Banks, 2018:10; Segon & Booth, 2015:796).

These choices may include but are not limited to:

- Familiarising oneself with the methodology
- Adhering to the systematic approach of the study design and method
- Recognition and utilisation of study supervisors as experts

Respectfulness towards individuals, something or situation entails recognising the worth of the person, conserving, and not terminating it. The researchers use the 'self' in developing relationships and familiarisation with perspective with those whom they work. The

researcher must embody respect, dignity, uphold privacy and individual choices as far as possible (Banks, 2018:10; Norwell *et al.*, 2022:3).

The researcher drew on this virtue to:

- Ensure that the original finding of other researchers is voiced and represented in its entirety and within the original context.
- Handle information recovered from databases and other sources with responsibility and confidentiality.
- Recognise the unique perspectives of fellow researchers and the value their work brings.

Trustworthiness speaks to a researcher who is considered reliable. The concept of trustworthiness is also employed to ensure rigour. Within ethical decision- making, the researcher is aware and accepts liability for and should be accountable for their conduct; and can give a reasonable account as a responsible and reliable individual. (Banks, 2018:11; Segon & Booth, 2015:797).

The researcher has an ethical obligation to:

- Ensure transparency during data collection, appraisal, and synthesis.
- Avoid plagiarism in all its forms and give due recognition to authors, researchers, and organisations where necessary.

Justice deals with the just distribution of benefit and burden. This value depend upon the person's capacity to draw sound conclusions. An unbiased researcher has the character to act reasonably in relation to persons or situations to whom they owe a specific responsibility and act in a way that endorses and promotes fair social arrangements (Banks, 2018:11; Slote, 2020:2).

The researcher may draw on this virtue to:

- Express any limitations and threats to rigour in the study.
- Make appropriate and meaningful recommendations for further studies.
- Recognise that though the researcher may follow a virtue-based approach, the proposed study should, thus, inherently fulfil the requirements of principled-based bioethics to comply with the Health Sciences Research Ethics Committee (HSREC) standards.

It is also important to note that the HSREC at the UFS operates within a principle-based bioethical approach. In this respect, the HSREC contributes uniquely to excellence in research and oversight, facilitating the ethical governance in research. Through the utilisation of the principle-based approach put forward by Beauchamp and Childress (1985), researchers are required to hold themselves accountable first by adhering to these principles (Gustafson and Peterson, 2021:3; University of the Free State, Faculty of Health Sciences, 2018:58).

Though the researcher may follow a virtue-based approach, the proposed study should, thus, inherently fulfil the requirements of principled-based bioethics to comply with the standards of the HSREC. Adopting a virtue-based approach provided a link between self-improvement, the human pursuit of happiness, and ethical conduct (Resnik, 2012:5). Practicing virtue and following rules assist in acting morally. This approach is grounded in e four ethical principles, *respect for autonomy, beneficence, non-maleficence* and *justice* (Morris & Morris, 2016:204; UFS, Faculty of Health Sciences, 2018:8). According to Resnik's (2012:5) augmentation view, virtue theories function harmoniously with principle-based approaches to ethics.

Accordingly, virtues supplement, but do not replace, principle-based theories. *Table 6* illustrates how the researcher will satisfy the requirements of the HSREC principle-based approach.

Table 6 Comparison of Principle Based and Virtue Based approaches to ethics

Principle Based Approach		Virtue Based Approach
Autonomy	Does the researcher respect and support autonomous decisions? To be autonomous requires participants to have legal capacity.	Practical Wisdom Justice
Non maleficence	Has the researcher outlined measures which intend to avoid the causation of harm to participants?	Respectfulness Practical Wisdom
Beneficence	Has the researcher taken steps to ensure the welfare of the participants and balanced benefits against risks?	Trustworthiness Practical Wisdom
Justice	Is there fair opportunity in the face of disparities in which the researcher fairly distributes benefits, burdens, risks, and costs?	Justice Practical Wisdom

(Adapted from Beauchamp and Childress (1985), Banks (2018:12), Morris & Morris (2016:204) and Slote (2020:6)

The virtues-based approach succinctly implies that the researcher must hold them accountable, guiding the researcher, while working on relationships with research partners, undertaking reasoning, including appropriate action and critically question the current or accepted values and standards of research (Banks, 2018:12; Morris & Morris, 2016:205; Slote, 2020:6). *Table 6* seeks to reiterate how an augmentation view approach to virtue-based ethics supported and complimented principled-based bioethics. The application of virtues throughout the research process assisted the researcher in compliance and fulfilment of the principled-based bioethics requirements of the HSREC. A virtue-based approach to ethics not only assisted but also guided the researcher in making ethical decisions but at the same time enhances rigour of the study.

3.7 CHAPTER SUMMARY

LGBTI health needs can be multifaceted and require a competent and compassionate nurse who draws on their knowledge base and skill set, while providing appropriate and fitting care. This chapter outlined a systematic approach the researcher followed to locate evidence of the addition of LGBTI health issues covered throughout the nursing academic programme. An overall description and rationale of the identified research design and methodology outlines the process the researcher embarked on. The research design plays a fundamental role in spanning gaps between the review question, the chosen research method and connects the review design to the choice of methods (Kaushik and Walsh, 2019:8). The researcher believes that the choice of a MMSR, convergent integrated design, is one way to answer several questions in one review while preserving the integrity of the findings. The researcher believes that MMSR represents a significant development in the field of research for individuals who attempt to increase utility of their inquiry. The researcher outlined all methods used while conducting research. All research process procedures and steps have been documented and discussed in full. Following this substantiation, an outline of the paradigmatic premise from which the researcher functions and the rationale for its employ were covered. The researcher connects the basic assumptions of the chosen paradigm (Pillay & Morel, 2020:3). The researcher also outlined measures to ensure rigour in the study and covered pertinent ethical issues that arose before, during and after the research process.

CHAPTER 4

DATA ANALYSIS & REVIEW FINDINGS

4.1 CHAPTER OVERVIEW

Literature indicates that LGBTI access to healthcare services rendered within cisgender, heteronormative perspectives could drive healthcare inequalities for this demographic. The disparities are encouraged by societal and cultural norms which are discriminatory and exclusionary in nature (Donisi *et al.*, 2019:979; Müller, 2013:4). The accounts of discrimination and exclusionary practices represent but a fragment of the lived experiences of LGBTI persons, which are both complex and intersectional. Intersections of diverse social, personal, and professional roles, and norms and beliefs, contribute to the social location or where individuals locate themselves within the larger social construct. One's social location could provide advantages in building resilience, however, in most cases, such intersections are often compound challenges (Travers *et al.*, 2022:4).

A dichotomous approach within society impacts nursing education in the sense that it ignores sexual and gender diversity, thus reinforcing stigma and discrimination. Such chasms adversely affect health-seeking behaviours of LGBTI persons and, subsequently, lead to poor health outcomes (Müller, 2015:6; Röndahl, 2011:345; Zeeman *et al.*, 2019:974). Considerations around inclusion, influence, and the nature of educational content in nursing curricula in this regard led to the review question:

What evidence exists in the literature on LGBTI content in nursing programmes?

The researcher anticipated that a MMSR process would be beneficial in producing a variety of evidence to answer the review question. A convergent approach to data synthesis would contribute implicitly to the knowledge advancement of LGBTI content in nursing programmes and assist in answering the review question. The MMSR findings could inform future nursing education and facilitate social change. In this chapter, the researcher describes the application of the steps of the MMSR that is Steps 2-4 before discussing the findings in triangulation with literature (Step 5).

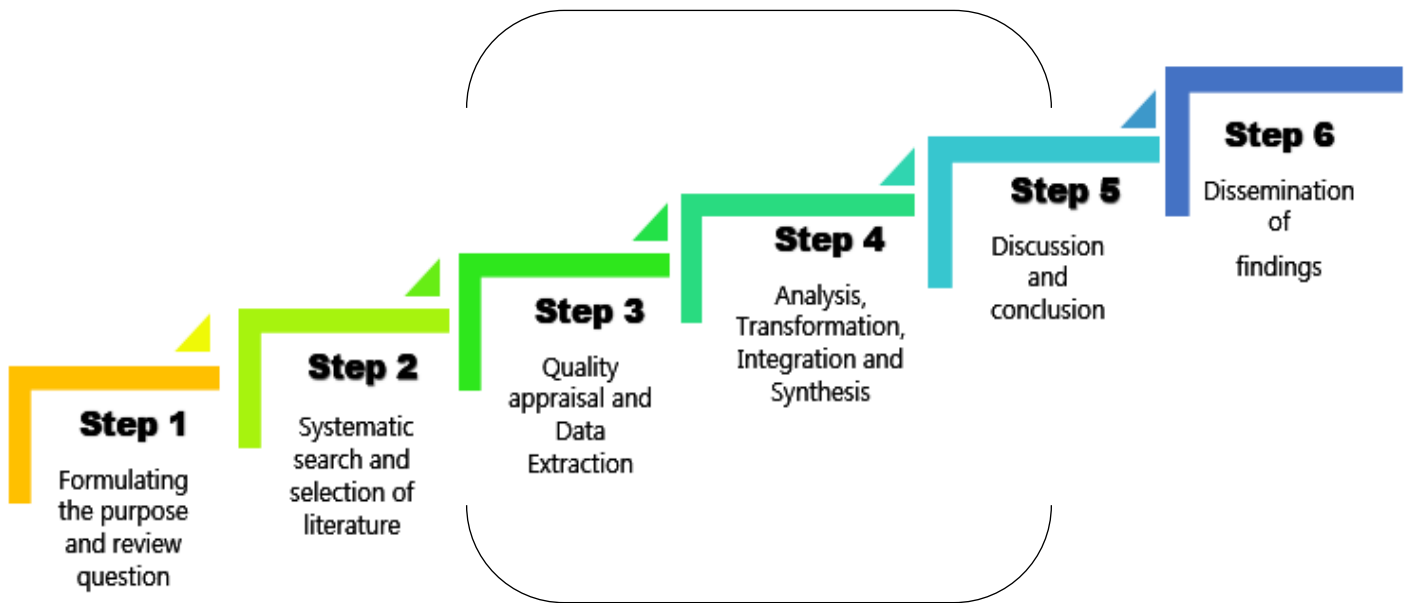


Figure 9 Chapter Four - Location within the MMSR process

4.2 APPLICATION OF THE STEPS OF THE MMSR

The steps followed from the screening and selection of literature to the discussion of results as described in section 3.4. (Refer to Figure 9 for a visual representation of the steps.) Having formulated the purpose and review question for the study, the researcher proceeded to *Step 2* and conducted a *systematic search and selection of literature* using multiple electronic databases. *Step 3* involved *Quality Appraisal process* and *data extraction* of the selected publications. During *Step 4*, the process of *data analysis and data synthesis* was undertaken. Data analysis included data transformation, thematic analysis, data integration and culminated in data synthesis. Data from numerous sources, across paradigms and methodologies were used. Data were transformed by “*qualitising*” quantitative data to enable the thematic analysis (Lizarondo *et al.* 2020:273,277). The transformed data were categorised and integrated based on similar meanings (Lizarondo *et al.*, 2021:282; Lizarondo *et al.*, 2020:271). The findings are discussed in triangulation with the literature. (Refer to section 4.5.)

4.2.1 Step 2 - Systematic Search and Selection of Literature

Step 2 was overseen by the study supervisors and guided by the data specialist. The Boolean Search String (refer to section 3.4.1) was formulated which assisted and guided the 1st *exploratory search*. This exploratory search focusing on locating evidence specific to the undergraduate nursing programme, resulted in limited titles. Informed by the results of the search, a resolution was reached to extend the scope of the review. This was done in consultation with the study supervisors. The search string was adjusted to include all academic offerings within the nursing programme. (Refer to section 3.4.3.4.) The main purpose was *to critically synthesise existing evidence in the literature on LGBTI content in nursing programmes. Evidence relating to both undergraduate and postgraduate programmes was included.*

The main search produced diverse results. A quarter of the publications referred to the term *sexuality education or sexual health course*. These included aspects of LGBTI education, even though it was not explicitly mentioned. At the onset of the review process, a distinction was sought around using the chosen acronym **LGBTI**. The most appropriate acronym, which would be inclusive and representative of the LGBTI community, was required. The search provided insight into the use of LGBTI and other related acronyms within academia. While the use of the chosen acronym, LGBTI, is common, variations were noted in the use thereof.

A globally accepted, inclusive form of the acronym includes lesbian, gay, bisexual, transgender, intersex, queer and or questioning, asexual and + (**LGBTIQA+**). (Refer to *Clarification and Operationalising of Concepts*.) The acronym, LGBTIQA+, describes the diversity in gender identities and sexual orientations, including individuals *questioning* their gender identities and sexual orientation (Qureshi *et al.*, 2020:113). The word *queer* may also describe gender and/or sexuality. *Asexuality* also offered some complexities. Individuals who identify as asexual may or may not identify as members of the LGBTI community. The plus (+) represents all marginal gender identities and sexualities not included or represented in the acronym.

As mentioned previously in the study, the researcher focused on the universally accepted variation “*LGBTI*” since this acronym is familiar and known by many communities. The researcher submits the assertion that the deliberate exclusion of sections of the **LGBTI [QA+]** demographic should, in no way, be interpreted as an exclusion of QA+ individuals from the current discourse.

The researcher believed the purposeful omission of *Queer/Questioning, Asexual and others (+)*, would: (1) negate a convoluted discourse around the duplicity in meaning of **QA+**; (2) broaden the scope of the search (and thus, the review) for LGBTI content.

Literature indicates that researchers and authors, at their discretion, and guided by methodological and philosophical underpinning, should select appropriate acronyms or terms which best suite their purpose (Qureshi *et al.*, 2020: 113). The acronym, *LGBTI*, is therefore used interchangeably with *LGBTIQA+* in this review. As indicated, the acronym used in this study includes queer/questioning, asexual and other gender identities, and sexual orientations [QA+]. The formulation and results of the structured Boolean Search string (Refer to *Table 3*) offered evidence that publications which met the review inclusion criteria not only contained references to QA+ individuals but sought to represent all persons who may identify within the LGBTI community. The main search resulted in titles that included alternative terms and references to the *LGBTIQA+* ‘community’. Alternative terms and variations thereof were identified – *gender diverse; non-binary, two-spirited; gender and sexual minorities* and were used to construct the Boolean search string.

The same process was applied to the search term “*nursing education*”. The main search used both *collective* (the combined academic programme undergraduate and postgraduate) and *specific* (which referred to the academic programmes in isolation from one another) terms, as indicated in the PRISMA Flow Diagram.

4.2.2 Step 3 – Quality Appraisal and Data Extraction

During this step, articles for inclusion to review are assessed for methodological quality. Subsequently, relevant data relative to the review question, were extracted. (Refer to section 3.5.1.3 which outlines the process followed by the researcher.)

4.2.2.1 Quality appraisal

The *MMAT Appraisal tool* and the *JBI critical appraisal checklist for systematic reviews* were used to evaluate methodological quality. The MMAT was used to evaluate eight of the nine articles pertaining to quantitative and mixed method designs. *The JBI checklist was used to assess the SR.* (Refer to *Chapter 3.*) The appraisal process commenced with two screening questions (S1 and S2).

The screening questions were applicable across research methods and designs, and therefore, they could be applied generally:

S1. Are there clear review questions?

S2. Does collected data allow us to address the research questions?

The screening questions were applied to all publications for appraisal. The five quality questions in the *MMAT, version 2018*, and the eleven quality questions in the *JBI critical appraisal checklist for systematic reviews* remained unchanged. In response to the screening questions, one publication was removed, and the rest of the process applied to nine others. The researcher remained vigilant in outlining all considerations, for each publication, during the quality appraisal process. Once all parties concluded quality appraisal, the data from respective appraisal sheets were condensed to holistically represent both the *MMAT, version 2018* developed by Pluye *et al.* (2018) and the *JBI critical appraisal checklist for systematic reviews and research syntheses*. This exercise allowed the researchers to streamline a uniform approach while reporting the quality appraisal process. The quality appraisal process was tabulated as a consolidated table. (Refer to *Table 7. Quality appraisal of selected articles*)

The heterogeneity of data obtained led the researcher to formulate an **additional exercise**. Based on the degree to which the publications meet the quality criteria, the researcher decided to allocate a score to each publication. As a novice, the researcher believed that this task would assist in prioritising quality over methodology and to address possible bias. Publications scored using the *MMAT*, saw each publication receive a score out of seven (7). The researcher allocated one (1) mark for every “yes” answer. A half mark for “can’t tell” was allocated in cases where it was difficult to identify quality descriptors in relation to the text. A zero was allocated for “no” in where quality descriptors were lacking. When using the JBI appraisal Tool, it was scored out of 13.

The researcher allocated a half mark for each item present. The scoring of publications was undertaken for the researcher’s insight only, in other words as a personal exercise. The allocation of scores did not compromise or influence the overall quality appraisal process.

While independently assessing *Article 8 (Tables 4.1 & 4.2)* by *McNiel and Elertson (2017)*, the researcher and the two study supervisors could not identify a clear research question. Details related to data collection techniques were lacking and were not appropriate to answer the review question. The publication by McNiel and Elertson (2017) failed the two screening questions (S1 and S2). According to the MMAT appraisal tool, further appraisal may not be realistic or suitable when the answer is 'No' or 'Can't tell' to one or both screening questions. Subsequently, the study by McNiel and Elertson (2017) was excluded from the review to preserve rigour.

Table 7 Quality appraisal of selected articles

Quality Appraisal of Selected Articles																		
Article No	Name	Methodology	S1	S2	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Score	Decision	
Responses to Appraisal Questions																Out of 7	Include	Exclude
1	Aaberg, V., 2016. The state of sexuality education in baccalaureate nursing programs. <i>Nurse education today</i> , 44, pp.14-19.	Quantative Explorative	Yes	Yes	Yes	Yes	Yes	Yes	Yes							[7]	✓	
2	Eickhoff, C., 2021. Identifying gaps in LGBTQ health education in baccalaureate undergraduate nursing programs. <i>Journal of Nursing Education</i> , 60(10), pp.552-558.	Quantative Descriptive	Yes	Yes	Yes	Yes	Yes	Yes	Yes							[7]	✓	
3	Elertson, K. and McNeil, P.L., 2021. Answering the call: Educating future nurses on LGBTQ healthcare. <i>Journal of homosexuality</i> , 68(13), pp.2234-2245.	Mixed Method	Yes	Yes	Yes	Yes	Yes	Can't Tell	Yes							[6.5]	✓	
4	Hand, M.C. and Gedzyk-Nieman, S., 2022. Graduating nursing students' preparedness and comfort level in caring for LGBTQ+ patients. <i>Journal of Professional Nursing</i> , 41, pp.75-80.	Quantative Descriptive	Yes	Yes	Yes	Yes	Yes	Yes	Yes							[7]	✓	
5	Koch, A., Ritz, M., Morrow, A., Grier, K. and McMillian-Bohler, J.M., 2021. Role-play simulation to teach nursing students how to provide culturally sensitive care to LGBTQ health education. <i>Nurse education in practice</i> , 54, p.103123.	Mixed Method	Yes	Yes	Can't Tell	Yes	Yes	Can't Tell	Yes							[6]	✓	
6	Maruca, A.T., Diaz, D.A., Stockmann, C. and Gonzalez, L., 2018. Using simulation with nursing students to promote affirmative practice toward the lesbian, gay, bisexual, and transgender population: A multisite study. <i>Nursing Education Perspectives</i> , 39(4), pp.225-229.	Quantative Descriptive	Yes	Yes	Yes	Yes	Yes	Yes	Yes							[7]	✓	
7	McCann, E. and Brown, M., 2018. The inclusion of LGBT+ health issues within undergraduate healthcare education and professional training programmes: A systematic review. <i>Nurse education today</i> , 64, pp.204-214.	Systematic Review	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	[7]	✓	
8	McNeil, P.L. and Elertson, K.M., 2017. Advocacy and awareness: Integrating LGBTQ Health Education into the Prelicensure curriculum. <i>Journal of Nursing Education</i> , 57(5), 312-314	Mixed Method	No	No												[0]		✗
9	Shortall, Chris, 2019. Teaching and Evaluation/Assessment Requirements for LGBTQI2S+ Health and Wellness: A Call to Include LGBTQI2S+ Content in Canadian English Baccalaureate Nursing Curricula. <i>Quality Advancement in Nursing Education - Avancées en formation infirmière</i> : (5) 1,7.	Quantative Descriptive	Yes	Yes	Yes	Yes	Yes	Yes	Yes							[7]	✓	
10	White, B.P., Abuelezam, N.A., Dwyer, A.A. and Fontenot, H.B., 2020. A sexual health course for advanced practice registered nurses: effect on preparedness, comfort, and confidence in delivering comprehensive care. <i>Nurse Education Today</i> , 92, p.104506	Quantative Descriptive	Yes	Yes	Yes	Yes	Yes	Yes	Yes							[7]	✓	

4.2.2.2 Quality appraisal process - results

On completion of the quality appraisal, nine (n=9) of the ten publications met the criteria to be considered trustworthy. Quality appraisal was the final task in arranging studies for data analysis and synthesis and refined the list of full-text articles selected and was (Pollock & Berge, 2018:147, Xiao & Watson, 2020:106). At this juncture, the researcher ascribed a code to each publication, namely A1-A9. This was done to differentiate (in text) between reference to literature (used to substantiate or refute) and references to publications included in the review. *Table 8* provides a tabulated representation of publications included for review.

Table 8 Publications included for review

Article code	Publication details	Method /design	Article code	Publication details	Method /design
A1	Aaberg, V., 2016. The state of sexuality education in baccalaureate nursing programs. <i>Nurse education today</i> , 44, pp.14-19.	Quantitative explorative design	A6	Maruca, A.T., Diaz, D.A., Stockmann, C. and Gonzalez, L., 2018. Using simulation with nursing students to promote affirmative practice toward the lesbian, gay, bisexual, and transgender population: A multisite study. <i>Nursing Education Perspectives</i> , 39(4), pp.225-229.	Quantitative descriptive
A2	Eickhoff, C., 2021. Identifying gaps in LGBTQ health education in baccalaureate undergraduate nursing programs. <i>Journal of Nursing Education</i> , 60(10), pp.552-558.	Quantitative descriptive	A7	McCann, E. and Brown, M., 2018. The inclusion of LGBT+ health issues within undergraduate healthcare education and professional training programmes: A systematic review. <i>Nurse education today</i> , 64, pp.204-214.	Systematic review
A3	Elertson, K. and McNeil, P.L., 2021. Answering the call: Educating future nurses on LGBTQ healthcare. <i>Journal of homosexuality</i> , 68(13), pp.2234-2245.	Mixed method	A8	Shortall, Chris, 2019. "Teaching and Evaluation/Assessment Requirements for LGBTQI2S+ Health and Wellness: A Call to Include LGBTQI2S+ Content in Canadian English Baccalaureate Nursing Curricula / Vol. 5: Iss. 1, Article 7.	Quantitative descriptive design
A4	Hand, M.C. and Gedzyk-Nieman, S., 2022. Graduating nursing students' preparedness and comfort level in caring for LGBTQ+ patients. <i>Journal of Professional Nursing</i> , 41, pp.75-80.	Quantitative descriptive design	A9	White, B.P., Abuelezam, N.A., Dwyer, A.A. and Fontenot, H.B., 2020. A sexual health course for advanced practice registered nurses: effect on preparedness, comfort, and confidence in delivering comprehensive care. <i>Nurse Education Today</i> , 92, p.104506.	Quantitative descriptive design
A5	Koch, A., Ritz, M., Morrow, A., Grier, K. and McMillian-Bohler, J.M., 2021. Role-play simulation to teach nursing students how to provide culturally sensitive care to transgender patients. <i>Nurse education in practice</i> , 54, p.103123.	Mixed method			

Post quality appraisal, the articles which passed the quality threshold found the research questions of respective publications, were formulated, and aligned with the design, method, and data collection techniques. The six *quantitative publications* addressed issues related to attrition and statistical analysis during the research processes. The reporting of findings was concise and apt. Publication A7 also passed the quality threshold. As an SR, A7 provided a well-detailed process. Systematic processes were followed, and the approach conformed to recognised standards for conducting a SR.

All actions, amendments, limitations, and variables of interest were unpacked and were well explained. Overall, the two *mixed method publications*, A3 and A5 exhibited a seamless synthesis of qualitative and quantitative data. However, there were shortcomings with reporting. It was found that contrary views were not adequately explored and discussed. Publication A5 lacked rationale for choosing a mixed method design, and both A3 and A5 misplaced adequately elaboration on any deviations or variations between quantitative and qualitative results. However, both publications exhibited methodological and conceptual quality. All limitations identified by the respective authors and the perceived value of the studies conducted were overt. Accordingly, A3 and A5 were included for review.

Remaining within the guidance of the pragmatic paradigm and its axiological and epistemological assumptions, the chosen quality appraisal tools not only assisted evaluating the quality of chosen articles but also aided in identifying similarities and differences across multiple study designs. The researcher attributed no hierarchy in respect of research approach or design. All data were viewed as equally important in answering the review question.

4.2.2.3 Data extraction

In MMSRs following a convergent integrated approach, relevant data were extracted to answer the review question and allow data preparation for the next stage of the MMSR process (Lizarondo *et al.*, 2020:271). *Data extraction* was conducted using the standardised *JBI Mixed method Data Extraction Form following a Convergent Integrated Approach*. One extraction form was used per publication, as per JBI guidance. Together with the *JBI Mixed method Data Extraction Form* and drafted a tabulated version, an extraction table was drafted to assist the researcher in the easy identification of relevant information.

Additional items were included: the study purpose, study limitations, the type of data collection tool used and the authors' recommendations. The draft table was vetted by the two study supervisors and returned to the researcher with comments. The formulated extraction table (*refer to Table 3*) assisted the researcher in covering a broader range of relevant information which may not have been overt in the JBI tool.

The *JBI Mixed method Data Extraction Form* and the extraction table formulated by the researcher allowed an opportunity to compare, confirm, compare, refute, and collate information. The additional items were included:

Bibliographical details of the article | Nature of inquiry | Research Method & Design | Details on Population and Sampling | Ethical Considerations | Study Aim/Objectives/Purpose | Location | Publication Relevance to Purpose of The Review | Research Findings and Recommendations | Limitations

Comprehensive extraction items were summarised in the formulated extraction table, as per the *JBI Mixed method Data Extraction Form (Addendum E, F and G)*. The data extracted during this process would further assist the researcher in delineating findings, and positions and elucidating limitations and strengths. The purpose and objectives of publications included spoke to the review question, with clear reference to the presence of LGBTI content and type of content. The characteristics of the publications covered the following: geographical location/where the study was conducted; the presence and nature of LGBTI content; location of LGBTI content within nursing programmes (undergraduate/postgraduate); research approach and population, and sample composition, along with recommendations and limitations of the study.

Within the nine (n=9) publications, the following characteristics were noted:

- Country of origin – Seven studies were conducted in the US; one in the UK and one in Canada.
- Content - Two publications placed meaningful emphasis on transgender content, while the rest referred broadly to LGBTI content.
- Nursing programmes – All studies spoke to LGBTI inclusivity. Across programmes (undergraduate, postgraduate, and short learning programmes).
- Research approach and method – There were six quantitative studies; two mixed method studies (surveys, written and verbal comments, pre/post-test measures and focus groups) and one review type study.
- Sample size - Participant numbers varied between 30 and 900.
- Participants - to nurse educators, nursing students and nurses in clinical practice.
- Participant Identity – Participants predominantly identified as Caucasian, cisgender female or male.
- Recommendations and limitations of the respective studies are unpacked later in relation to the review findings in Section 4.3.

4.2.3 Step 4 - Data Analysis

Guided by the review purpose a convergent integrated approach, the fourth step in the MMSR, data analysis, included data transformation, a thematic analysis, data integration and data synthesis. (Refer to Table 5) In this process, unique to the MMSR, the researcher transformed quantitative data in preparation for thematic analysis. Data from themes identified could be integrated into narrative descriptions. Data were synthesised into factual, conceptual, and inferential conclusions. The synthesised data were reviewed for correctness, context representation and completeness by the researcher and the two study supervisors.

4.2.3.1 Data transformation

Before the thematic analysis data from quantitative sources were “*qualitised*”. Data transformation involves the conversion of numerical representations of findings into textual narrative descriptions. Results derived from quantitative experimental and observational studies were transformed to answer the review question while maintaining the original meaning and context (Lizarondo *et al.*, 2021:277). (Refer to Figure 10).

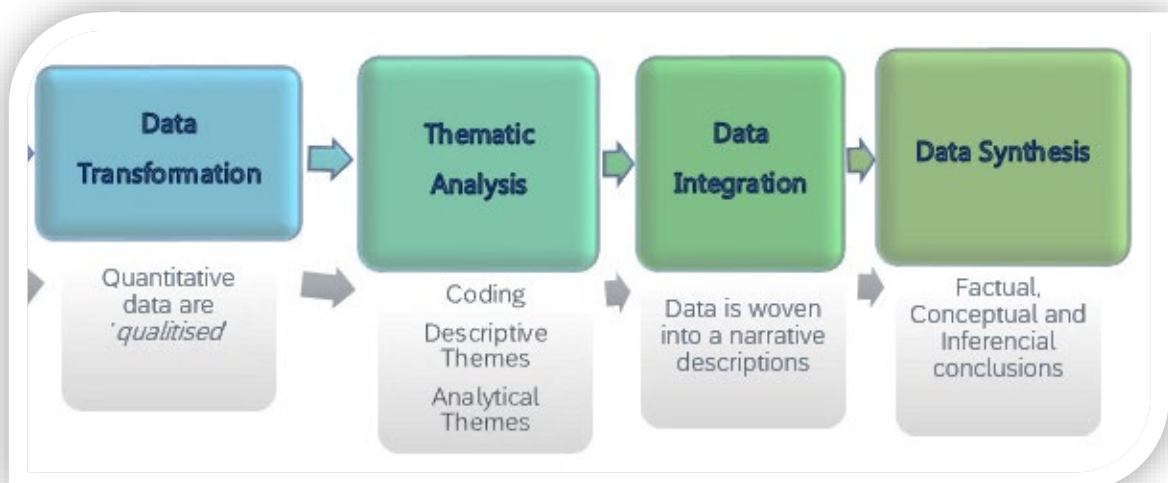


Figure 10 Data Analysis and MMSR

Data transformation, Data Integration and Data Synthesis processes

A pragmatic alignment allowed the inclusion of a plurality of views and lived realities centred on LGBTI inclusivity in nursing programmes, espoused within the respective publications. (Kaushik and Walsh, 2019:1). The transformation of data allowed the researcher to effectively analyse contemporary social issues related to LGBTI inclusivity and social inequality. The process prepared data for further engagement in the development of the themes.

4.2.3.2 Thematic analysis

The researcher and study supervisors were guided by a three-step approach to thematic analysis, espoused by Purssell and Gould (2021), which is based on the work of Braun and Clarke (2006) and Thomas and Harden (2008). The pragmatic philosophical and/or methodological approach allowed the researcher to employ best methods to answer the review problem and question. This approach allowed the researcher to report beyond study findings (Kaushik & Walsh, 2019:2; Purssell & Gould, 2021:3).

Stage 1: Coding of the text – Firstly, the researcher coded publication texts in line-by-line coding. The researcher drafted a data table or review matrix which allowed coded data to be transferred, word-for-word, to the review matrix. Based on the review question, items were coded in terms of this analytical framework (Purssell & Gould, 2021:4). The review matrix was created using Microsoft Word™, which allowed the researcher to sort codes in relation to one another.

Stage 2: The generation of descriptive categories – Based on common and divergent findings, codes were assembled into categories. Categorisation was a reiterative process that supported identifying patterns in the data (Lizarondo *et al.*, 2021:166).

Stage 3: Development of the final analytical themes – The preceding stage allowed data to be pooled and arranged into themes (Lizarondo *et al.*, 2021:244). The data was copied from the original textual context, tabulated with headings and subheadings drawn during the previous stage and sorted using the review matrix. The thematic analysis allowed for large volumes of data to be analysed. An inductive, data-driven approach aligned with choice of paradigmatic perspective, identified five themes with subthemes (Kiger & Varpio, 2020:5). (Refer to *Table 4.3*).

4.2.3.3 Data integration

Data transformation and thematic analysis prepared portions of the data set to integrate *qualitised* and qualitative data. The process was facilitated with the help of a review matrix/framework, as suggested by Lizarondo *et al.* (2020:284). Data were organised into qualitative, narrative interpretations. The data were sorted and merged based on likeness and inference to develop a combined set of themes.

4.2.3.4 Data synthesis

The aggregation or synthesis of findings produced during *Data Integration* created a set of integrated findings. These findings were generated into a set of summary statements representing that aggregation, using qualitative synthesis (Polit & Beck, 2021:671, Toronto & Remington, 2020:58; Xiao & Watson, 2020:107). Based on the similarity in meaning, synthesised data were presented as a comprehensive set of findings, which could be useful in informing nursing educational practice (Lizarondo *et al.*, 2020:284).

4.3 Review findings

Five categories were identified during data analysis (relating to the LGBTI content), each discussed in its own subsection in triangulation with literature. The subsequent discussion presented by the researcher offered an analysis of the included studies, and five main themes, with subthemes, as identified. (Refer to *Table 9*).

Table 9 Summary of themes and sub-themes

THEMES	SUBTHEMES
LGBTI CONTENT IN NURSING PROGRAMMES	Inclusion (of LGBTI Content) Characteristics of included content
CONTEXT SPECIFICITY	Geographical and demographic Generalisability
THE ADVANCEMENT OF SOCIAL JUSTICE	The social location of the nurse Attitudes and perceptions (of the nurse) The nurse and nursing education
CHALLENGES AND BARRIERS TO LGBTI INCLUSION	Will and capacity Time Cultural and religious beliefs
CURRICULAR REVISION	Teaching strategies Sensitisation programmes

The main identified themes are: LGBTI content in nursing programmes; context specificity; the role of the nurse in the advancement of social justice; challenges and barriers to LGBTI inclusion; and curricular revision.

4.3.1 LGBTI Content in Nursing Programmes

Theoretical and practical teaching and learning activities aim to educate and capacitate healthcare professionals, equipping them with the skills and competencies needed to engage in diverse people's unique and nuanced healthcare needs. In line with the review purpose and question, the first theme was central to answering the review question. On review of the publications, all referred or alluded to the presence of LGBTI content within the nursing programme. The researcher also reflected on the characteristics or nature of the LGBTI content included in the nursing programme and the time spent teaching LGBTI content. Publications were also scrutinised to gauge whether the LGBTI content that was included was deemed suitable. For the researcher to ascertain the educational and philosophical premise from which LGBTI content had been dispensed, inspecting the epistemological underpinning of content was necessary. One of the last sub-themes to emerge was the perceived impact of including LGBTI content in nursing programmes.

Inclusion: Regarding LGBTI content inclusion in nursing programmes all studies positioned LGBTI content within the nursing programmes, at some point, as indicated in Table 4.4. The content was included across nursing programmes – from basic nursing qualification/degree; postgraduate specialisation; master and doctoral; and continuous development/short learning programmes. Seven of the nine studies related to LGBTI content in undergraduate nursing programmes, while the remaining two indicated LGBTI content in postgraduate nursing programmes. All nine focused on programmes/content disseminated to nurses in clinical practice. (Refer to *Table 10*).

Table 10 LGBTI Inclusivity

Nursing Programme and Status of LGBTI Content Inclusion			
A1	Undergraduate Partially Taught	A6	Undergraduate Partially Taught
A2	Undergraduate Widely Taught	A7	Undergraduate/Clinical Practice Partially Taught
A3	Undergraduate Partially Taught	A8	Across Nursing Programme Partially Taught
A4	Undergraduate/Postgraduate Partially Taught	A9	Postgraduate Partially Taught
A5	Undergraduate Partially Taught		

Surprisingly, it was found that although LGBTI content was indeed present and widely taught within the undergraduate nursing programme, it was identified as being inconsistent and inadequate (A2, A3, A5, A7, A8 and A9). A disagreement was noted; (A1) provided no evidence supporting or refuting claims that nursing programmes were failing to provide sexuality education specifically LGBTI content. Notwithstanding, the evidence presented by most publications suggested LGBTI content is taught, but poorly so. A study exploring the readiness of nurses to care for LGBTI persons was published in the U.S in 2015. It is consistent with the view of the majority of publications, which reported that 75% of nurse educators teaching in US baccalaureate nursing programmes did not include sufficient/adequate content on LGBT health topics or excluded LGBTI content altogether (Muckler *et al.*, 2018:45; Lim *et al.*, 2015:144).

It may be important to note the key findings of Lim *et al.* (2015:144), which were made before those of the reviewed publications (Date range: 2016-2022). Given the same geographical context, it would be possible to infer that the last six to seven years have seen little to no impetus to advance LGBTI inclusivity within nursing programmes.

A North American study, *Evidence for LGBTI Competency Training*, by Grove *et al.* (2021:169) elaborates on the lack of LGBTI content in postgraduate and post-basic qualifications within the health sciences, stating that LGBTI content appears to be unstandardised and inconsistent with 75% of postgraduate offerings containing no LGBTI content at all. The publications reviewed reveal congruent findings which indicated sparse LGBTI inclusion related as part of clinical content which was mostly covered in requisite courses. This LGBTI content was not contained elsewhere in the nursing programme (A8, A4 and A7). Findings suggest that sexual health content was not consistently included (A9). Correspondingly, the review findings indicate less than half of institutions/participants/nurse educators (identified as study sample/participants) in respective studies and reported including LGBTI education (gender-confirming care, gender reaffirming surgery, intersex, and gender expression and or transitioning). However, review findings indicated the clinical care management (of LGBTI persons) across gender and sexually diverse populations, as well as gender reaffirming practices and surgery, were never covered (A2, A4 and A8).

Characteristics of included LGBTI content found in the nursing programme: While engaging in the exercise of identification of LGBTI content within nursing programmes, it is important, not only consider the accepted philosophical assumptions and principles and notions but also what/how is being taught (Ross & Mitchell, 2018:1). This theme, thus, sheds light on the how LGBTI content is taught i.e., whether LGBTI content is embedded in the nursing programme or presented as stand-alone content.

Epistemological underpinning / didactic approach: The following section aimed to unpack characteristics of included LGBTI content. A closer deliberation of the epistemic underpinnings from whence LGBTI content is delivered was necessary. This refers to broadly accepted philosophical assumptions, principles and notions on the nature and confines of knowledge and how it is acquired (Ross & Mitchell, 2018:1). Heteronormativity, as a common epistemology, relates to sexual stigma and homonegativity, encompassing negative attitudes toward sexual minorities perceived as not conforming to traditional masculine and feminine roles (Mprah, 2016:18; Müller, 2013:2). Literature, speaking to the South African context, explains how the overriding teaching approach to sexuality remains biomedical and developmental (Müller, 2015:4; Müller, 2013:1). Furthermore, a heteronormative lens suggests that the concept of sexuality is currently taught as reproduction, risk or dysfunction. This leaves little space for discourse around the constructs of gender and sexuality. Clearly, recognition is needed to acknowledge that teaching LGBTI content as a determinant of health is merited (Müller, 2013:2; Reygan, 2021:114).

The publications reviewed shared a surprising parallel to the South African context. LGBTI content within nursing programmes lacked LGBTI inclusivity and representation within nursing programmes due to the prevailing heteronormative didactic approach. The overriding didactic approach to sexuality (LGBTI) content is within a biomedical and developmental frame (A1-A9).

A perplexing outcome. The review's findings submit evidence of sub-optimal LGBTI content inclusion within the nursing programme. This deficiency fails to guide students on sexual orientation and gender identity-affirming practices (A2, A4 and A8). There was an overwhelming consensus across publications to explore the concept of inclusivity holistically and define what that means, within our respective contexts.

Embedded content versus stand-alone content: This subtheme was identified through the iterative process undertaken during data transformation and thematic analysis. To draw distinction between these concepts, a distinction is made between embedded and stand-alone content is outlined:

Embedded content This is a highly contextualised approach which values teaching the lived experience provided through the practical/work integrated learning. Understood to be comprised of knowledge sharing, skills and attitudes embedded in nursing education programmes.

Stand-alone content Stand-alone content offerings are primarily dedicated to addressing the learning standards of a single subject area. Offers dedicated time to specific subject but may lack context.

It is of considerable interest to the researcher because this theme sheds light on how LGBTI content is taught and, perhaps to a lesser extent, why it is presented in this way. Stand-alone content, or content structured independently, in relation to additional content (theory and practical) is geared to address specific LGBTI health-related issues. This approach has proven beneficial to students; however, research suggests that LGBTI health-related issues should be systematically interwoven throughout the nursing programme to create opportunities for LGBTI educational inclusiveness (Carabez *et al.*, 2015; McEwing *et al.*, 2020:2).

Included publications revealed the following LGBTI health-related content was present and embedded throughout the nursing programme: disparities faced by sexual and gender minorities, inter-partner violence and mental health issues. This content was present and embedded in modules and subjects such as Medical and Surgical Nursing in General Nursing Science, throughout the nursing programme (A1, A2, A7, A8 and A9). Though the presence of LGBTI content can be confirmed, the positioning and location of LGBTI content within nursing programmes means that in-depth understanding of the abovementioned concerns are left without any comprehensive investigations and discussion in relation to LGBTI healthcare disparities, inter-partner violence and mental health issues.

Relevance and aptness of LGBTI content: The former publications further reiterated the importance of ensuring that embedded content sufficiently covers issues such as intersectionality, healthcare disparities associated with sexual and gender minorities, racial/ethnic minorities, persons who experienced sexual trauma, disabilities, and comorbidities. Review findings indicated that clinical care management (of LGBTI persons) across gender and sexually diverse populations, but specifically related to clinical care management (intra-operative clinical care and management) in the cases of transgender, were never covered (A2, A4 and A8). The former content was found to be completely lacking within nursing programmes. The effects of prejudice, discrimination and victimisation were seemingly covered. There are clear links in reviewed literature which highlighted the connection between these experiences and the occurrence of profound, long-lasting effects on an individual’s well-being, leading to minority stress (A1, A2, A7, A8 and A9).

Literature suggests that for nursing schools and other institutions of higher learning to ensure relevance and aptness of LGBTI content, suitable content should incorporate three critical areas for nurses to focus on: attitudes, knowledge, and skills. (Refer to *Table 11*).

Table 11 LGBTI content inclusion - ensuring relevance and aptness

AREAS	OBJECTIVE	DOMAIN
ATTITUDES	Be aware of own beliefs and attitudes about LGBTI persons. Become aware of pre-existing biases and fostering a positive position on multiculturalism.	Affective
KNOWLEDGE	Should reflect awareness of the needs and struggles of LGBTI individuals, as well as social determinants of health in LGBTI populations.	Cognitive
SKILLS	Use scientifically sound methods in caring for LGBTI populations. The clinician should reflect on their own perceived ability (self-efficacy) to incorporate these techniques in practice.	Psychomotor

Adapted from Dutton *et al.* (2021); McEwing *et al.* (2020)

Time: The subtheme, *Time*, was anticipated. However, the review findings included *Time Spent* (or notional hours) on *Presenting on LGBTI Content* and *Factors that Influence Time Spent on LGBTI Content*. This sub-theme overlaps with the sub-theme *Time* in *Challenges/Barriers*. This was one of the early recurring themes. Research findings by the *Johns Hopkins School of Nursing (JHSON) LGBTQI+ Health Initiative* (LHI) was established to develop a strategic response to the gaps in LGBTI health content in nursing programmes. The findings purport that U.S baccalaureate nursing programmes cover, on average, two, point twelve hours (2.12 h) of LGBTI content for an entire programme (Dutton *et al.*, 2021:5; Sherman *et al.*, 2022:2). This is a significant nursing education deficit. The review findings (A2, A3, A4, A5, A6, A7 and A9) echoed those found in literature, citing *Time Spent* at a mean of two hours (2h).

Conversely, (A2 and A8) which describes the amount of time spent on LGBTI content, revealed that in some cases a mere half hour was dedicated to both LGBTI health and sexual health issues. In addition to this, is the submission that nursing educators have recognised that they refuse to advocate for the inclusion of LGBTI content. Educators cited a lack of comfort and knowledge in the subject area as the reason for not advocating for LGBT content inclusion in lectures.

4.3.2 Context Specificity

A summary of the contextual characteristics was needed to elaborate on two important aspects, unpacked as follows: **Where** the study took place (geographic location and location within the nursing programme, also alluded to in the *Theme, Inclusion*); and **who** comprised the study sample. The researcher believes answering these two questions, contextualised the reviewed articles and illuminated possible impact on generalisability of the review. Publications identified for inclusion for review were dated between 2016 and 2022.

Geography: All publications emanated from the Global North, signalling contextual differences, as described in section 2.3. The review suggests that LGBTI content in nursing programmes from the Global North, share the same scope as the studies included for review. The studies displayed valuable insights into creating safe and effective teaching and learning strategies, capacitating students and staff with the necessary cultural competency, recommendations on curriculum development. All studies referred to barriers to LGBTI inclusion and benefits of LGBTI inclusion. With reference to LGBTI content inclusion in nursing programmes, all studies referred to LGBTI inclusivity in nursing programmes. The nine (n=9) studies included, focused on nurses in clinical practice. These were registered nurses currently occupying posts within clinical facilities, such as hospitals, clinics, and healthcare adjacent facilities. Three (n=3) of the nine studies included the perspectives of student nurses, at various levels of training, enrolled for a four-year professional qualification. Two (n=2) of the nine studies made specific reference to perspectives of nurse educators and the nursing education institutions.

Moving beyond generalisability: The researcher agrees with Burchett *et al.* (2020) who argue that generalisability statements in article discussion sections assist in judging whether an intervention really could be implemented in other settings or populations, with similar effects. These statements are typically based on observable similarities (or more likely, differences) in generic population and setting characteristics (Burchett *et al.*, 2020:2). Beyond the USA, where most of the studies had been conducted, however, paucity of evidence on LGBTI inclusivity in nursing programmes emanating from developing nations limits the extent to which respective studies could be generalised. As alluded to in Chapter One (refer to section 1.8), because of the descriptive nature of the MMSR, the criteria to ensure trustworthiness was employed. Since the researcher was tasked with representing multiple realities. With this review, the researcher screened for similarity and richness of reports and recounts to give credence to the lived experiences of participants, the authors interpretations etc., to allow a conclusion beyond that of 'generalisability' (Burchett, 2020:2; Polit & Beck, 2010:500).

4.3.3 The advancement of Social Justice

All the studies included in the review made specific reference to preparing nurses to offer guidance and support. The role of the nurse was a recurring theme. All the studies included in the review made specific reference to preparing nurses to offer guidance and support in respect of sexual functioning. The role of the nurse, in the context of this review, goes beyond the role of advocating on behalf of the patient to the advancement of social justice (Donisi *et al.*, 2019:979).

The social location of the nurse: We cannot ponder on the social location of the nurse without referring to the concept of intersectionality. (Refer to *section 2.5.*) Intersectionality refers to the intersecting/interacting categories of one's identity, such as gender, race, sexual orientation, ability, and socio-economic status, in interrelated ways (Patterson *et al.*, 2020:4; SANAC, 2017:viii). An individual's social location connotes changing social circumstances and positions held within the social systems based on experiences of privilege and exclusion (Daynes, 2005:8). Review findings suggest that because nurses are the first port of care for many patients/clients, they should not take their unique position within society lightly (A7, A8 and A9). However, it is important to acknowledge the social location of those who practice as nurses and avoid linking that aspect to their role of the profession in their daily lives. An example would be:

“a 45 year old mixed race female is a mother and also cares for her ill father. She does so only when she rotates from day shift to night shift.”

The example encourages the realistic view that before the person identifies as a nurse, (s)he is a mixed-race female who is also a mother. This in no way, precludes the nurse from stepping into the role which affords them the ability, authority, and discernment to contribute positively to the lives of the people entrusted in their care. Review findings indicate congruence on consideration of the role of the nurse, that nurses could make a profound contribution to the promotion of health equity and social justice. It is not unexpected, then, that the role of the nurse, according to (A1, A2 and A4,) should include educating clients about sexuality and should be able to provide inclusive, and culturally congruent care. Nurses should critically reflect on their position held within the social systems. Reflection on experiences of privilege or exclusion allow these experiences to inform ways in which the nurse could advance social justice by drawing on their own experiences. Adequately prepared professional nurses would be able to appreciate and understand the social location of *LGBTI* patients lived realities. This appreciation enables nurses to provide inclusive, comprehensive, person-centred care, while being solution focused (A5, A6, A7, and A9).

Attitudes and perceptions of nurses – Caring for LGBTI persons: Literature, within the South African context indicates that care and management of LGBTI individuals, their partners, and families within the context of healthcare varies vastly across social and political landscapes. It is, however, expected that healthcare professionals provide quality care that is inclusive and non-discriminatory (Donisi *et al.*, 2019:979). Regrettably, a large portion (around 65%) of international and national nurses have demonstrated deep prejudice against LGBTI individuals (Fauer *et al.*, 2020:599, Wang *et al.*, 2020:606). Review findings suggested similar reports. As respective publications reported on prejudice against LGBTI persons, almost all (A1, A3, A5, A7, A8 and A9) named nurses as negative contributors, adversely impacting health-seeking behaviour, in some cases, openly voicing negative attitudes including prejudice and biases about LGBTI persons. This finding correlates strongly with findings in background literature unpacked in Chapter 2. Stigma, discrimination, and victimisation continue to negatively impact the lives of LGBTI persons by influencing the health-seeking behaviours (Juan *et al.*, 2021:80; Müller, 2013:2; Reygan, 2021:114). The prevailing heteronormative practices and policies appear to contribute to alienation from healthcare services.

The research outcomes of the respective publications included for review indicate that a person's outlook, beliefs, and perceptions are not static and are amenable to change. Studies structured with pre- and post-interventions showed marked improvement in the post-tests scores after almost half of the participants were taught to obtain information about gender identity. Participants expressed *feeling more competent* in conducting *person-centred health assessments* after being exposed to an array of LGBTI+ interventions and empowered regarding social justice issues. In study A9, students who enrolled in the LGBTI course displayed *improved preparedness, comfort, and confidence* in applying (LGBTI) course content practically.

The nurse, nursing education: the South African context: In South Africa, the nurse is expected to hold an array of skills and competencies needed to provide holistic patient care to a range of diverse individuals (Henriquez *et al.*, 2019:508; Sommers *et al.*, 2020:126). Similar sentiments were echoed in the review findings, the bold realisation of social justice through LGBTI inclusion *should be championed by the registered nurse*. Nurse educators were encouraged to influence curricular change and identify innovative ways to include this content in their respective nursing programmes (A1, A3, A6, A7 and A9). The nurse must play an active role in filling the gaps, identifying what information on LGBTI content is applicable and relevant. These exclusionary practices are rooted in pervasive patriarchal norms and conventions of heteronormativity (Sutherland *et al.*, 2016:3-39; Zeeman *et al.*, 2019:974). In cases where institutions and staff were inadequately capacitated to facilitate change, nurses are unwilling to engage with the topic (A5, A7 and A9). The researcher agrees that nurse educators should ensure that LGBTI content is relevant, guided and informed by best practice, and covers a host of LGBTI-related topics as A3, A9 and A6 recommend. The nurse educator should employ several methods of content delivery to create important opportunities for acquiring and applying knowledge.

4.3.4 Challenges and Barriers to LGBTI Inclusion

One of the most obvious yet necessary benefits of LGBTI inclusivity in nursing programmes is appreciating *“an awareness of one’s possible biases, knowledge deficits and the willingness to be educated, are vital first steps in developing empathy and cultural competence”* (Lim *et al.*, 2015:3). This theme is underpinned the views of pockets of individuals, institutions, and society, and highlights resisters to change typified by stereotypical opinions and dated gendered values. This theme unpacked the will and capacity of persons and organisations; lack of knowledge, clinical exposure, cultural, religious, and traditional views which challenge and present barriers to LGBTI inclusion. This theme supports the review findings related to the challenges and barriers to LGBTI inclusion with the following questions: “What type of barriers exist to LGBTI inclusion in nursing programmes?” and “How we could possibly negate these barriers?”

The will and capacity – persons and organisations: Unfortunately, as mentioned, there remains resistance to actions which seek to embrace diversity. Some of the challenges or barriers to the inclusion of LGBTI content most cited include: inadequate knowledge of LGBTI health issues, limited guidance on the inclusion of LGBTI content, and open opposition to LGBTI content (Lim *et al.*, 2015:5).

Lack of knowledge and clinical exposure: The review findings unpacked some barriers to LGBTI inclusion. A lack of content in theory and practice may have led to a false sense of cultural competence by nursing students and could be attributed to limited exposure to LGBT population in training and clinical placements demonstrates (A6 and A4). The lack of knowledge and clinical exposure, contributed negatively on students' and nurses' comfort to speak on LGBTI health related issues (A2, A4, A5 and A6). Furthermore, the review findings suggested that negative attitudes in clinical placement contributed to a lack of knowledge for student and staff (A6 and A4). This submission draws attention to the prevailing heteronormative andragogic and pedagogic approaches within nursing programmes which appears to be fixed to exclude those who identify as LGBTI (Donisi *et al.*, 2019:979; Müller, 2013:2; Müller, 2015:2).

Cultural, religion and traditions: Within the South African context, literature raises four main challenges to LGBTI inclusivity, (1) diversity in culture, (2) religious beliefs, (3) ethnic backgrounds, and (4) a mainstream educational approach that excludes LGBTI individuals from its discourse (Mprah, 2016:18; Müller, 2013:2). It is not surprising that exclusive attitudes and associated skewed views of sexuality and gender identity were linked to religious beliefs, resulting in substandard, or a refusal to, care (A2, A3, A4, A7 and A8).

When all social determinants of health impact the lives of LGBTI persons, this contributes *minority stress* – this adequately sums up intersectionality. The review findings suggest that objections and disapproval, centred on cultural, religious, and traditional beliefs are self-limiting. This approach may contribute to a lack of knowledge about the social location and lived realities of individuals who are sexually or gender non-conforming.

In South Africa, persons who identify as highly religious, strongly agreed that homosexuality is “wrong” and “disgusting” are more likely to uphold principles and values taught in the Bible. (Moagi *et al.*, 2020:10; Mprah, 2016:18). Currently, cultural, religious, and traditional beliefs on LGBTI persons remains a challenge. Persons with strong religious or cultural beliefs often advocate heterosexuality and believe those who do not conform, live in sin. Nurses working in healthcare settings could also hold such conservative views on LGBTI persons. Subsequently, such nurses may be more likely to disregard aspects of the healthcare needs of LGBTI persons.

Time: The majority of publications included suggested *time*, or the notional hours allocated, as a challenge to implementing LGBTI content in the nursing programme. The issue of time is different from the subtheme identified in the first theme because, within this context, it referred to the burden of adding information to a currently overtaxed curriculum/programme. The review findings described the number of notional hours spent on LGBTI content, it was cited a mean of over half hour dedicated to both LGBT and sexual health issues.

4.3.5 Curricular revision

Education has often been pushed as the great equaliser, as the road out of poverty (Pearson & Reddy, 2021:6). However, failing to adjust curricular offerings may cause gaps in knowledge. This theme looked at **what** type of teaching and learning activities best advance LGBTI inclusivity in nursing programmes. This emerging theme looked at restructuring didactic and pedagogic approaches within the nursing programme. The following strategies were included: developing Safe Spaces for Teaching and Learning, Developing Cultural Competencies, the utilisation of Sensitisation Programmes and Curricular Revisions.

Safe spaces for teaching and learning: In nursing, there exists a close relationship between theory and practice. Inextricably linked, as one informs the other, we draw on our wealth of knowledge, when needed. A student who has undertaken nursing training is required to undergo theoretical and practical training, with the didactic and pedagogic approaches within nursing programmes functioning within a heteronormative frame (Donisi *et al.*, 2019:979; Müller, 2013:2; Müller, 2015:2). Inclusive, safer spaces which are more transparent encourage discourse around LGBTI healthcare needs. Safer spaces for nursing students and educators, alike, are indispensable in the quest to develop culturally sensitive and empathetic nurses (A1, A2, A4, A7 and A8). Safer spaces and platforms for open discussion may negate the deficits in foundational knowledge.

Cultural competencies: Cultural competency is considered a sensitive appreciation of challenges faced and disparities associated with sexual orientation and gender identity minorities (A1, A2, A3, A5, A8, and Mertens, 2021:2). To advance diversity and recognition for LGBTI persons and *cultivate culturally sensitive* nurses, we need to challenge exclusionary practices (Mertens, 2021:2; White *et al.*, 2020:2). This subtheme focused on **how** nursing schools could nurture/foster culturally competent and culturally sensitive nurses. Review findings suggest that, for nursing schools to meet the unique health needs of diverse populations (such as LGBTI), an essential first step is to address *the self* as a foundational exercise to cultivate culturally sensitive and empathetic nurses (A1, A2, A3, A5 and A8).

Across all studies included for review, reference was made to *five dimensions* that support and foster culturally competent and culturally sensitive nurses, these were: *the role of self-awareness, areas of support, understanding sexuality, sexual concerns, and health inequalities*. It is, perhaps, not far-fetched to consider the power of critical self-reflection – that critical and open self-reflection (on these five dimensions) may facilitate a transformative learning moment which aids in reframing personal beliefs, prejudices, and assumptions (A1 – A7).

The content covered the following: *life history of discrimination, areas of support* (family, friends, and community), the *acceptable use of pronouns, insecurity and fear* and *structural inequalities/discrimination*. Literature on cultural competencies supports the review findings. Donna M. Mertens summarises the process of cultural sensitivity and competence:

“It is true commitment to addressing intersectionality of relevant dimensions of diversity, such as gender, disability, poverty status and language, with the incorporation of cultural competence, equity-focused and indigenous approaches we are assured that we wilfully seek to dismantle stigma and discrimination, in order to increase social equity”.

The summary underscores how true empathetic understanding could be unearthed through the *process* of critical self-awareness and reflection (Mertens, 2021:3). The congruence met here speaks to the importance of understanding one’s own biases for students and professionals alike and work towards a reframing and transforming it anew. This, in turn, creates inclusive, safer spaces that are more transparent and nursing students and educators alike appreciate the importance of culturally sensitive and empathetic nurses (A7, A8).

Transformative teaching and learning practices: One of the emerging themes communicated by an article included for review, reports on undergraduate students enrolled in the study and verbalised an *increased sense of awareness* post discourse. The critical discourse on LGBTI health needs and disparities related to healthcare, should be underscored by the lived experiences and experiences of health inequalities faced by LGBT persons (A3). Half of the participating students mentioned that they *reconsidered their approaches to LGBTI patients*. Students reported being more sensitive about how they communicated with LGBTI persons. *Students expressed a willingness to use gender-sensitive language* when dealing with LGBTI individuals after the session. In the same way, A5 cited that through simulation, a safe learning environment was created which assisted students in *assessing their own biases* and encouraged them to reflect on communication through a process of *critical self-awareness*. There is need for competence (attitude, knowledge, and skills) development which should address cognitive, affective, and psychomotor learning. A critical awareness of personal bias, prejudice and intersectionality are needed. In creating safe spaces for critical dialogue, we could encourage and facilitated transformative learning. These approaches would allow students to be well vested in this foundational learning, throughout the curriculum and should not only be "exposed" to it when it comes to the topic of LGBTI.

Teaching strategies: In recognition of the importance of LGBTI inclusivity in the nursing programme, this theme covered **what** teaching strategies were used to facilitate LGBTI content inclusion? **How** effective were these options? All studies reviewed utilised, and outlined, a range of teaching and learning strategies to appropriately facilitate LGBTI content into the nursing programme. The strategies outlined, included useful tools to identify personal strengths, weaknesses.

Teaching and learning strategies that were beneficial included:

Advocacy awareness sessions | didactic lecture | role play | Difficult Dialogues | critical self-reflection on stereotypes and biases | expert panel discussions | simulations (low and intermediate fidelity) | didactic guest lectures/content experts | in-depth case studies | small group discussions online | reflection work | clinical placement

All publications reiterated the importance of developing or augmenting current didactic approaches to facilitate knowledge transfer of LGBTI content, in relation to teaching and learning strategies mentioned (A1-A9). A good example of using what is already at your disposal are the examples found in (A5 and A6). A well-designed, ***standardised patient simulation*** was developed and integrated into the nursing programme. The use of simulation aimed to prepare students to engage sensitively and respectfully with LGBTI persons and to assist nursing students in identifying challenges and barriers to effective nursing care within an LGBTI framework. This teaching and learning strategy permitted questioning of the complexities and health care needs experienced during gender reaffirming surgery and issues related to transitioning (A6 and A5).

Sensitisation programmes: Teaching and learning strategies were also strongly recommended according to review findings. There are numerous international organisations and non-governmental organisations (NGO) who are highly specialised and assist in monitoring LGBTI social justice issues. Sensitisation programmes and content to assist introduction to, and inclusivity of, LGBTI content run by reputable NGO's and advocacy platforms are presented in Table 12.

Table 12 Sources of LGBTI sensitisation programmes and content

	NGO's	Gov. Organelles	Multinational
South Africa	South African National Aids Council (SANAC)	Dept. Social Development; Dept. Health and Wellness	Office of the High Commissioner, United Nations Human Rights Commission (OHCHR)
	Networking HIV, AIDS Community of South Africa (NACOSA)		
	OUT LGBT Wellbeing		ARCUS Foundation: Social Justice Project
United States	GLSEN	State Dept. Education,	Human Rights Watch
	GLAAD	U.S. President's	
	Human Rights Campaign	Emergency Plan for	Astraea Foundation
	National Black Justice Coalition,	AIDS Relief (PEPFAR)	
	National LGBTQ Task Force,		

Table 12 depicts the numerous NGO's, both nationally and internationally dedicated to realising the inclusion of LGBTI health related content within and outside academic spaces. This study and background literature offered concrete contributions to tailored teaching interventions, such as the utilisation of open online courses (MOOCs), which have been developed as a new form of education, devoted to various topics. Topics ranged from the importance of interventions to challenge and eliminate maltreatment, ranging from commonplace disrespect to total violence, abuse (as the denial of human dignity) (A1, A3 and Longhini *et al.*, 2021:104812).

Significant global advances in promotion of LGBTI rights have seen new Open Access content and programmes (subjects) in sexual development: *gay men; men who have sex with men, or MSMs; lesbians; women who have sex with women (WSW)s; transsexuals, and other non-normative identities* (Lind, 2010:3). The use of web-based sensitisation programmes and other online resources are recommended (A1, A7 and A3). Formulated as a set of *guidelines for applicable sexuality education* in American nursing programmes, they are easily and readily accessible. This tool may assist nursing schools, nurse educators and facilitators in making LGBTI content more thorough, consistent, and appropriate (A1; A2; A7 and A8).

Curricular revision: Revision or curricular overhaul exercises were deemed helpful in the identification of LGBTI content deficits (A1, A2, A5, and A9). The current range of LGBT health issues covered, and the amount of time spent on instruction must be known to identify gaps in the curricula (Lim *et al.*, 2014:26). In a best practice review talking to healthcare disparities in the LGBTI population, the study boldly states that nursing programmes need to be assessed in alignment with evidence-based practice. This statement is one which carries weight. It also speaks to the slow pace at which inclusivity, in a broad sense, is being integrated into nursing practice (Carabez *et al.*, 2015).

Within the US context, curricular revision was conducted using the established *Students, Staff, and Faculty for Equality (SAFE)* teaching toolkit. In this study the Centres for Disease Control and Prevention (CDC): Lesbian, Gay, Bisexual, and Transgender Health, (2018), *Evidence-based Standards of Care for LGBTI population*, provided clear guidance creating safe spaces for engagement using a *participatory redesign* of the nursing curriculum assisted in the realignment of the programme. The goal was to effect long lasting change. This exercise, according to the author, created more inclusive content recommendations and safe spaces.

There is an agreement between the review findings and literature. Triangulation of data on the benefits of this process revealed three main advantages, cited as (1) identifying gaps and barriers to the inclusion of LGBTI content in the nursing programme, (2) providing a means of ascertaining the amount of time and focus of LGBTI content currently taught and (3) assisted in identifying appropriate content be integrated into the nursing programme (A1, A2, A5, and A9) (Keepnews *et al.*, 2021:168; Lim *et al.*, 2014:26). Review findings indicated concerns that nursing curricula were lacking content that addresses LGBTI healthcare needs. Inclusivity should be viewed as a requisite for effective education and health service delivery. In addition, the nursing programme could be supplemented and diversified through periodical review, incorporating current Best Practice Guidelines on LGBTI health-related topics needed to inform the education and training of undergraduate students and health professionals (A7).

Review findings support this approach and call on nursing education institutions' management and nurse educators to reflect on the current state of LGBTI inclusivity and consider whether LGBTI topics are only taught about disease and abnormality, neglecting patient-centred health promotion and individualised care following diagnosis.

4.4 CHAPTER SUMMARY

In observing the steps of the MMSR, the researcher draws attention to the importance of laying sound foundations. This speaks to the acknowledgement of the significance of each step of the MMSR to position and contextualise the study with available literature, creating the background and supporting rationale for the study. Answers were sought in literature through the MMSR process to answer the review question:

What evidence exists in the literature on LGBTI content in nursing programmes?

The comprehensive search for literature, the use of multiple electronic databases, and the selection and screening of publications contribute to credible and rigorous research. *Appraising quality* of the selected studies allowed for the *extraction of data* from numerous sources across paradigms and methodologies. Quantitative data were *transformed* or "*qualitised*" into narrative descriptions in preparation for *thematic analysis*. The data were *integrated*, pooled, and categorised based on similarity in implication/meaning and were later combined to produce comprehensive findings.

The researcher sought to answer the review question through discussion of the main themes identified, namely: *LGBTI content in nursing programmes; context specificity; the role of the nurse in the advancement of social justice; challenges and barriers to LGBTI inclusion and curricular revision*. The research findings reveal congruence and substantiate claims submitted by the larger body of work around the subject area. The researcher recognises the conclusion of this MMSR as a catalyst to spur critical thinking around the concept of inclusivity. The researcher was resolved to contribute meaningfully to the available body of knowledge through advancement in social justice issues for all people who identify as LGBTI, ensuring representation and advocating inclusivity.

CHAPTER 5

CONCLUSION

5.1 CHAPTER OVERVIEW

Current research and literature allude to inadequate LGBTI content in nursing programmes and how this causes deficits in training and development of professional nurses. Nurses and their role in the provision of care of LGBTI persons and other marginalised groups are critically important. The researcher embarked on an exploration of the research phenomenon, in this chapter, offers answers to the review question and argues achievement of the purpose of the study - to synthesise existing evidence in the literature on LGBTI content in nursing programmes. The researcher views the conclusion of this MMSR as a catalyst to critical thinking around the concept of LGBTI inclusivity. The researcher recognises the conclusion of this MMSR as a catalyst, to spur on critical thinking around the concept of inclusivity.

This chapter focused on parts of *Step 5: Discussion and Conclusion* and *Step 6: Dissemination of Findings* (Refer to *Figure 11*). The summary of the review process (factual conclusions) is presented before coming to contextual, conceptual, and inferential conclusions on the MMSR. Implications for theory and practice are offered, together with recommendations for prospective research. A concise summary of the review findings is presented. In seeking to answer the review question, the researcher can thus enable to draw and present important conclusions stemming from the MMSR. In this concluding chapter, the researcher therefore offers answers to the review question. The strengths and limitations of the study are identified, and the chapter concludes with a reflection on the researcher's learning and an appreciation of the value of the research.

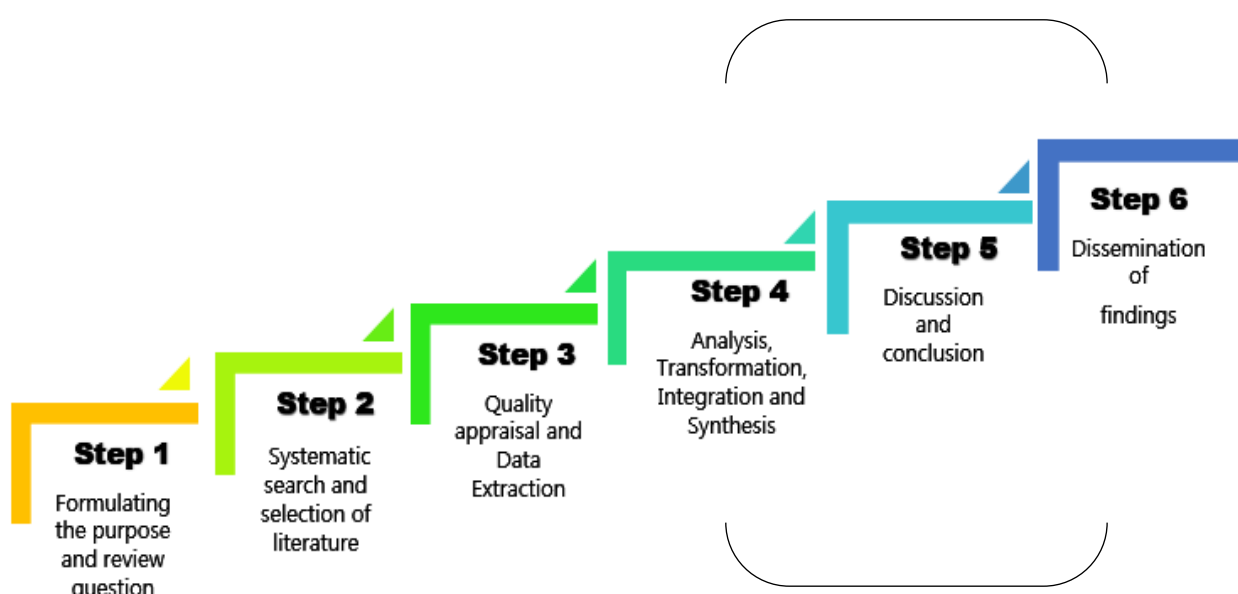


Figure 11 Chapter Five - Location within the MMSR process

5.2 SUMMARY OF THE MMSR PROCESS

The researcher maintains that inquiry into LGBTI content in nursing programmes is an important consideration to be unpacked. For us all to realise a truly inclusive, accepting, and representative society, the researcher recognises the magnitude of work yet to be done towards social justice. Obtaining a comprehensive understanding of the topic required a broad focus which supported the development of a refined review question, MMSR process and dissemination of findings based on the available evidence (Dhoulande *et al.*, 2021:428; Polit & Beck, 2020:666; Toronto & Remington, 2020:2). The MMSR provided the researcher with an opportunity to develop a contextual and comprehensive understanding of appraised evidence. Acknowledging that realities are wholly subjective and shaped by our perceptions and position within this world, through critical self-reflection and upholding the virtues, (noted in section 3.7), the researcher came to realise review purpose and subsequently, answered the review question.

This study was guided by the six steps of an MMSR according to the *JBI Manual of Evidence Synthesis* by Lizarondo *et al.* (2021) as well as Toronto and Remington (2020:6), who referred to Cooper (1982) as a seminal source. Of these sources Toronto and Remington (2020:6) offered the most comprehensive explanation that assisted and guided the researcher along the MMSR process.

Step one involved the formulation of the purpose and review question. Identification of gaps in knowledge allowed the researcher to optimise the MMSR. The researcher utilised an approach which best reflected the epistemological assumptions of the pragmatic paradigm (Creswell & Creswell, 2018:48). The MMSR could be structured in explicit ways that contribute to contextualising the need for further inquiry. The research problem provided sufficient justification for the MMSR (Lizarondo *et al.*, 2021: 85; Mertens, 2021:2; Toronto & Remington, 2020:15-17).

Step two encompassed the systematic search and selection of literature. With the use of the SPIDER mnemonic to conduct the search, the MMSR question was left specific yet broad to enable a well-defined scope of literature. (Refer to section 3.5.2.) With the help of a data specialist, the researcher, selected an effective combination of databases to find eligible primary and secondary data sources. The review purpose and question along with exclusion/inclusion criteria, guided a three-step systematic search. The search for literature was purposefully left broad, using more than one strategy.

In **step three**, the researcher engaged in quality appraisal of selected data sources. The quality of the included studies was assessed using the *MMAT* developed by Pluye *et al.* (2009) and the *JBI critical appraisal checklist for systematic reviews and research synthesis*. These appraisal tools were deemed most appropriate to evaluate publications within the respective methodological domains.

The list of full-text articles was refined as the literature suggests (Pollock & Berge, 2018:147, Xiao & Watson, 2020:106). Data were extracted and prepared for thematic analysis in step 4.

In the **fourth step** the researcher engaged in transformation, analysis, integration, and synthesis of data. Data was transformed through '*qualitising*' quantitative data from quantitative and mixed method publications. Once transformed, data could be analysed thematically. A three-step approach to thematic analysis was taken by coding and categorising the data towards the development of analytical themes. This process supported the concise organisation of data in a data table (Polit & Beck, 2021:671; Xiao & Watson, 2020:107).

The process culminated in **the fifth step**, reaching conclusions. In the final step, **step six**, dissemination of findings occurs through submission of the dissertation and sharing of research findings on relevant academic platforms.

5.3 FACTUAL CONCLUSIONS

The facts uncovered and discussed in Chapter 4 culminated in the factual conclusions of this study, namely LGBTI content in nursing programmes; context-specificity; the advancement of social justice; challenges and barriers to LGBTI inclusion; curricular revision. Arrival at factual conclusions are portrayed in Figure 12.

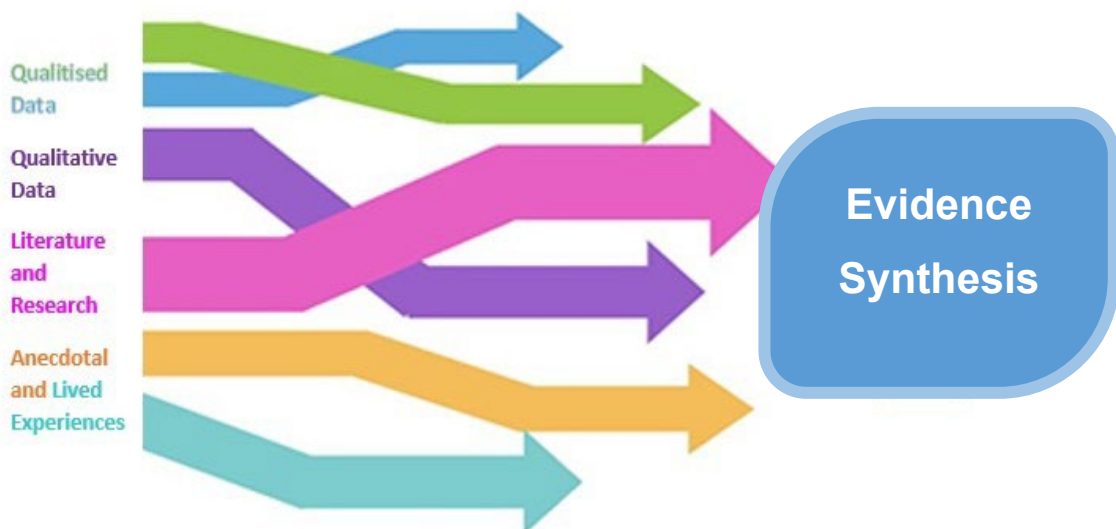


Figure 12 Factual Conclusions - Interweaving of Data

Interweaving of data extracted from various sources illustrates the manner in which the researcher sought knowledge creation through the MMSR. Moreover, it illustrates how the researcher remained aligned within the paradigmatic perspective. Upholding the notion of a non-singular reality and recognising intersubjectivity, the researcher was able to generate knowledge, representing multiple realities portrayed in the variety of data sources. (Refer to

section 3.2.) The synthesis of evidence suggests that LGBTI content was included and present within nursing programmes but comprehensive, adequate, and relevant LGBTI health content inclusion may be lacking. All nursing students and educators should be well vested in LGBTI learning throughout the curriculum and should not only be "exposed" to it when it comes to the topic of sexual health. Thus, there is need for competence (attitude, knowledge, and skills) development which should address cognitive, affective, and psychomotor learning. Critical self-awareness (including critical awareness of personal bias, prejudice, and intersectionality) and transformative learning are facilitated through critical dialogue.

5.3.1 LGBTI Content in Nursing Programmes

The review findings suggest that LGBTI content was found to partially include within both undergraduate and postgraduate nursing programmes. However, the content was found to be inconsistent, incomplete, and presented within short timeframes. Heteronormativity and homonegativity mostly informed the didactic approach, providing little room for open discussion and questioning around LGBTI health related issues. Inclusions of LGBTI content must cover effects of prejudice, discrimination and victimisation and its profound, long-lasting effects. Embedding LGBTI content which includes three critical areas attitudes, knowledge, and skills, throughout the nursing programme.

5.3.2 Context-specificity

Generalisability across sources may be less likely. All the publications originated from studies conducted in the Global North. The paucity of insights from the Global South restricts applicability and contextualising of the results within an African and more importantly the South African context. (Refer to sections 1.8 and 2.3.2.) The researcher endeavoured to position the study in honouring truth value of the data and the interpretations thereof. The emphasis was on the richness of the findings rather than generalisability.

5.3.3 The advancement of Social Justice

The registered nurse is widely accepted as a key role player in advancing social justice for LGBTI persons in healthcare settings. Through understanding and appreciation of the lived realities and challenges faced by LGBTI patients, nurses can deliver more comprehensive, person-centred care. Evidence suggests that positive outcomes, such as better interpersonal relationships, therapeutic communication, feeling more competent, improved comfort and confidence in relation to personally held biases and knowledge deficits, and exposure to an LGBTI course may expedite the need for nurses to uphold diversity and remain open-minded during patient encounters, resulting in effective nursing practice.

5.3.4 Challenges and Barriers to LGBTI Inclusion

Stereotypical and prejudicial views, and gendered values upheld by religious objection and prevailing heteronormative practices lead to a lack of knowledge around the lived realities of LGBTI individuals. These dynamics impact the will and capacity to overcome challenges related to including LGBTI content. Barriers, such as time (notional hours) and the already congested curriculum can only be addressed through the will for change. Overcoming barriers, such as the lack of clinical exposure to the LGBT population in training and the lack of content in theory, the amount of time spent on LGBTI content, and negative attitudes, need to be addressed.

5.3.5 Curricular Revision

Within the public and private healthcare sectors, the nurse may be the clients' "first point of call". This said, comprehensive and inclusive foundational education is important in rendering culturally congruent care. Nursing educators are well positioned to scrutinise nursing programmes for inclusivity critically.

Tools and guidelines needed to assist nursing education institutions during inclusive **curricular revision** should be easily accessible. LGBTI courses covering sexual health and health disparities have positively improved perceived preparedness, comfort, and confidence in delivering comprehensive and culturally sensitive care. To ensure institutional relevance and that nursing graduates are optimally prepared, nursing schools/nursing education institutions ought to periodically evaluate and update their content during curricular review curricular.

The **teaching and learning strategies** implemented were most effective when several didactic approaches were combined. Safe teaching and learning spaces may prove beneficial in cultivating culturally competent and sensitive nurses, allowing for the unfolding of a frank critical self-awareness process, debate, and appropriate knowledge transfer of LGBTI content. Simulation, as a teaching and learning modality, may assist in addressing a range of complexities and barriers to LGBTI healthcare provision within the nursing programme. It exposes nursing students and nurse educators to realities and challenges associated with sexual and gender minorities.

5.4 CONCEPTUAL CONCLUSIONS

The factual conclusions drawn from this review of literature, take the form of synthesised knowledge through the unique processes associated with the MMSR.

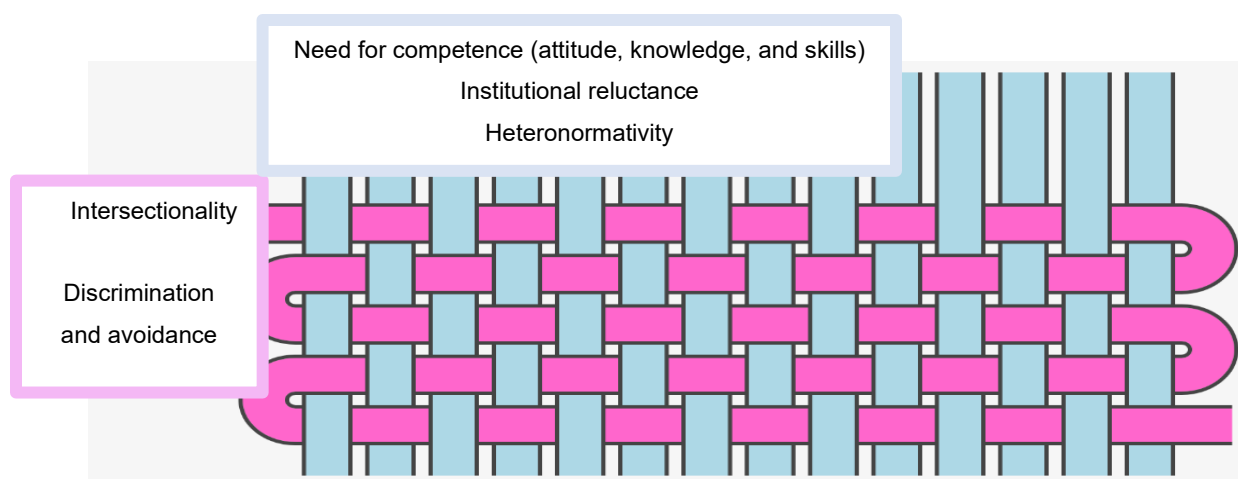


Figure 13 Interweaving - Conceptual Conclusions

The conceptual conclusions represent the interpretations or interweaving of the knowledge synthesis, following data integration and synthesis. The following insights are submitted.

This interweaving (refer to Figure 5.3) assisted in the portrayal of complexities in relation to inclusion of LGBTI content in nursing programmes. Evidence and the review findings suggest that it is not as simple as integrating LGBTI content in curricula, moreover, there is need for competence (attitude, knowledge, and skills) development which should address cognitive, affective, and psychomotor learning. The *paucity of appropriate and sufficient LGBTI content in nursing programmes* suggests nursing education institutions should consider *curriculum revision development* to structure context specific content. Cognisance of prevailing norms, beliefs and societal standards must be upheld to dispense much needed LGBTI clinical skills and knowledge by use of *effective teaching and learning strategies*.

Void of support, multiple repressions entrench and precipitate one another creating new areas and dimensions of human suffering. The concept of **intersectionality**, thus, presents in negative cognitive (the way we think), affective (how one feels) and may dictate and perpetuate poor coping mechanism, as psychomotor responses to stigma and discrimination.

The review findings outline discussion around the effects discrimination, violence, and exclusions. *The individual* is faced with a clear demarcation and repercussion if the individual fails to comply. In the case of the LGBTI persons, avoiding, ignoring, or dismissing acts of violence, discrimination and victimisation are usually unconsciously incorporated as mechanisms to cope with relentless barrages of disgust and disapproval. The review findings, however, compel the researcher to engage in further discussions around the compounding nature of divisive forces which populate the lives of many LGBTI person. Moreover, the researcher, based on the findings of this MMSR, would offer possible means of negating challenges. Literature indicates that exclusionary, discriminatory attitudes are fostered and nurtured. The process of socialisation and those responsible for socialising us into our larger communities, succinctly, share with us prevailing norms, beliefs, and standards.

Evidence suggests that when we assist one another in the identification of barriers and appreciate benefits of LGBTI inclusion within nursing programmes, we assist development and nurturing of cultural competencies.

Covertly within the nursing education context, by virtue of what is taught, we are instructed to learn along this dichotomous arrangement of man and woman, left and right and right and wrong. Deviations from this are often met with resistance and substantiations which seek to maintain the status quo. The problem with this, thus, is that same coping mechanism used to shield oneself from the damaging effects of heteronormativity, pulls us further away from realising who we really are. LGBTI Students, teachers, educators, and professionals in clinical practice sequester aspects of themselves in a bid at self-preservation. The examples of transformative learning emanating from the review findings support the claims of nurses reported being more sensitive of how they communicated and mindful of the challenges faced by LGBTI clients.

5.5 NURSING EDUCATION: IMPLICATIONS FOR THEORY AND PRACTICE

The researcher views further large-scale inquiry into evidence on LGBTI inclusivity in nursing programmes within the South African context. There remains a paucity of literature on the developments across South Africa in relation to the inclusion of LGBTI content in nursing programmes. The researcher is of the opinion that “*small manageable steps are always best, before we run*”.

This said, it is of utmost importance that those who find themselves in direct opposition of LGBTI inclusion in the nursing programme should know that decisions to employ small and increment changes are not implemented to ease their discomfort and discontent, however, it should be done to ensure that change is sustainable. Before real change could be affected, the researcher suggests that University Faculties of Health Sciences and Nursing education institutions, at large should consider development of a LGBTI sensitisation pilot project.

5.5.1 Theoretical implications

The researcher is of the opinion that before meaningful change could be effected or even realised, a fundamental shift in thinking should be encouraged within Faculties of Health Sciences and Nursing Education institutions or Schools. It remains imperative that foundational knowledge on the subject be ascertained. Theoretical instruction should be evidence based/informed by literature.

The review findings the following are suggested:

i) The development of sensitisation programmes incorporating transformative learning

Examining the self and where we situate ourselves within the greater context/social make-up. Collaboration with LGBTI activists and role-players to assist in identifying appropriate content. A tailored, context specific approach to transformative Teaching and Learning, should ideally encompass the following:

- 1) An ethical stance that challenges oppressive structures that sustain inequality and discrimination with the aim to promote social inclusion. To meet the nuanced healthcare needs of the LGBTI communities, nurses should be capacitated in roles which align the nurse with the *advancement of social justice*. The review findings indicate and support the notion of developing a sensitivity and appreciation, in student nurses and nurse educators.
- 2) Sharing of information in ways which allows advocacy and enhancement of human rights and social justice. The inclusion of LGBTI content could enrich the nursing programme and have positive outcomes for nursing education and healthcare service delivery, at large.
- 3) Content inclusion (LGBTI) within nursing programmes should address aspects of intersectionality and diversity—such as gender identity and expression, disability, indigeneity, poverty status, and language, in a culturally responsive manner. Nursing education institutions must reaffirm their commitment in advancing a social justice agenda which extends beyond LGBTI content which includes marginalised, vulnerable, and high-risk communities.
- 4) The use of transformative learning and emancipatory approaches could assist the development of cultural competencies within the nursing, a cultural competency that shifts current discourse, to questioning structures and processes of power instead of accepting them.

5.5.2 Implications for clinical and educational practice

Given the factual finding of this MMSR, as nurses, we can function as protective buffer to assist staff and or students to navigate the often-uncertain landscape faced by LGBTI persons.

Educational Practice - Participatory content analysis workshops

This workshop process assists in identifying gaps and barriers to the inclusion of LGBTI content in the nursing programme, while providing a means of ascertaining time and focus of

LGBTI content currently taught. It may also assist in identifying appropriate content be integrated into the nursing programme.

Despite current approaches, the researcher advocates for an emancipatory approach to the development of cultural competencies, for three reasons:

- 1) Identify appropriate LGBTI clinical and cultural competencies regarding the social location of this demographic and source partners for clinical placement.
- 2) Active promotion of equitable healthcare services which address the unique needs of LGBTI persons.
- 3) Identify organisational barriers of facility-based frameworks which fail to name processes of power, which influence collective experiences and runs the risk of propagating stereotypes and upholding implicit bias, and discrimination.
- 4) Utilisation of Continuous Professional Development (CPD) continuous teaching and learning approaches to develop and enhance LGBTI educative moments, practical skills, and competencies to work ethically and effectively with LGBT clients and their families.

The content should ideally cover LGBTI specific healthcare screenings, invitations to LGBTI guest speakers to facilitate and guide: life history of discrimination; areas of support (family, friends and community); the acceptable use of pronouns; insecurity and fear and structural inequalities/discrimination.

5.6 SUGGESTIONS FOR FUTURE RESEARCH

There remains a need for comprehensive inquiries into LGBTI inclusivity within nursing programmes, especially within the African and South African context. The issue of LGBTI health related content and the advancement of social justice for LGBTI persons (including marginalised and vulnerable populations) depends on location, societal norms, values, and beliefs. To investigate limitations and barriers to LGBTI inclusion in teaching and learning spaces, there needs to be an increase in output of qualitative studies. Studies which shed light on the entrenchment of heteronormativity. This may allow for a more comprehensive picture of the degree to which LGBTI is routinely included in nursing programmes. The researcher aims to utilise findings if this MMSR to inform further study, towards a PhD (Doctor of Philosophy), through the application of a mixed method approach.

5.7 LIMITATIONS OF THE STUDY

The **limitations** of this research pertain to restrictions of the review and possible bias. During the conceptualisation of the research purpose, review question and subsequent search strategy, the researcher made use of the SPIDER framework. It is acknowledged that use of the PICO(T) could have rendered different results. Furthermore, the choice of databases and

the eligibility criteria could have an influence on the search results. Bias of the reviewers could influence the review results. The researcher identifies as a member of the LGBTI community. First-hand experience with the challenges faced by this community could have produced a level of bias in favour of the plight of LGBTI persons. Measures taken to enhance trustworthiness, as indicated in Sections 1.9 and 3.5, addressed researcher bias.

The **strengths** of the review are that it plants a seed in the minds of those who oppose change and inclusivity, yet, at the same time, challenges those at the vanguard of LGBTI social justice issues. Notwithstanding the review findings, the use of the MMSR as a design, the paradigmatic frame allowed the researcher to employ “*what works best*”. Though this body of work may fulfil requirements for qualification, it should also be viewed as an inquiry which advances social justice for LGBTI persons. The study, further highlights the changing sociodemographic of the nurses currently undergoing training across nursing institutions, allowing us to consider teaching and learning engagements which are reflective of a more diverse and inclusive mind frame.

5.8 CONCLUSION

The researcher adhered to a rigorous, systematic review process and reporting guidelines to realise the purpose of the review. Conducting a MMSR, following a convergent integrated design was implemented to answer the question:

What evidence exists in the literature on LGBTI content in nursing programmes?

In consideration of the factual conclusions, the researcher believes that review findings and insights of this MMSR not only demonstrated the interwoven nature of the data but also speak to the complexities of LGBTI health related content inclusion within nursing programmes. LGBTI health related content in nursing education and healthcare service delivery programmes could enrich and supplement content currently presented in nursing programmes. The concepts of inclusivity, representation, respect, and recognition, according to the review findings, should be included in teaching and learning offerings. In this way, advance a social justice agenda for marginalised and vulnerable populations.

The review findings could provide new foci and understandings within the LGBTI research area. Education on LGBTI health disparities could foster a keen appreciation of the impact stigma and discrimination experienced by LGBTI persons. Such realisation among nursing graduates is vital in effectively and efficiently meeting the healthcare needs of the LGBTI community.

This submission, of knowledge synthesis, by means of MMSR, aimed to show insight in the area of research, equally important is the researcher’s ability to reflect on the areas of learning

and development. A postscript reflection has been included to enhance worth of the study (Polit and Beck, 2021:164).

SECTION 6

POSTSCRIPT REFLECTION - REFLECTIONS ON MY INTELLECTUAL/ACADEMIC JOURNEY

6.1 SECTION OVERVIEW: Critical Reflection: The Deal Model

To me, the review process, from start to finish, embodies one of the most important learning experiences I have had, thus far. A great need exists, compelling me to share unseen moments, happy and sad with struggles and tears. A process of critical reflection (CR) was undertaken. CR served to guide serious discussion around the researcher's: (a) personal experiences, perceptions, and feelings, (b) considerations on social justice and the perceived contribution the study makes and (c) How did these experiences enhance my knowledge – focussing specifically on my own learning and development, how the learning took place and why this learning is viewed as important.

Table 13 Unpacking the DEAL Model

D	Describe	Provide context and describe the experience objectively
E	Examine experiences	Personal Growth Civic Engagement/Social Contribution Academic Enhancement
A	Articulate learning	Using responses in D and E outline what learning has occurred
L		

Guided by *the DEAL model*, developed by Dr Patti Clayton, I have chosen to include a reflective summary, on the research process I chose to utilise. For the purposes of this Chapter, the *learning experience* shall refer to activities and processes involved in the research/review process [Step 1 – Step 6].

The DEAL model (*Table 13*) (Lay & McGuire (2010) adapted from Ash & Clayton (2004) was chosen as a constructive way in which to reflect on my *learning experience* - This involves all research activities, from the conceptualisation to dissemination of findings.

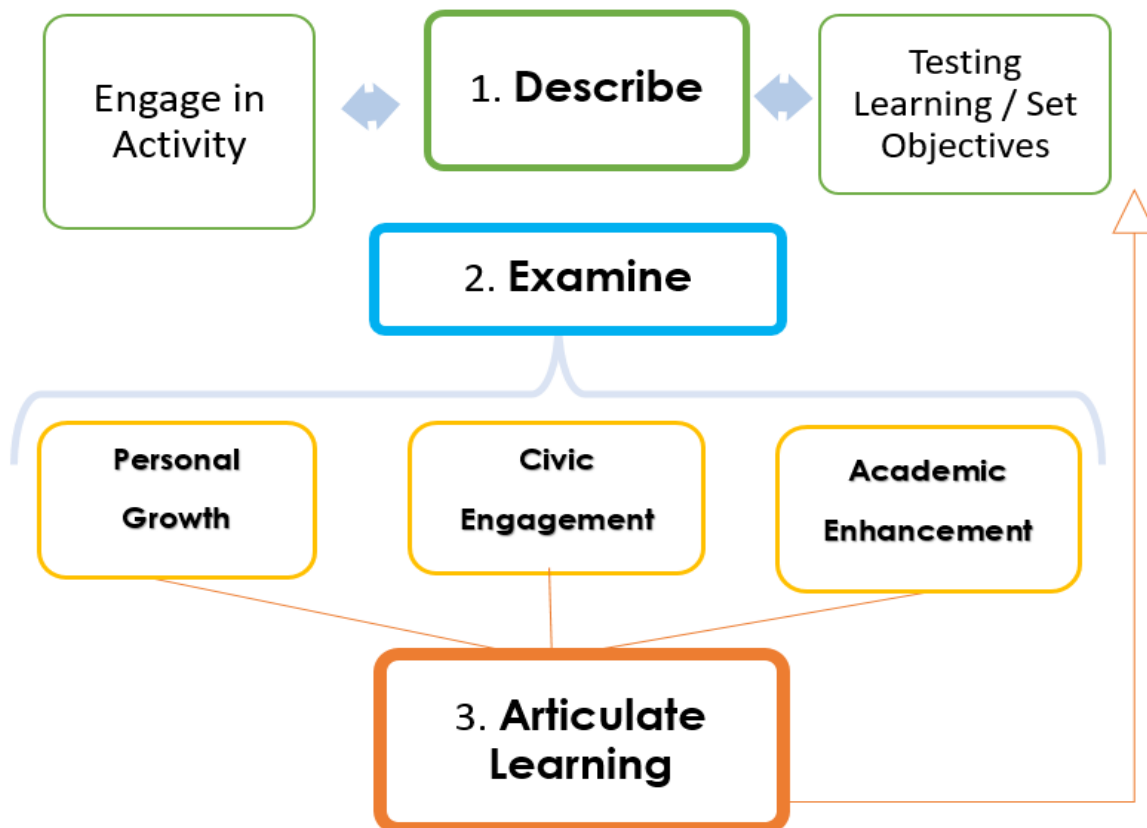


Figure 14 The DEAL Model

Lay & McGuire (2010) adapted from Ash & Clayton (2004).

The exercise of reflection is appreciated to articulate and deepen critical reflective practices and position oneself, strategically, within the broader discourse. It further aids in identification of links between learning objectives and personal experiences and how these may influence the different learning domains – Cognitive – Psychomotor and Affective.

6.2 DESCRIBE THE EXPERIENCE OBJECTIVELY

As I recall, it was early 2020. A hot Bloemfontein afternoon, with me sitting my first Research Methodology class. I recall feeling tired and hungry, as the guest speaker moves to the front. I am almost forcing myself to listen – goes on about *gaps in knowledge* and *practice* and the *intent to improve practice*. My postgraduate [MNurs] journey started in 2021. Initially, I was working on a qualitative study, using a *Participatory Action Learning and Action Research* (PALAR) approach. To contribute to more inclusive language and advocate inclusion of LGBTI content in the undergraduate Nursing programme, the study was aimed at sensitising healthcare professionals to the unique and nuanced healthcare needs of LGBTI persons. Functioning within a transformative emancipatory paradigmatic lens, I envisaged incorporating *Forum Theatre*, as a means of data collection, along with surveys, participant's responses, and dialogue. The thought of an opportunity to combine elements of the dramatic arts and nursing science, as part of a qualitative inquiry, presented an opportune moment to gather rich data. I believe that it would have proven that; when we create safe teaching and learning spaces, we promote critical dialogue, which ultimately aids in dismantling negative

social norms which perpetuate and drive heteronormative standards. The message is clear - recognise the rights and liberties of LGBTI individuals.

In retrospect... the only thought that is very clear in my mind, is that I never really intended on conducting a MMSR for qualification purposes. In fact, **I really did not want to**. It was envisaged that the study would shed light on diverse student perceptions around sexual and gender stereotyping/discrimination, reflective and transformative learning, amongst others, in relation to LGBTI inclusivity within the undergraduate programme. I continued on, galvanised and assured after having sat my Departmental Evaluation Committee, in defence of the proposed study. The feedback was fair and very appreciative of the bold stance taken in the proposal document.

The HSREC submission was successful. I was, subsequently, granted conditional approval. Commencement of data collection remained contingent on agreement of the Vice Rector of Student Affairs (at the time) at the University of the Free State, who functioned as the gatekeeper to my research population. Since submitting a somewhat innovative approach to data collection, great care was taken to ensure that all ethical considerations were explicitly mentioned, accompanied by concrete examples of action steps. Guided by a transformative-emancipatory paradigm, the researcher selected virtues (practical wisdom, respectfulness, trustworthiness, and justice) to lead ethical decision making. As the case with many other Ethics Committees, the HSREC at UFS continues to function from a positivist, principle-based approach. Responses noted from HSREC were always met in good spirits but because the person functioning as the gatekeeper to my study population, the Vice-Rector: Research & Internationalisation and Chair: Senate Research Ethics Committee, at the time declined access.

In the light of research which lead to qualification, one could look past the conservative milieu which governs the research process. Commencement of the proposed study was halted. The primary reason, provided to me (paraphrased) read as follow:

"It is at the concern of this Committee...that we believe a platform, such as the planned theatre piece may, inadvertently create or encourage negative and discriminatory responses...Placing students who identify as LGBT or I at risk of further persecution".

This news and the reason took me by surprise. I recall speculating about the thought process of the adjudicating authority, *did the protocol not outline some aspect sufficiently? Did I forget to consider something important?*

These questions... as relevant as they *are*, were met with resistance. Little did I know, at the time, I would have to abandon the concept, completely. I grew frustrated, there was a constant nagging, a restless feeling about my experiences at the UFS as a "gay" person. I am able to recognise the countless times I was made to diminish who I am, for the sake of

social acceptance or at times, just to blend in. This was difficult. Knowing the direction and message must be realised, my study supervisors suggested conducting an IR. As a design, the IR direction made perfect sense. This trusted methodology which could see credible contributions to evidence-based practice and policy within the nursing education discipline. Moreover, the HSREC processes excluded the approval for human participant. In so doing, I would be spared the same fate, I had the ill-informed understanding that an IR would be a quick and easy way of completing my master's qualification.

In line with the accepted prescripts of the systematic review, I once again set out to construct and compiled a research/review protocol. I believed that a shift away from the dichotomous views and teachings of conventional research approaches was necessary. Our experiences and realities should inform how we view ourselves, the beliefs we hold and how these impact on those and the world, at large. For this reason, I ruled out the option of conducting a Systematic Review. The IR was an interesting approach to synthesised information using multiple sources. The similarities, differences, and strengths of each approach within the field of Review studies led me to keenly focus on trying to immerse myself in this methodology. In comparison to traditional forms of inquiry, the IR seemed inclusive and less ridged.

Upon reference to literature, a clear distinction surfaced. The mixed method approach within SR's were an emerging and developing area. This further led me, together with my study supervisors, to consider the aptness of the IR in comparison to the MMSR. The MMSR, as a design was more reflective of the position I aimed to take. Subsequently, I spent many nights, hours, days, just reading. I read broadly, immersing myself in the approach, method, and design. I must admit, as a novice researcher, following the review process, to the letter, was arduous. I recognised that I needed guidance on the method and design. I am thankful that the UFS School of Nursing has expertise on review type studies and I am thankful that I had a wealth of experience to draw on, throughout my review process. Over and above that, I am very fortunate to have had study supervisors who were open to exploring new possibilities in conducting the review. They provided a degree of support and respect which is admirable, yet they remained sharp enough to seek substantiation and command defence of certain methodological choices - Always questioning, always supporting, and guiding. The setback regarding my 1st proposal, still lingered at this stage. I was thinking about the extended timeline and the further repercussions this would have, mostly financially. During the review process, there were periods of reiteration which comes with each step in the MMSR.

Through the completion of the MMSR, the researcher now appreciates the value mixed method research can add. As we continue to venture into new areas or nursing education, as we continue to develop new and innovative ways in which to facilitate teaching and learning activities. I believe that the MMSR represents collaboration, anew - a coming together of ideas, paradigms, and teaching. The process, from conceptualisation, execution to termination and submission, is appreciated to be a valuable learning experience.

6.4 EXAMINE EXPERIENCES

6.4.1 Personal Growth

This is a long journey...Because as I write this, I am far from complete. I am at the adjusting rewording and reworking stage, peppered with editing and the technical aspect of this document. To this end, I echo this statement - I am continually learning. I am learning new aspects of myself, of the research area as well as issues pertaining to the current outlook on nursing education. The review findings indicate and support the notion of developing sensitivity and appreciation, in student nurses and nurse educators, for the intersections LGBTI persons face. Given the factual finding of this MMSR. I have grown in my understanding of the impact and interrelation of theories and social constructs and how, as nurses, we can use constructive or supportive social theories to function as protective factors and assist staff and or students to navigate the often-uncertain landscape faced by LGBTI persons.

The discussion around the effects of this social construct have been discussed at length throughout this review. The review findings, however, compelled me to engage in further discussions around the compounding nature of divisive forces which populate the lives of many LGBTI people. Moreover, based on the findings of this MMSR, I was able to offer suggestions for challenges.

Heteronormativity is a system of beliefs. Heterosexuality assumes a binary approach as the only natural option for human relationships. As a societal construct, this term describes the privileged position associated with heterosexuality and discriminates against other sexual orientations (SANAC, 2017:vii-viii). Literature indicates that exclusionary, discriminatory attitudes are fostered and nurtured. The process of socialisation and those responsible for socialising us into our larger communities succinctly share prevailing norms, beliefs, and standards. The individual is faced with a clear demarcation and repercussion if they fail to comply. In the case of LGBTI persons, avoiding, ignoring, or dismissing acts of violence, discrimination and victimisation are usually unconsciously incorporated as mechanisms to cope with the relentless barrage of disgust and disapproval.

Covertly, within the nursing education context, by virtue of what is taught, we are instructed to learn the dichotomous arrangement of man and woman, left and right and right and wrong. Deviations from this are often met with resistance and substantiations which seek to maintain the status quo.

The problem with this is that the same coping mechanism used to shield oneself from the damaging effects of heteronormativity pulls us further away from realising who we really are. LGBTI Students, teachers, educators, and professionals in clinical practice sequester aspects of themselves in a bid at self-preservation.

Void of support, multiple repressions entrench and precipitate one another, creating new areas and dimensions of human suffering. The individuals' social positions, derived from interdependent roles/identity, such as race/ethnicity, class, and generation, are shaped by, and interact with, systemic oppressions and changes in the social acceptance of sexual minorities over time (Hagai *et al.*, 2020:973). Studies conducted across the globe support long lasting effects of stigma and discrimination, which leaves indelible marks on the gender and sexual development of the individual (Cederved *et al.*, 2021:3; Reygan, 2021:114).

Wider reading, accompanied by deep reflection (on personal experiences) unravelled the concept of intersectionality. Intersectionality and its effects may manifest and present negatively. Its effects are cognitive (the way we think) and affective (how one feels) and may dictate and perpetuate poor coping mechanisms, as a direct psychomotor response to stigma and discrimination.

Supported by the review findings, as well as the body of work, a correlation could be made between such intersections and the development and experiences of minority stress. The minority stress model, by (Meyer, 2003; Meyer & Dean, 1995) deals with the lived experience of LGBTI persons who daily experience and describe the process of a host of chronic, minority stressors (i.e., acts of antigay discrimination and victimisation) place gay and bisexual men at risk of internalise homonegativity and self-stigmatisation (DWYPD, 2020:29; SANAC, 2017:xxi; Patterson *et al.*, 2020:25; SANAC, 2017:xxi). The model links higher levels of internalised homonegativity among LGBTI persons to increased rates of substance use, risky sexual behaviours as well as increased risk to mood and anxiety disorders (Theodore, 2011:3).

The former served to recap the detrimental effects of constructs such as heteronormativity, intersectionality, and minority stress. This implies, as alluded to by the review findings, a comprehensive history taking, coupled with an investigation regarding the individual's gender identity and sexual orientation. This informs and creates context regarding social location, current stressors, precipitating and predisposing factors and protective factors, which according to literature, facilitates formation of a comprehensive picture of the clients' concerns (Patterson *et al.*, 2020:25). However, this inclusive and sensitive approach can only be realised considering the review findings.

6.4.2 Civic Engagement/Social Contribution

I have had the assistance and guidance of two seasoned supervisors. In choosing to conduct a MMSR, which is in essence a synthesis of works previously published, I believe that I cannot take full credit and recognition for the work that has been produced. This guidance, however, has allowed me to put forward insights and recommendations which advances issues around social justice and inclusivity of LGBTI persons and marginalised persons. I recount strong opposition to embarking on a journey which sought to highlight the exclusion

of LGBTI persons from discourse on health and wellbeing. This, unfortunately, took place both inside and outside the UFS context. The epistemic heteronormative assumptions shared among nurses and nurse educators may present as a lack of comfort, which impedes knowledge on teaching LGBTI content within the nursing programme (Müller *et al.*, 2020:10; Müller, 2013:4).

Considering this, the findings of this MMSR indicated that when LGBTI content inclusion within the nursing programme becomes a “tick-box-exercise” or executed to appease or fails to guide students on sexual orientation and gender identity affirming practices and impedes nursing schools, educators, nurses, and students from addressing the impact of intersectionality within the LGBTI context, such content is often found to be irrelevant and inappropriate. The consequence of such highly stigmatised environments, constant victimisation and degradation leads to avoidance, a reluctance to access early diagnostic treatment and care programmes. In highlighting this important aspect, I believe that an important dialogue within academic spaces – especially in spaces which could be viewed as conservative can commence.

To drive this point home, let me make a comparison between exposure and inclusivity when considering geographical location within South Africa. Cape Town is considered to be the most progressive city when we consider inclusivity and acceptance of LGBTI persons. As a member of the LGBTI community, I am free to engage in public displays of affection. Though this may still turn some heads (dependant on local geography and location within the Cape Metro) doing so is not met with extreme forms of violence. If the same action is repeated in a metro such as Mangaung – Bloemfontein, verbal and or physical assaults are imminent.

6.4.3 Academic Enhancement

If I have summarised the perceived or anticipated impact of this work, I would definitely consider it in light of the current discourses currently taking place within Higher Education at large. Especially in terms of inclusivity, diversity, and accessibility. It must be noted that despite positive moves towards a truly inclusive teaching and learning spaces, we are still a long way from realising this goal. I have read, a few times, a quote which says: Legislation is meant to bring order to prevent social chaos. However, we can never legislate what is in the mind. In nursing education institutions, LGBTI content inclusion is mainly done for appeasement and credit and usually the result of entrenched heteronormativity.

A fundamental shift is necessary, one where LGBTI healthcare, sexual health issues related and inclusivity and diversity, engages students in a transformative process. This review study has highlighted the dire need for increased dialogue and discussion around LGBTI issues and to be willing to unpack stigma and discrimination, still meted out on campuses across South Africa.

6.5 ARTICULATE LEARNING

Firstly, there are perhaps two points I would like to focus on, as part of my own academic enhancement in relation to what was found during the review process: (1) The hegemony of Global North within the field of research and (2) The paucity of studies emanating from Africa, speaks to the prevailing non-inclusive, heteronormative beliefs which dominate the African continent and developing nations at large. The possibilities of countless theories governing a phenomenon of interest, would see one set of ideas or theories favoured above others. *This* best encapsulates academic and scientific hegemony. The future status of the scientific discipline must seek ways in which to set itself against institutions which question the credibility of and dismiss indigenous knowledge. Secondly, in relation to what was (not) found in review. Characterised by poor and ill-informed understandings of gender identity and sexual orientation, LGBTI content and its inclusion are simply not a consideration, in most Countries on the African Continent.

Secondly, I now understand the importance of teaching and facilitating dialogue around cultural competence, critical reflection and transformative teaching and learning practices. When used appropriately, these tools may contribute to the advancement of social justice for LGBTI persons and engender change through a process of reframing biases, preconceptions and gendered value systems within a safe space allowed them to critically reflect. Research supports the fact that teaching and learning environment which are perceived as safe, create spaces conducive to questioning and probing concepts which may be uncomfortable to deal with in a traditional setting.

Lastly, we should never look past the value of the lived experience, in relation to one's social location. As valuable and subjective as our personal experiences may be, they too, offer valuable insight into commonalities we all face. I have learned that we could learn so much – if we just took the time to share and learn from one another.

6.6 LIMITATION OF THE REFLECTIVE PROCESS

There are many reflection frameworks which advise that steps be followed in a defined way we don't always start '*at the beginning*' – There is no definitive start. Models on reflection may assist in comprehension but cannot be applied in every situation. I view reflective practices as continuous, an almost cyclical process. This presents an advantage in and of itself, however, as the primary investigator, embarking on a MMSR for qualification purposes can be daunting.

Reflection on the challenges and learning developmental areas were kept to a minimum in the description. (Refer to 6.2.) Some of the steps which proved most challenging were:

Step 1 – the formulation of the Boolean search string and the selection of the appropriate search approach i.e.: SPIDER vs PICO(T) format.

Step 2 – Sifting, selecting, and sorting through publications.

Step 4 – Thematic analysis.

The reason the above were selected is because they were identified as the most labour intensive. To remedy the pitfalls identified during this process, in future, it would be beneficial to co-opt more role-players in those areas of the review process to ensure a stepwise approach.

6.7 EXIT STATEMENT

The MMSR review findings have emphasised that half of nursing programmes lack sufficient and relevant LGBTI content. The inclusions (of LGBTI content) found were wholly inadequate to affect even low levels of preparedness to deal with LGBTI health related issues upon entering clinical practice. Nurses and the populations they serve are implored to challenge exclusionary prevailing social norms and facilitate social change.

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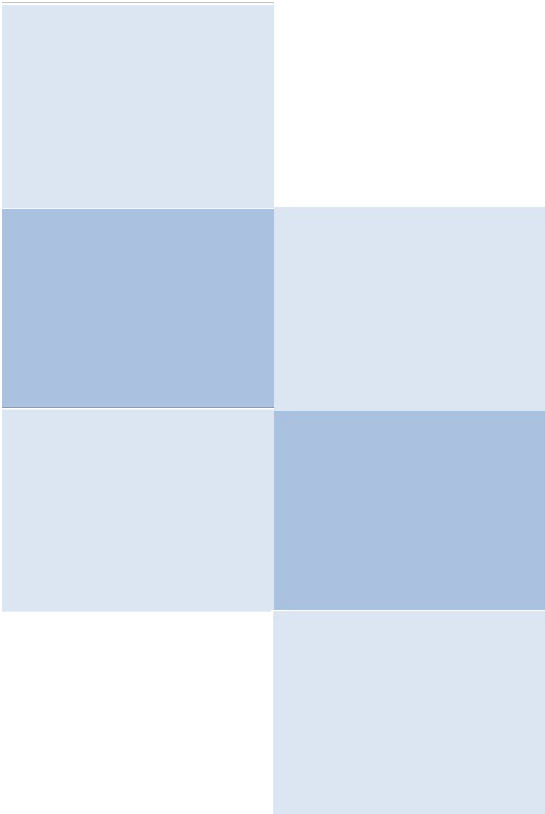
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ADDENDUM A - NUMBER OF STUDIES ISOLATED IN EACH ELECTRONIC DATABASE

EBSCOHost			
Africa-Wide Information	[0]	Academic Search Ultimate,	[23]
APA PsycInfo,	[38]	APA PsycArticles	[0]
CINAHL with Full Text	[35]	CAB Abstracts,	[1]
ERIC	[6]	Communication & Mass Media Complete	[0]
Health Source - Consumer Edition	[0]	GreenFILE	[0]
Nursing/Academic Edition	[3]	Health Source	[0]
MasterFILE	[0]	Humanities Source Ultimate	[0]
MEDLINE	[72]	Reference eBook Collection	[0]
Sociology Source Ultimate	[0]	OpenDissertations	[6]
		SPORTDiscus with Full Text	[0]
TOTAL	184		

ADDENDUM B - QUALITY APPRAISAL TOOL: MIXED METHOD RESEARCH AND MIXED STUDIES REVIEWS



**MIXED METHODS
APPRAISAL TOOL
(MMAT)
VERSION 2018
User guide**

Prepared by

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Innovation et excellence académique dans les soins, l'enseignement et la recherche

Part I: Mixed methodMixed methods Appraisal Tool (MMAT), version 2018

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?				
	S2. Do the collected data allow to address the research questions?				
	<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?				
	1.2. Are the qualitative data collection methods adequate to address the research question?				
	1.3. Are the findings adequately derived from the data?				
	1.4. Is the interpretation of results sufficiently substantiated by data?				
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?				
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5. Did the participants adhere to the assigned intervention?				
3. Quantitative nonrandomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methodMixed methods	5.1. Is there an adequate rationale for using a mixed methodMixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

Part II: Explanations

1. Qualitative studies	Methodological quality criteria
<p>“Qualitative research is an approach for exploring and understanding the meaning individuals or groups ascribe to a social or human problem” (Creswell, 2013b, p. 3).</p> <p>Common qualitative research approaches include (this list if not exhaustive):</p> <p>Ethnography The aim of the study is to describe and interpret the shared cultural behaviour of a group of individuals.</p> <p>Phenomenology The study focuses on the subjective experiences and interpretations of a phenomenon encountered by individuals.</p> <p>Narrative research The study analyzes life experiences of an individual or a group.</p> <p>Grounded theory</p>	<p>1.1. Is the qualitative approach appropriate to answer the research question?</p> <p>Explanations The qualitative approach used in a study (see non-exhaustive list on the left side of this table) should be appropriate for the research question and problem. For example, the use of a grounded theory approach should address the development of a theory and ethnography should study human cultures and societies.</p> <p>This criterion was considered important to add in the MMAT since there is only one category of criteria for qualitative studies (compared to three for quantitative studies).</p>
	<p>1.2. Are the qualitative data collection methods adequate to address the research question?</p> <p>Explanations This criterion is related to data collection method, including data sources (e.g., archives, documents), used to address the research question. To judge this criterion, consider whether the method of data collection (e.g., in depth interviews and/or group interviews, and/or observations) and the form of the data (e.g., tape recording, video material, diary, photo, and/or field notes) are adequate. Also, clear justifications are needed when data collection methods are modified during the study.</p>
	<p>1.3. Are the findings adequately derived from the data?</p> <p>Explanations This criterion is related to the data analysis used. Several data analysis methods have been developed and their use depends on the research question and qualitative approach. For example, open, axial and selective coding is often associated with grounded theory, and within- and cross-case analysis is often seen in case study.</p>
	<p>1.4. Is the interpretation of results sufficiently substantiated by data?</p> <p>Explanations The interpretation of results should be supported by the data collected. For example, the quotes provided to justify the themes should be adequate.</p>

Generation of theory from data in the process of conducting research (data collection occurs first).

Case study

In-depth exploration and/or explanation of issues intrinsic to a particular case. A case can be anything from a decision making process, to a person, an organization, or a country.

Qualitative description

There is no specific methodology, but a qualitative data collection and analysis, e.g., in-depth interviews or focus groups, and hybrid thematic analysis (inductive and deductive).

1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?

Explanations

There should be clear links between data sources, collection, analysis and interpretation.

2. Quantitative randomized controlled trials	Methodological quality criteria
<p>Randomized controlled clinical trial: A clinical study in which individual participants are allocated to intervention or control groups by randomization (intervention assigned by researchers).</p> <p>Key references: Higgins and Green (2008); Higgins et al. (2016); Oxford Centre for Evidence-based Medicine (2016); Porta et al. (2014)</p>	<p>2.1. Is randomization appropriately performed?</p> <p>Explanations In a randomized controlled trial, the allocation of a participant (or a data collection unit, e.g., a school) into the intervention or control group is based solely on chance. Researchers should describe how the randomization schedule was generated. A simple statement such as ‘we randomly allocated’ or ‘using a randomized design’ is insufficient to judge if randomization was appropriately performed. Also, assignment that is predictable such as using odd and even record numbers or dates is not appropriate. At minimum, a simple allocation (or unrestricted allocation) should be performed by following a predetermined plan/sequence. It is usually achieved by referring to a published list of random numbers, or to a list of random assignments generated by a computer. Also, restricted allocation can be performed such as blocked randomization (to ensure particular allocation ratios to the intervention groups), stratified randomization.</p>
	<p>2.2. Are the groups comparable at baseline?</p> <p>Explanations Baseline imbalance between groups suggests that there are problems with the randomization. Indicators from baseline imbalance include: “(1) unusually large differences between intervention group sizes; (2) a substantial excess in statistically significant differences in baseline characteristics than would be expected by chance alone; (3) imbalance in key prognostic factors (or baseline measures of outcome variables) that are unlikely to be due to chance; (4) excessive similarity in baseline characteristics that is not compatible with chance; (5) surprising absence of one or more key characteristics that would be expected to be reported” (Higgins et al., 2016, p. 10).</p>
	<p>2.3. Are there complete outcome data?</p> <p>Explanations Almost all the participants contributed to almost all measures. There is no absolute and standard cut-off value for acceptable complete outcome data. Agree among your team what is considered complete outcome data in your field and apply this uniformly across all the included studies. (Thomas et al., 2004; Zaza et al., 2000) to 95% (Higgins et al., 2016). Similarly, different acceptable withdrawal/dropouts rates have been suggested: 5% (de Vet et al., 1997; MacLehose et al., 2000), 20% (Sindhu et al., 1997; Van Tulder et al., 2003) and 30% for a follow-up of more than one year (Viswanathan and Berkman, 2012).</p>
	<p>2.4. Are outcome assessors blinded to the intervention provided?</p> <p>Explanations Outcome assessors should be unaware of who is receiving which interventions. The assessors can be the participants if using participant reported outcome (e.g., pain), the intervention provider (e.g., clinical exam), or other persons not involved in the intervention (Higgins et al., 2016).</p>

2.5 Did the participants adhere to the assigned intervention?

Explanations

To judge this criterion, consider the proportion of participants who continued with their assigned intervention throughout follow-up. “Lack of adherence includes imperfect compliance, cessation of intervention, crossovers to the comparator intervention and switches to another active intervention.” (Higgins et al., 2016, p. 25).

3. Quantitative non-randomized studies	Methodological quality criteria
<p>Non-randomized studies are defined as any quantitative studies estimating the effectiveness of an intervention or studying other exposures that do not use randomization to allocate units to comparison groups (Higgins and Green, 2008).</p> <p>Common designs include (this list if not exhaustive):</p> <p>Non-randomized controlled trials The intervention is assigned by researchers, but there is no randomization, e.g., a pseudo-randomization. A nonrandom method of allocation is not reliable in producing alone similar groups.</p> <p>Cohort study Subsets of a defined population are assessed as exposed, not exposed, or exposed at different degrees of interest. Participants are followed over</p>	<p>3.1. Are the participants representative of the target population?</p> <p>Explanations Indicators of representativeness include: clear description of the target population and of the sample (inclusion and exclusion criteria), reasons why certain eligible individuals chose not to participate, and any attempts to achieve a sample of participants that represents the target population.</p>
	<p>3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?</p> <p>Explanations Indicators of appropriate measurements include: the variables are clearly defined and accurately measured; the measurements are justified and appropriate for answering the research question; the measurements reflect what they are supposed to measure; validated and reliability tested measures of the intervention/exposure and outcome of interest are used, or variables are measured using ‘gold standard’.</p>
	<p>3.3. Are there complete outcome data?</p> <p>Explanations Almost all the participants contributed to almost all measures. There is no absolute and standard cut-off value for acceptable complete outcome data. Agree among your team what is considered complete outcome data in your field (and based on the targeted journal) and apply this uniformly across all the included studies. For example, in the literature, acceptable complete data value ranged from 80% (Thomas et al., 2004; Zaza et al., 2000) to 95% (Higgins et al., 2016). Similarly, different acceptable withdrawal/dropouts rates have been suggested: 5% (de Vet et al., 1997; MacLehose et al., 2000), 20% (Sindhu et al., 1997; Van Tulder et al., 2003) and 30% for follow-up of more than one year (Viswanathan and Berkman, 2012).</p>
	<p>3.4. Are the confounders accounted for in the design and analysis?</p> <p>Explanations Confounders are factors that predict both the outcome of interest and the intervention received/exposure at baseline. They can distort the interpretation of findings and need to be considered in the design and analysis of a non-randomized study. Confounding bias is low if there is no confounding expected, or appropriate methods to control for confounders are used (such as stratification, regression, matching, standardization, and inverse probability weighting).</p>

time to determine if an outcome occurs (prospective longitudinal).

Case-control study

Cases, e.g., patients, associated with a certain outcome are selected, alongside a corresponding group of controls. Data is collected on whether cases and controls were exposed to the factor under study (retrospective).

Cross-sectional analytic study

At one particular time, the relationship between healthrelated characteristics (outcome) and other factors (intervention/exposure) is examined. E.g., the frequency of outcomes is compared in different population subgroups according to the presence/absence (or level) of the intervention/exposure.

Key references for non-randomized studies: Higgins and Green (2008); Porta et al. (2014); Sterne et al. (2016); Wells et al. (2000)

3.5 During the study period, is the intervention administered (or exposure occurred) as intended?

Explanations

For intervention studies, consider whether the participants were treated in a way that is consistent with the planned intervention. Since the intervention is assigned by researchers, consider whether there was a presence of contamination (e.g., the control group may be indirectly exposed to the intervention) or whether unplanned co-interventions were present in one group (Sterne et al., 2016).

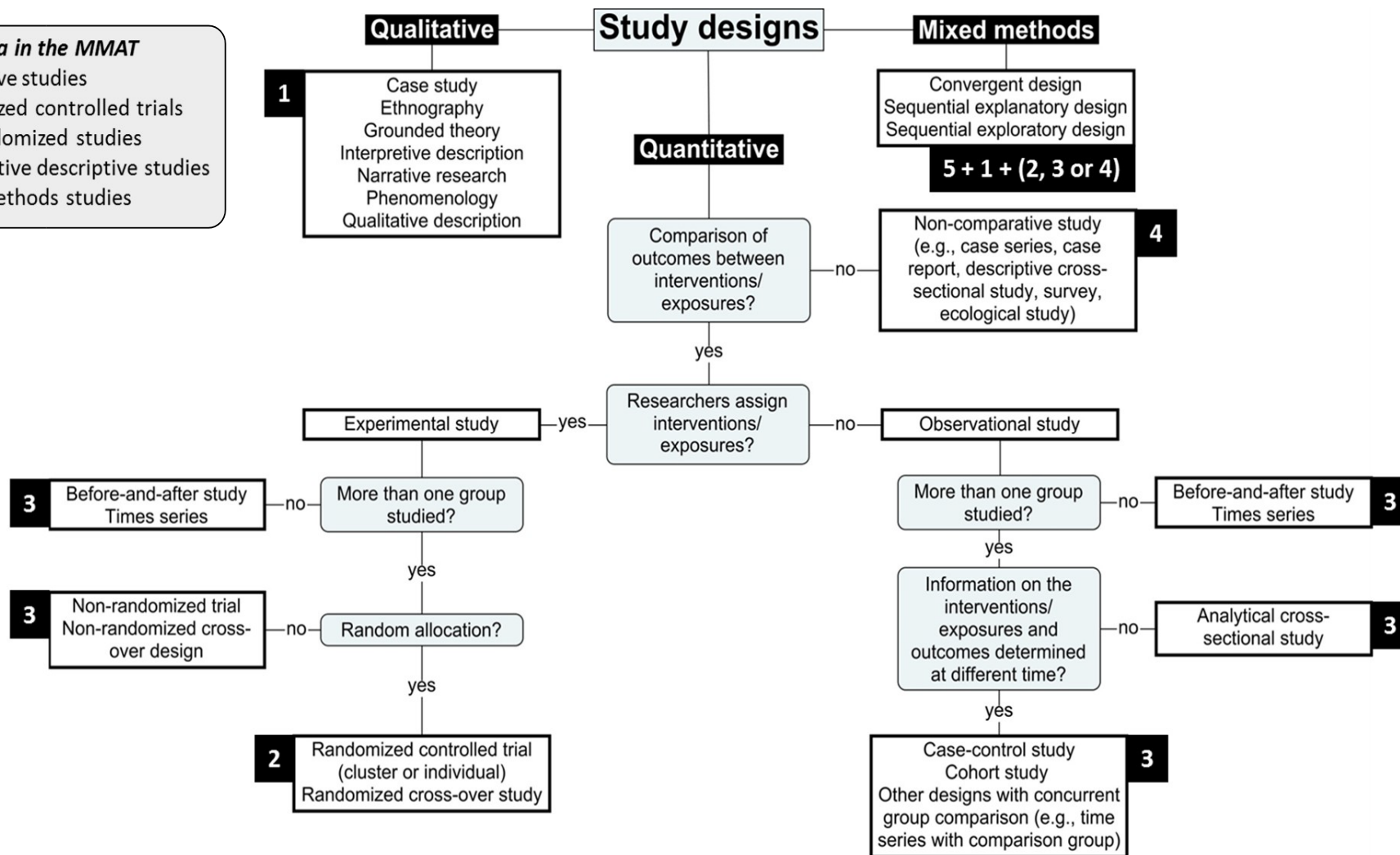
For observational studies, consider whether changes occurred in the exposure status among the participants. If yes, check if these changes are likely to influence the outcome of interest, were adjusted for, or whether unplanned co-exposures were present in one group (Morgan et al., 2017).

4. Quantitative descriptive studies	Methodological quality criteria
<p>Quantitative descriptive studies are “concerned with and designed only to describe the existing distribution of variables without much regard to causal relationships (Porta et al., 2014, p. 72). They are used to monitoring the population, planning, and generating hypothesis (Grimes and Schulz, 2002).</p> <p>Incidence or prevalence study without comparison group In population at one particular time, what is happening in a population, e.g., frequencies of factors (importance of problems), is described (portrayed).</p> <p>Survey “Research method by which information is gathered by asking people questions on a specific topic and the data collection procedure is standardized and well defined.” (Bennett et al., 2011, p. 3).</p> <p>Case series A collection of individuals with similar characteristics are used to describe an outcome.</p> <p>Case report An individual or a group with a unique/unusual outcome is described in detail.</p>	<p>4.1. Is the sampling strategy relevant to address the research question?</p> <p>Explanations Sampling strategy refers to the way the sample was selected. There are two main categories of sampling strategies: probability sampling (involve random selection) and non-probability sampling. Depending on the research question, probability sampling might be preferable. Nonprobability sampling does not provide equal chance of being selected. To judge this criterion, consider whether the source of sample is relevant to the target population; a clear justification of the sample frame used is provided; or the sampling procedure is adequate.</p>
	<p>4.2. Is the sample representative of the target population?</p> <p>Explanations There should be a match between respondents and the target population. Indicators of representativeness include: clear description of the target population and of the sample (such as respective sizes and inclusion and exclusion criteria), reasons why certain eligible individuals chose not to participate, and any attempts to achieve a sample of participants that represents the target population.</p>
	<p>4.3. Are the measurements appropriate?</p> <p>Explanations Indicators of appropriate measurements include: the variables are clearly defined and accurately measured, the measurements are justified and appropriate for answering the research question; the measurements reflect what they are supposed to measure; validated and reliability tested measures of the outcome of interest are used, variables are measured using ‘gold standard’, or questionnaires are pre-tested prior to data collection.</p>
	<p>4.4. Is the risk of nonresponse bias low?</p> <p>Explanations Nonresponse bias consists of “an error of nonobservation reflecting an unsuccessful attempt to obtain the desired information from an eligible unit.” (Federal Committee on Statistical Methodology, 2001, p. 6). To judge this criterion, consider whether the respondents and nonrespondents are different on the variable of interest. This information might not always be reported in a paper. Some indicators of low nonresponse bias can be considered such as a low nonresponse rate, reasons for nonresponse (e.g., noncontacts vs. refusals), and statistical compensation for nonresponse (e.g., imputation).</p> <p>The nonresponse bias is might not be pertinent for case series and case report. This criterion could be adapted. For instance, complete data on the cases might be important to consider in these designs.</p>
	<p>4.5. Is the statistical analysis appropriate to answer the research question?</p> <p>Explanations The statistical analyses used should be clearly stated and justified in order to judge if they are appropriate for the design and research question, and if any problems with data analysis limited the interpretation of the results.</p>

5. Mixed methodMixed methods studies	Methodological quality criteria
<p>Mixed methodMixed methods (MM) research involves combining qualitative (QUAL) and quantitative (QUAN) methods. In this tool, to be considered MM, studies have to meet the following criteria (Creswell and Plano Clark, 2017): (a) at least one QUAL method and one QUAN method are combined; (b) each method is used rigorously in accordance to the generally accepted criteria in the area (or tradition) of research invoked; and (c) the combination of the methods is carried out at the minimum through a MM design (defined <i>a priori</i>, or emerging) and the integration of the QUAL and QUAN phases, results, and data.</p> <p>Common designs include (this list if not exhaustive):</p> <p>Convergent design The QUAL and QUAN components are usually (but not necessarily) concomitant. The purpose is to examine the same phenomenon by interpreting QUAL and QUAN results (bringing data analysis together at the interpretation stage), or by integrating QUAL and QUAN datasets (e.g., data on same cases), or by transforming data (e.g., quantization of qualitative data).</p> <p>Sequential explanatory design Results of the phase 1 - QUAN component inform the phase 2 - QUAL component. The purpose is to explain QUAN results using QUAL findings. E.g., the QUAN results guide the selection of QUAL data sources and data collection, and the QUAL findings contribute to the interpretation of QUAN results.</p> <p>Sequential exploratory design Results of the phase 1 - QUAL component inform the phase 2 - QUAN component. The purpose is to explore, develop and test an instrument (or taxonomy), or a conceptual framework (or theoretical model). E.g., the QUAL findings inform the QUAN data collection, and the QUAN results allow a statistical generalization of the QUAL findings.</p>	<p>5.1. Is there an adequate rationale for using a mixed methodMixed methods design to address the research question? Explanations The reasons for conducting a mixed methodMixed methods study should be clearly explained. Several reasons can be invoked such as to enhance or build upon qualitative findings with quantitative results and vice versa; to provide a comprehensive and complete understanding of a phenomenon or to develop and test instruments (Bryman, 2006).</p>
	<p>5.2. Are the different components of the study effectively integrated to answer the research question? Explanations Integration is a core component of mixed methodMixed methods research and is defined as the “explicit interrelating of the quantitative and qualitative component in a mixed methodMixed methods study” (Plano Clark and Ivankova, 2015, p. 40). Look for information on how qualitative and quantitative phases, results, and data were integrated (Hong et al., 2018). For instance, how data gathered by both research methods was brought together to form a complete picture (e.g., joint displays) and when integration occurred (e.g., during the data collection-analysis or/and during the interpretation of qualitative and quantitative results).</p>
	<p>5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted? Explanations This criterion is related to meta-inference, which is defined as the overall interpretations derived from integrating qualitative and quantitative findings (Teddlie and Tashakkori, 2009). Meta-inference occurs during the interpretation of the findings from the integration of the qualitative and quantitative components and shows the added value of conducting a mixed methodMixed methods study rather than having two separate studies.</p>
	<p>5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed? Explanations When integrating the findings from the qualitative and quantitative components, divergences, and inconsistencies (also called conflicts, contradictions, discordances, discrepancies, and dissonances) can be found. It is not sufficient to only report the divergences; they need to be explained. Different strategies to address the divergences have been suggested such as reconciliation, initiation, bracketing and exclusion (Pluye et al., 2009b). Rate this criterion ‘Yes’ if there is no divergence.</p>
	<p>5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved? Explanations The quality of the qualitative and quantitative components should be individually appraised to ensure that no important threats to trustworthiness are present. To appraise 5.5, use criteria for the qualitative component (1.1 to 1.5), and the appropriate criteria for the quantitative component (2.1 to 2.5, or 3.1 to 3.5, or 4.1 to 4.5). The quality of both components should be high for the mixed methodMixed methods study to be considered of good quality. The premise is that the overall quality of a mixed methodMixed methods study cannot exceed the quality of its weakest component. For example, if the quantitative component is rated high quality and the qualitative component is rated low quality, the overall rating for this criterion will be of low quality.</p>

Algorithm for selecting the study categories to rate in the MMAT*

- Set of criteria in the MMAT**
- 1** Qualitative studies
 - 2** Randomized controlled trials
 - 3** Non-randomized studies
 - 4** Quantitative descriptive studies
 - 5** Mixed methods studies



ADDENDUM C - JBI CRITICAL APPRAISAL TOOL FOR SYSTEMATIC REVIEWS



a

CHECKLIST FOR SYSTEMATIC REVIEWS AND RESEARCH SYNTHESES

Critical Appraisal tools for use in JBI Systematic Reviews

JBI CRITICAL APPRAISAL CHECKLIST FOR SYSTEMATIC REVIEWS AND RESEARCH SYNTHESSES

Reviewer _____ Date _____

Author _____ Year _____ Record Number _____

	Yes	No	Unclear	Not applicable
Is the review question clearly and explicitly stated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were the inclusion criteria appropriate for the review question?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the search strategy appropriate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were the sources and resources used to search for studies adequate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were the criteria for appraising studies appropriate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was critical appraisal conducted by two or more reviewers independently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were there methods to minimize errors in data extraction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were the methods used to combine studies appropriate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the likelihood of publication bias assessed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were recommendations for policy and/or practice supported by the reported data?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were the specific directives for new research appropriate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Overall appraisal: Include Exclude Seek further info

Comments (Including reason for exclusion)

REFERENCES

Whiting P, Rutjes AWS, Reitsma JB, Bossuyt PMM, Kleijnen J. The development of QUADAS: a tool for the quality assessment of studies of diagnostic accuracy included in systematic reviews. *BMC Medical Research Methodology*, 2003(3):25. doi:10.1186/1471-2288-3-25.

ADDENDUM D - QUALITY APPRAISAL

1. Aaberg, 2016. The state of sexuality education...	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	X			
	S2. Do the collected data allow to address the research questions?	X			
	<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>				<i>Include</i>
Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	X			
	4.2. Is the sample representative of the target population?	X			
	4.3. Are the measurements appropriate?	X			
	4.4. Is the risk of nonresponse bias low?	X			
	4.5. Is the statistical analysis appropriate to answer the research question?	X			7/7

2. Eickhoff, 2021 Identifying gaps in LGBTQ health education...	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	X			
	S2. Do the collected data allow to address the research questions?	X			
	<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>				<i>Include</i>
Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	X			
	4.2. Is the sample representative of the target population?	X			
	4.3. Are the measurements appropriate?	X			
	4.4. Is the risk of nonresponse bias low?	X			
	4.5. Is the statistical analysis appropriate to answer the research question?	X			7/7

3. Elertson & McNiel, 2021 Educating future nurses...	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	X			
	S2. Do the collected data allow to address the research questions?	X			
	<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>				<i>Include</i>
Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?	X			
	5.2. Are the different components of the study effectively integrated to answer the research question?	X			
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	X			
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?			X	
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	X			6 1/2/7

4. Hand & Gedzyk-Nieman Graduating nursing students' preparedness...	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	X			
	S2. Do the collected data allow to address the research questions?	X			
	<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>				<i>Include</i>
Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	X			
	4.2. Is the sample representative of the target population?	X			
	4.3. Are the measurements appropriate?	X			
	4.4. Is the risk of nonresponse bias low?	X			
	4.5. Is the statistical analysis appropriate to answer the research question?	X			7/7

5 Koch <i>et al.</i> , 2021 Role-play simulation...	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	X			
	S2. Do the collected data allow to address the research questions?	X			
	<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>				<i>Include</i>
Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?			X	
	5.2. Are the different components of the study effectively integrated to answer the research question?	X			
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	X			
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?			X	
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	X			6/7

6	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Maruca <i>et al.</i> , 2018 Using simulation with nursing students...					
Screening questions (for all types)	S1. Are there clear research questions?	X			
	S2. Do the collected data allow to address the research questions?	X			
	<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>				Include
Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	X			
	4.2. Is the sample representative of the target population?	X			
	4.3. Are the measurements appropriate?	X			
	4.4. Is the risk of nonresponse bias low?	X			
	4.5. Is the statistical analysis appropriate to answer the research question?	X			7/7
7	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
McCann & Brown 2018 The inclusion of LGBT+ health issues...					
Screening questions (for all types)	S1. Are there clear research questions?	X			
	S2. Do the collected data allow to address the research questions?	X			
	<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>				Include
Systematic review	4.1. Is the review question clearly and explicitly stated?	X			
	4.2. Were the inclusion criteria appropriate for the review question?	X			
	4.3. Was the strategy appropriate?	X			
	4.4. Were the sources and resources used to search for studies adequate?	X			
	4.5. Were the criteria for appraising studies appropriate?	X			
	4.6. Was critical appraisal conducted by two or more reviewers independently?	X			
	4.7. Were there methods to minimize errors in data extraction?	X			
	4.8. Were the methods used to combine studies appropriate?	X			
	4.9. Was the likelihood of publication bias assessed?	X			
	4.10. Were recommendations for policy and/or practice supported by the reported data?	X			
	4.11. Were the specific directives for the new research appropriate?	X			7/7

8 McNiel & Elertson, 2018 Advocacy and awareness: ...	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?		X		Not methodologically sound
	S2. Do the collected data allow to address the research questions?		X		0/7
<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>					Exclude

9 Shortall, 2019 Teaching and Evaluation/ Assessment Requirement...	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	X			
	S2. Do the collected data allow to address the research questions?	X			
	<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	X			
	4.2. Is the sample representative of the target population?	X			
	4.3. Are the measurements appropriate?	X			
	4.4. Is the risk of nonresponse bias low?	X			
	4.5. Is the statistical analysis appropriate to answer the research question?	X			

10 White et al., 2020 A sexual health course advanced practice...	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	X			
	S2. Do the collected data allow to address the research questions?	X			
	<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	X			
	4.2. Is the sample representative of the target population?	X			
	4.3. Are the measurements appropriate?	X			
	4.4. Is the risk of nonresponse bias low?	X			
	4.5. Is the statistical analysis appropriate to answer the research question?	X			7/7

ADDENDUM E - EXTRACTION TABLE

Citation Number and Bibliographical details	Approach – Design – Method Population and Sampling, Ethical Considerations	Study - Aim - Objectives	Country - Location	Publication relevance to Review	Research Findings and Recommendations	Limitations
<p>Number 1 Aaberg, V., 2016. The state of sexuality education in baccalaureate nursing programs. Nurse education today, 44, pp.14-19.</p>	<p>Approach Quantitative</p> <p>Design Exploratory, descriptive study</p> <p>Method Online email survey with closed and open questions.</p> <p>Population 640 baccalaureate nursing programmes in the USA Nursing faculty - Nurse educators - The number of subjects invited to participate 300 as homogeneity of the sample was assumed</p> <p>Sampling Purposive sampling Sample = 44 participants from 44 separate</p>	<p>Purpose The purpose of this descriptive study is to discover the amount and focus of sexuality content taught currently and to identify barriers to the inclusion of sexuality education in baccalaureate nursing programmes in the United States</p>	<p>United States.</p>	<p>Inclusion of LGBTI content in baccalaureate nursing programmes in the United States. (Undergraduate curriculum)</p>	<p>Curricular content in Table 2, p16</p> <p>Research Findings The current state of sexuality education in nursing programmes in the United States was examined and found to be lacking consistent and adequate information.</p> <p>86.5% of participants reported that LGBT content should be part of the nursing curriculum. 82% of participants reported they would be comfortable teaching sexuality content, 9% said they would not, and another 9% reported they would possibly be comfortable teaching sexuality content.</p> <p>Only 16% of nurse educator participants believe their students are prepared to deal with sexuality issues in the clients they work with and 27% report that sexuality</p>	<p>The small sample size</p> <p>This study was completed in the United States; therefore the results cannot be generalized to nursing education in other countries.</p> <p>When responding to the questions - the author would have liked to have offered more possible responses including pharmacology</p>

	<p>programmes responded to the survey for a 14.67% response rate</p> <p>Analysis Survey monkey – basic tally and basic arithmetic to calculate means and percentages. Open-ended questions – content analysis for responses through identifying themes.</p> <p>Ethics IRB approval.</p>				<p>content is not part of their curriculum.</p> <p>Some programmes do not cover content such as LGBT sexual health, normal sexual function, and taking a sexual history.</p> <p>Barriers to sexuality education include lack of time, higher priority given to other content, and lack of comfort with the topic.</p> <p>Conclusion In 1974 the WHO strongly recommended that nurse educators address knowledge, skills, attitudes, and values around sexuality. More than 40 years later, 84% of nurse educators reported their students are not prepared to address the sexuality concerns of clients. Failure to prepare nursing students in this critical area has serious consequences for public health. More thorough and consistent sexuality education in nursing programmes is urgently needed so that graduate nurses will be prepared to address sexuality issues professionally and</p>	<p>More free-text type questions and fewer closed questions would have provided broader information</p>
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					comfortably in ways that reflect the high expectations and trust level of their clients	
					<p>Recommendations</p> <p>A set of guidelines for appropriate sexuality education in American nursing programmes may help to make the teaching of sexuality content more thorough, consistent, and appropriate</p>	
<p>Number 4 Eickhoff, C., 2021. Identifying gaps in LGBTQ health education in baccalaureate undergraduate nursing programs. Journal of Nursing Education, 60(10), pp.552-558.</p>	<p>Design Cross sectional descriptive design</p> <p>Approach Quantitative</p> <p>Method Online email survey with closed and open questions</p> <p>Sampling Purposive</p> <p>Population 887 CCNE-accredited schools with undergraduate and baccalaureate nursing programmes</p> <p>Analysis Statistical analysis – SPSS version 26</p>	<p>Objectives Hours spent on content Topics Taught Are schools considering expanding on LGBTI content Do any demographic factors present barriers</p>	USA	Time spent and barriers to the current LGBTI content in the Undergraduate nursing programme	<p>Curricular content in Table 1, p556 and Figure 1, p554</p> <p>Findings Content widely taught – LGBTI health disparities. IPV and mental health issues. 53%</p> <p>65 students at Nursing schools contracted into the study indicated – no sufficient content related LGBTI</p> <p>80 schools agree that there is capacity to expand LGBTI inclusivity</p> <p>Close to 70 schools indicated that Nur School leadership’s reluctance to commit to LGBTI inclusivity</p>	<p>No valid survey tool cited-no metrics available</p> <p>Number of responses = generalisability</p> <p>Time – L in south Lower than 5% MOE – actual 7.6%</p>

Tool used in Assessment

Self-developed tool
6-point Likert Scale type Q's
Variable - Time spent on content
Uncertain Type, nature – in relation to barriers.136

Larger schools = more inclusive

2/3 schools indicated - not prepared, not doing enough

Content not always consistently or comprehensively provided

Recommendations

More education on the LGBTQ population's health needs necessary for nursing students

Faculty need continuing education

Faculty and students would benefit from succinct and nursing-focused educational materials

Curricular review – more often

More institutional applicability.

New didactic approaches

Limitation

- No validated tool available, no metrics
- No. of responses not sufficient to reach 5% margin of error

					<ul style="list-style-type: none"> - Strong possibility of self-selection bias – views often socially charged (+/-) were asked to answer on behalf of the school, thus not representative 	
<p>Number 5 Elertson, K. and McNiel, P.L., 2021. Answering the call: Educating future nurses on LGBTQ healthcare. Journal of homosexuality, 68(13), pp.2234-2245.</p>	<p>Design Not mentioned</p> <p>Approach Mixed method</p> <p>Method Online email survey Deidentified journal entries</p> <p>Population Students; Nursing baccalaureate nursing programme [Staff and Faculty for Equality (SAFE) training developed the material/curriculum]</p> <p>Sampling A convenience sample of Senior 1 level baccalaureate nursing students (N = 51) - homogeneously comprised of Caucasian,</p>	<p>Objectives to evaluate student response to the revised curriculum. to increase LGBTQ cultural awareness and ally training for nurses with a focus on the student nurse transitioning into the professional role.</p>	USA	<p>Responses of students in relation to the inclusion of LGBTI content within the Undergraduate nursing programme</p> <p>SAFE toolkit was used to develop curriculum</p>	<p>Findings Quantitative data regarding achievement of stated objectives, enhanced knowledge, increased awareness, and clinical relevance were collected via electronic survey and summarized</p> <p>Survey results indicated 88% (n/N = 29/33) increased awareness of health disparities</p> <p>82% (n/N = 27/33) verbalize increased awareness of health services</p> <p>85% (n/N = 28/33) able to identify two methods to engage individuals who identify as LGBTQ</p> <p>67% (n/N = 22/33) gained one or more ideas or approaches to care in their practice</p>	<p>The sample size was limited with one university of senior 1 nursing students in a baccalaureate nursing programme.</p> <p>Majority of the students in this cohort were female, single, and living independently</p> <p>The debriefing time of twenty minutes could have been doubled.</p> <p>The electronic survey and learning</p>

	<p>cisgender females and males</p> <p>Analysis Qualitative data - content analysis to identify themes and patterns Quantitative data – descriptive analysis with means and percentages</p> <p>Ethics Approval for a minimal risk protocol from the university Institutional Review Board (IRB),</p>				<p>Qualitative findings were organized into the following themes:</p> <ul style="list-style-type: none"> • knowledge (is power) • experience (influences) • advocacy (in practice) <p>Students reported positive experiences and increased knowledge through attending the training.</p> <p>Recommendations The results of this pilot education highlight the need for a more inclusive nursing education curriculum related to LGBTQ health.</p>	<p>reflection were optional and therefore limited the responses</p>
<p>Number 6 Hand, M.C. and Gedzyk-Nieman, S., 2022. Graduating nursing students' preparedness and comfort level in caring for LGBTQ+ patients. Journal of Professional Nursing, 41, pp.75-80.</p>	<p>Design Multisite descriptive correlational design.</p> <p>Approach Quantitative</p> <p>Method Survey</p> <p>Population total of 1350 nursing schools were queried to participate in the study.</p> <p>Sampling</p>	<p>Purpose The purpose of this study was to conduct a national survey of graduating prelicensure nursing students to assess their perceived preparedness for and comfort level with providing care for LGBTQ+ patients</p>	<p>USA</p>	<p>LGBTI content in prelicensure nursing programmes nationally</p>	<p>Curricular content in Table 2, p77</p> <p>Findings In regard to overall preparedness, 49% of participants felt somewhat prepared and 34% felt prepared to care for LGBTQ+ patients, although 55% indicated that their level of preparedness was not attributed to their nursing education</p>	<p>Limitations Deans/directors for survey distribution</p> <p>Relied on student recall</p> <p>Excluded: - students from RN to BSN, LPN, and diploma programmes were not invited</p>

	<p>The sample included part-time or full-time prelicensure nursing students graduating from their nursing programme.</p> <p>Participants who indicated that they were graduating from a diploma program, a total of 359 participants were included in the study. The demographic characteristics of the sample.</p> <p>Tool Lesbian, Gay, Bisexual, & Transgender Medical Education Assessment (LGBT-MEA).</p> <p>The original 23-item questionnaire given a 3-point Likert scale rating their level of preparedness from “prepared,” “insufficiently prepared,” or “not prepared,” as well as the option of “I don’t know.”</p> <p>Reduced to 18 items – revised the language to</p>	<p>Aims/Objectives Specific aims were to examine participant demographic variables in relation to participants' perceived preparedness and comfort levels regarding provision of care</p>			<p>Participants in this study who (a) identified as part of the LGBTQ+ community or (b) knew someone in this community felt more prepared for and comfortable with providing LGBTQ+ patient care.</p> <p>Recommendations Consider a comprehensive and integrative approach to the inclusion of these topics as programmes begin to address the new American Association of Colleges of Nursing (AACN) Essential (2021). Placing these topics in one course or at one level of the programme are insufficient and ineffective, especially as programmes shift to competency-based education.</p> <p>Programmes should also seek out clinical sites that specialize in LGBTQ+ care or are specifically associated with LGBTQ+ communities to allow students more opportunities to enhance their knowledge and confidence.</p> <p>Nursing faculty should examine their own knowledge</p>	
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	<p>reflect nursing and incorporate Q+ Added 3 open-ended questions re preparedness Cronbach alpha</p> <p>Analysis Descriptive statistics – IBM SPSS version 27.0 An independent samples t-test was conducted to compare participants who identified as heterosexual to LGBTQ+ participants on their self-reported levels of preparedness. A series of Pearson correlations and one-way analyses of variance (ANOVAs) were conducted to determine whether there were any associations or differences in preparedness and comfort based on age, race, and gender</p> <p>Ethics East Carolina University and Duke University IRB</p>				<p>and comfort level as they prepare to incorporate LGBTQ+ health topics into their curriculum.</p>	
<p>Number 7 Koch, A., Ritz, M., Morrow, A., Grier, K. and McMillian-Bohler, J.M., 2021.</p>	<p>Design Pre-test/post-test Approach</p>	<p>Research question</p>	<p>USA</p>	<p>LGBTI content with a focus on</p>	<p>Significant impact om K – 10 = extremely helpful</p>	<p>The context and specific geographical</p>

<p>Role-play simulation to teach nursing students how to provide culturally sensitive care to transgender patients. Nurse education in practice, 54, p.103123.</p>	<p>Mixed method</p> <p>Method Culturally intelligent LGBTQIA+ health care provider education simulation roleplay scenario developed with post simulation survey (3 questions, p3) Scale of 0 (not helpful) -10 (extremely helpful)</p> <p>Population N = 72 students in class (Accelerated Bachelor of Science in Nursing Programme)</p> <p>Sampling n = 29 26 completed the survey</p> <p>Analysis Thematic content analysis of qualitative data Descriptive statistics</p> <p>Ethics University IRB approved</p>	<p>Will a transgender simulation better equip students with the ability to conduct culturally sensitive assessments and provide support to transgender patients in the hospital?</p>		<p>cultural competencies.</p> <p>(Done with associate degree graduates = comparable to RSA Staff Nurse)</p>	<p>41.67% (N = 10) - extremely helpful for their education (M = 8.29, SD= 1.93, Min =3, Max= 10, N = 26). 87.5% (N = 21) had a score of at least 6 or above on the scale 12.5% (N = 3) selecting 5 or below.</p> <p>Although we were unable to compare the findings with statistics that showed nursing student's knowledge before the simulation, the qualitative data support evidence that the simulation positively affected comfort and confidence in (a) caring for a patient who is transgender, and (b) engaging a colleague in a difficult conversation about insensitivity and the need for culturally sensitive care.</p> <p>5 themes:</p> <ul style="list-style-type: none"> - History of discrimination - Support (family, friends, community) - Use of pronouns - Insecurity and fear of making mistakes - Hospital policies may not be inclusive 	<p>focus mean that the findings cannot be generalised.</p> <p>Participants comfort, knowledge was not gauged</p> <p>No pre-test results to compare with post intervention.</p>
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<p>Number 8 Maruca, A.T., Diaz, D.A., Stockmann, C. and Gonzalez, L., 2018. Using simulation with nursing students to promote affirmative practice toward the lesbian, gay, bisexual, and transgender population: A multisite study. Nursing Education Perspectives, 39(4), pp.225-229.</p>	<p>Design A descriptive pre-test/post-test, nonexperimental research design</p> <p>Approach Quantitative</p> <p>Method A transgender simulation was created to provide students with the opportunity to establish therapeutic communication and to assess anxiety levels while providing safe care. Students completed both a pretest and posttest survey.</p> <p>Population Undergraduate prelicensure BSN nursing students from two different state university systems, one in Connecticut and one in Florida.</p> <p>Sampling A convenience sample of students in their psychiatric mental</p>	<p>Purpose/question The aims of this study are to promote nursing students' knowledge, skills, and attitude in caring for LGBT persons and to determine if they demonstrate affirmative practice after a simulation.</p>	<p>USA</p>	<p>LGBTI simulation as didactic modality for undergraduate prelicensure to evaluate the impact of a transgender simulation on nursing students' affirmative practice when caring for a transgender person.</p>	<p>Findings A Wilcoxon signed-rank test revealed a statistically significant increase in GAP scores after the simulation.</p> <p>The median score on the overall GAP scale increased from 114 before to 125 after the simulation.</p> <p>The simulation supported nursing students' interactions and affirmative practice when providing nursing care to a transgender person.</p> <p>The results suggest a significant positive change in affirmative practice after the simulation but no significant difference in attitudes and beliefs from pretest to posttest.</p> <p>Simulation is an effective teaching strategy that can be readily incorporated into the nursing curriculum. Experiential learning is an effective approach to teach cultural competence and sensitivity in caring for vulnerable populations. It will also be important to examine</p>	<p>There was a large dropout rate. The GAP instrument could have presented limitations with nursing students with only two semesters of clinical practice and minimal exposure to the LGBT population.</p>
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	<p>health didactic and clinical course was recruited</p> <p>Data Collection Tool The Gay Affirmative Practice (GAP)30-item self-report survey.</p> <p>Analysis Descriptive statistics were done using Statistical Package for the Social Science (SPSS) version 23. Wilcoxon signed-rank test.</p> <p>Ethics IRB approved</p>				<p>faculty perceptions and knowledge base with this population to promote better learning for nursing students.</p> <p>Recommendations Training faculty is as important as educating students. Using this simulation with nurse faculty can be easily operationalized and important step to ensure they are supportive and engage in integrating LGBT education in other nursing courses. Creating different scenarios that cover issues across the lifespan, such as LGBT youths, and to address the complexities of health care needs such as surgeries for a transgender person who is in the process of transition are other ways to further advance this study. Nurse educators are encouraged to identify ways to include this content in their respective nursing programmes.</p>	
<p>Number 9 McCann, E. and Brown, M., 2018. The inclusion of LGBT+ health</p>	<p>Approach Mixed method</p> <p>Design</p>	<p>Purpose/question The aim of this systematic review was to examine</p>	<p>UK Ireland</p>	<p>Identification education and training requirements of</p>	<p>Findings Four main themes were identified: (1) Cultural competence and inclusivity.</p>	<p>The review is limited by the paucity of studies,</p>

<p>issues within undergraduate healthcare education and professional training programmes: A systematic review. Nurse education today, 64, pp.204-214.</p>	<p>A systematic review of the available published empirical studies.</p> <p>Method The systematic review was guided by recognised methods that supported the development of ‘mapping’ and ‘narrative integration’ of the data.</p> <p>Population and Sampling Studies that included the views of undergraduate students and healthcare professionals and educators regarding LGBT+-specific issues. of the following databases: CINAHL, PubMed, PsycINFO, Embase and Sociological Abstracts. All papers reviewed were from the years 2007 to 2017 and written in English.</p> <p>Analysis The process of data analysis and synthesis involved the extrapolation of themes that addressed the aims of the research. These were</p>	<p>the education and training requirements of undergraduate students and health professionals regarding the inclusion of LGBT+ health issues.</p> <ol style="list-style-type: none"> 1. What are the education and training requirements of undergraduate students and health professionals regarding the needs of LGBT+ people? 2. What are the approaches utilized in the education and training of undergraduate students and health professionals regarding the needs of LGBT+ people? 3. What are the best practice examples of the 		<p>undergraduate students and health professionals regarding the inclusion of LGBT+ health issues.</p>	<p>(2) Existing knowledge of LGBT+ health-related issues. (3) Curriculum developments and outcomes. (4) Evidence of best practice in education delivery and evaluation.</p> <p>Significant gaps in the development of cultural competence in LGBT+ health issues for undergraduate students and practitioners and the limited availability of appropriate education and training opportunities.</p> <p>Recommendations Developing curricula that is influenced by the latest evidence and include learning about key terminology, stigma and discrimination, sexuality and sexual concerns, talking about sex and LGBT+-specific health issues and health disparities.</p> <p>Educational programmes should be supported by professional Organisations.</p> <p>Development and inclusion of LGBT+-specific needs and</p>	<p>beyond the USA, where most had been conducted.</p>
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	coded from the results of the included studies, organised according to concepts and verified and agreed by the two researchers.	education and training of undergraduate students and health professionals?			issues within undergraduate, postgraduate and continuing professional development (CPD) programmes. Inter-professional teaching and learning approaches could be utilized to support practitioners to develop awareness, clinical expertise and skills to work competently, ethically and effectively with LGBT+ clients and their families.	
<p>Number 11</p> <p>Shortall, Chris, 2019. "Teaching and Evaluation/Assessment Requirements for LGBTQI2S+ Health and Wellness: A Call to Include LGBTQI2S+ Content in Canadian English Baccalaureate Nursing Curricula / Exigences en matière. Quality Advancement in Nursing Education - Avancées en formation infirmière: Vol. 5: Iss. 1, Article 7. DOI: https://doi.org/10.17483/2368-6669.1169</p>	<p>Design Critical discourse analysis</p> <p>Approach Mixed method</p> <p>Method Online survey on LimeSurvey – adapted questionnaire by Obedin-Maliver <i>et al.</i> (2011)</p> <p>Critical discourse analysis (CDA)- professional nursing education policy documents</p> <p>Population</p>	<p>Research question</p> <p>What information on sexuality and gender identity health and wellness exists in Canadian English baccalaureate nursing programmes and related policy?</p>	Canada	Inclusion of LGBTI content across baccalaureate nursing programmes.	<p>Findings (p4-8)</p> <p>Refer to Table 1, p5 – Inclusion of LGBTQI2S+ content in curriculum</p> <p>Survey - While not all the institutions educate on these fundamental sexual health issues, there was greater variety in institutions reporting LGBTQI2S+ health and wellness issues. Content location and particularities varied greatly depending on the instructor and their comfort level with the topics.</p> <p>Half of respondents reported “barriers to accessing medical care for LGBTQI2S+ people” and “chronic diseases relevant to LGBTQI2S+</p>	<p>Study was conducted by a student in Applied Health Services Research with no experience in the formal structure and organization of nursing curricula or nursing policy</p> <p>Topic area is being addressed faster than research can be conducted and published.</p>

	<p>Seventy-six (76) institutions teaching Canadian English-language BN programmes</p> <p>Sampling Seventeen (17) institutions responded (some provided multiple responses), and 24 completed surveys were returned (some institutions sent multiple responses)</p> <p>Survey – online search of listed BN programmes – grouped and coded (p6)</p> <p>CDA – snowball sampling – 52 Provincial and national documents (p7)</p> <p>Analysis Quantitative data? Qualitative data - Critical discourse</p>				<p>people” were covered in a required course, the other half said they are not in the curriculum at all.</p> <p>Rarely addressed - transitioning, Sex Reassignment Surgery.</p> <p>Some nursing school leadership admitted to not doing it well or avoiding it because of a lack of comfort or knowledge in the area.</p> <p>Nursing leadership reported limited opportunities for faculty to engage in continuing professional development in the area.</p> <p>Discourse analysis - None of the reviewed CNA documents adequately referenced sexuality and gender identity even when opportunities presented themselves (p7)</p> <p>The only articulated LGBTQI2S+ policy document identified during the research (2013-2016) was the Registered Nurses’ Association of Ontario Position Statement on</p>	<p>As well, nursing education is changing faster than research can be completed</p> <p>The survey also did not ask the respondents the number of years teaching or other faculty</p> <p>Demographic information that may have been useful.</p>
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	<p>analysis (qualitative analysis of textual data to identify prominent themes in written materials)</p> <p>Ethics Approval granted by the university</p>				<p>Respecting Sexual Orientation and Gender Identity (2007).</p>	
<p>Number 13</p> <p>White, B.P., Abuelezam, N.A., Dwyer, A.A. and Fontenot, H.B., 2020. A sexual health course for advanced practice registered nurses: effect on preparedness, comfort, and confidence in delivering comprehensive care. Nurse Education Today, 92, p.104506.</p>	<p>Design Descriptive, pre-post-intervention survey study design</p> <p>Approach Quantitative</p> <p>Method Online survey before attending the course (pre-test for baseline measures) and on completion (post-test) via Qualtrics®</p> <p>Population</p>	<p>Aim</p> <p>To evaluate the effectiveness of a new sexual health course for graduate students in improving nurses' knowledge, preparedness, comfort, and confidence in delivering comprehensive, culturally informed sexual healthcare.</p>		<p>LGBTI content in the Postgraduate nursing programme (Advanced practice registered nurses)</p>	<p>Findings</p> <p>Course content in Box 1, p2</p> <p>The majority of participants (72%) were younger than 30, non-Hispanic white (88%), identified as female (91%), and heterosexual (90%).</p> <p>Preparedness- At baseline, the majority of participants in both groups reported not feeling prepared (intervention: 2.87 ± 1.17, control: 2.73 ± 1.14). At course completion, participants in the intervention group reported significantly higher ratings of preparedness for delivering sexual healthcare (mean</p>	<p>Participants were relatively homogenous</p> <p>Some study design issues may limit generalizability of study findings.</p> <p>Sampling was not random and we only included APRN students (not undergraduate students).</p> <p>Potential risk of selection bias (i.e. students</p>

	<p>Advanced practice registered nurses attending sexual health course offered in spring 2018 at a medium-sized, Catholic Jesuit university with a nursing program</p> <p>Sampling</p> <p>Convenient</p> <p>T – n = 30 Graduate nursing students enrolled in the course (intervention group, n = 30) were recruited.</p> <p>C- n = 64 Graduate students enrolled at the institution but not enrolled in the course served as controls (n = 64).</p> <p>Variables</p> <p>Control – Graduate nurses not having had exposure to LGBTI health content - Course</p>			<p>difference (MD) = 1.50, 95% CI: 1.03–1.97, p < 0.05)</p> <p>Knowledge – baseline - (intervention: 94.2%, control: 92.7%). No significant change in post-test/ intervention results.</p> <p>Comfort - discussions about sexual health was moderate for both groups at baseline (intervention: 3.43 ± 1.19, control: 3.50 ± 1.05, N.S.). intervention group reported significantly higher comfort ratings (general and all sub-categories) on post-test</p> <p>Confidence - At baseline, all participants reported low confidence in providing sexual healthcare. After completing the course, students in the intervention group were more confident providing care, performing assessments, and describing sexual health disparities for all categories of patients compared to the control group.</p>	<p>with a strong interest in sexual health were registered for the course).</p> <p>Lastly, the number of participants identifying as non-heterosexual was too small to enable analysis for this population.</p>
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	<p>Test Group – Graduate nurses enrolled in the course</p> <p>Data Collecting tool Self-developed tool, guided by Theory of Planned Behavior (TPB)</p> <p>5-point Likert scale</p> <p>Statistical Analysis Statistical, multivariate analyses.</p> <p>Data consolidation- with SPSS version 24 (IBM, Armonk,</p> <p>Binomial linear regression was employed to evaluate the relationship between ‘religiosity’ and the outcome variables</p> <p>Outcome variables (overall preparedness, comfort, and confidence) remained in a five-point Likert format.</p> <p>Independent sample Student's t-tests were used to examine baseline</p>				<p>Recommendations</p> <p>Future studies should include a more diverse student body (racial/ ethnic diversity,</p> <p>There are novel opportunities to build multidisciplinary educational teams for cross-discipline learning and assess curriculum and new educational models across medical and nursing curriculum.</p> <p>Continue to explore best practices to educate all health providers to provide sexual health care for diverse populations</p>	
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differences between intervention and control groups.

Results with a p value of <0.05 were considered statistically significant.

Ethics

Approved by the Institutional Review Board
- Informed consent on first page
- no personal information asked

ADDENDUM F - JBI MIXED METHOD DATA EXTRACTION FORM FOLLOWING A CONVERGENT INTEGRATED APPROACH

Note: *This form should only be used for reviews that follow a convergent integrated approach, i.e. integration of qualitative data and 'qualitized' data following data transformation. For reviews that follow a convergent segregated approach, reviewers should use separate data extraction forms: the JBI quantitative data extraction tool and the JBI qualitative data extraction tool.*

Review Title:

Reviewer: Date:

Author(s) of the publication:

Journal Record Number:

Type of study

<input type="checkbox"/>	Quantitative study
<input type="checkbox"/>	Qualitative study
<input type="checkbox"/>	Mixed method/Mixed methods study
<input type="checkbox"/>	Review Study

Methodology: (e.g. randomized controlled trial, phenomenology).

Number of participants:

Characteristics of participants:

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Phenomena of interest:

Results:

Qualitative – Report on Themes and Sub-themes.

Quantitative – Report on Stats

Author's conclusions - Outcomes or findings of significance to the review objective

Reviewer's Comments

ADDENDUM G - DATA EXTRACTION - REVIEW MATRIX

Publications identified	Title	Method and Design	5.3.1 Contextual characteristics of selected studies/publications.	5.3.2 Existing knowledge on LGBTI inclusivity in nursing programmes	5.3.3 The Role of the Nurse	5.3.3 Developing cultural competency	5.3.4 Curriculum development	5.3.5 Effective teaching and learning strategies	5.3.6 Barriers to LGBTI inclusion	5.3.7 Benefits of LGBTI inclusion
Number 1 Aaberg, V., 2016.	The state of sexuality education in baccalaureate nursing programs. Nurse education today, 44, pp.14-19.	Quantitative Explorative, descriptive	Nurse educators were contracted to the study to investigate the amount and focus of sexuality content taught currently and to identify barriers to the inclusion of sexuality education in the Undergraduate programme	Literature search found no recent evidence to support or refute the suggestion that nursing programmes are failing to provide sexuality education.	Nurses should be prepared to provide education about normal sexual functioning. to educate clients about sexuality has severe consequences for client and public health.		A set of guidelines for appropriate sexuality education in American nursing programmes may help to make the teaching of sexuality content more thorough, consistent, and appropriate.		Nurse educator comfort level with sexuality topics is another barrier deficit in knowledge about the biological, psychological, and social aspects of sexuality among working nurses that limits their ability to adequately provide sexuality counselling. nurses were uncomfortable discussing sexuality because they believed the patients to be too ill or anxious to have any physical/intimacy questions,	Nursing literature suggests that attitudes and values about sexuality must be addressed in order to best prepare nurses to be able to discuss sexuality issues with clients. In
Number 2 Eickhoff, C., 2021.	Identifying gaps in LGBTQ health education in baccalaureate undergraduate nursing programs. Journal of Nursing Education, 60(10), pp.552-558.	Quantitative Descriptive	Undergraduate students and Educators were asked about Hours spent on content Topics Taught are schools considering expanding on LGBTI content Do any demographic factors present barriers	Content widely taught – LGBTI health disparities. IPV and mental health issues. 53%	The nurse must provide culturally congruent care - inclusive			New didactic approaches	65 students at Nursing schools contracted into the study indicated – no sufficient content related LGBTI Staff interested in expanding LGBTI content = 80% YES Student interested in this expansion? = 69% YES Do staff have the knowledge to teach LGBTI Health related issues? = 69% NO Are staff comfortable teaching LGBTI content? = 60% NO	

<p>Number 3 Eiertson, K. and McNiel, P.L., 2021.</p>	<p>Answering the call: Educating future nurses on LGBTQ healthcare. Journal of homosexuality, 68(13), pp.2234-2245.</p>	<p>Mixed method</p>	<p>Undergraduate nursing students to evaluate student response to the revised curriculum to increase LGBTQ cultural awareness</p>			<p>88% (n/N = 29/33) of participants were able to verbalize increased awareness of health disparities</p> <p>approach patients and clients in order to be cognizant of gender language and communication style with LGBTQ individuals after the session. Students</p>	<p>The curriculum was developed using the established SAFE training toolkit and evidence based standards of care for LGBTQ populations from the Centers for Disease Control and Prevention (Lesbian, Gay, Bisexual, and Transgender Health</p>	<p>The inclusive curriculum would help to address and eliminate "the mistreatment ranging from commonplace disrespect to outright violence, abuse and the denial of human dignity i</p> <p>multiple activities including advocacy awareness, didactic lecture, role playing, dialogue, self-reflection on stereotypes and biases, and panel discussion</p>		<p>Taking the time to explore individual experiences and bias reinforces the need for nurses to embrace diversity and remain open-minded with patient encounters. Inclusion = effective nursing practice.</p>
<p>Number 4 Hand, M.C. and Gedzyk-Nieman, S., 2022.</p>	<p>Graduating nursing students' preparedness and comfort level in caring for LGBTQ+ patients. Journal of Professional Nursing, 41, pp.75-80.</p>	<p>Quantitative Descriptive</p>	<p>Undergraduate nursing students. Demographic variables in relation to participants' perceived preparedness and comfort levels regarding provision of care for IGBTI persons</p>	<p>Half of programmes have no content</p> <p>. curricular inclusion of these topics was not sufficient to affect Preparedness positively.</p>						<p>Hist TAKING - 46.24% (n = 166) had been taught to obtain information about gender identity</p>
<p>Number 5 Koch, A., Ritz, M., Morrow, A., Grier, K. and McMillian-Bohler, J.M., 2021.</p>	<p>Role-play simulation to teach nursing students how to provide culturally sensitive care to transgender patients. Nurse education in practice, 54, p.103123.</p>	<p>Mixed method</p>	<p>Undergraduate nursing students asked whetherlgbt specific simulation assiststudents in developingthe ability to conduct culturallysensitivehealth assessments</p>		<p>As an adequately prepared professionalthe nurse should understandthe contexts of pT lives and are able todeliver more comprehensive and pat centred care</p>	<p>Portraying the symptoms and behaviours or history. Increased learning environment which is safe and assists the student to assess own biases and reflect on communication skills.</p> <p>5 themes: - History of discrimination - Support (family, friends, community) - Use of pronouns - Insecurity and fear of making mistakes</p>		<p>Standardised PT sim. Simulation designed to [prepare student to talk to Trans and Non-binary persons and assist student sin identifying factors which could challenge effective care .</p> <p>Using this simulation with nurse faculty can be easily operationalized and important step to ensure they are supportive and</p>	<p>HCW contribute negatively by contributing to the alienation of LGBTI persons from seeking health care . - Lack of competent care</p>	<p>Students expressed feeling more competent.</p> <p>Able to conduct person centred health assessment.</p> <p>Students felt empowered regarding social justice issuesand legal implications</p>

						- Hospital policies may not be inclusive		engage in integrating LGBT education in other nursing courses		
Number 6 Maruca, A.T., Diaz, D.A., Stockmann, C. and Gonzalez, L., 2018.	Using simulation with nursing students to promote affirmative practice toward the lesbian, gay, bisexual, and transgender population: A multisite study. Nursing Education Perspectives, 39(4), pp.225-229.	Quantitative Descriptive	Undergraduate nursing students. If affirmative practice in caring for LGBT persons improve after experiencing a transgender simulation?	Higher risk, such as depression, generalized anxiety disorder, panic attacks, and risk of harm by others	The nurse should be able appreciate the challenges faced, health disparities and be a part of the solution Provide equal care to people regardless of the gender identity and sexual orientation	Self-awareness is an essential first step in developing a sensitivity and understanding for diverse populations such as LGBT	The evidence shows that with nursing curricula lacking in content that addresses LGBT health care needs, nurse educators are encouraged to identify ways to include this content in their respective nursing programmes	Transgender simulation - Creating different scenarios that cover issues across the lifespan, such as LGBT youths, and to address the complexities of health care needs such as surgeries for a transgender person who is in the process of transition are other ways to further advance this study.	Lack of exposure to the LGBT population and lack of education on their health care needs in nursing programmes may lead to a false sense of cultural competence by nursing students	provide students with the opportunity to establish therapeutic communication and to assess anxiety levels while providing safe care.
Number 7 McCann, E. and Brown, M., 2018.	The inclusion of LGBT+ health issues within undergraduate healthcare education and professional training programmes: A systematic review. Nurse education today, 64, pp.204-214.	Systematic Review	Identification education and training requirements of undergraduate students and health professionals regarding LGBTI persons	negative consequences for LGBT+ people. Prejudice, discrimination and victimization experiences can have a profound effect upon a person's well-being and may result in minority stress The minority stress model demonstrates the potential damaging effects of internalized homophobia, biphobia and transphobia. These negative societal reactions to an LGBT+ identity can lead to poor psychosocial outcomes including anxiety, depression, drug use and suicidality	There is an important role for higher education providers and nurses to support the development of curricula that can reach all groups, including people who identify as LGBT+	importance of developing curricula that is influenced by the latest evidence and include learning about key terminology, stigma and discrimination, sexuality and sexual concerns, talking about sex and LGBT+-specific health issues and health disparities	Significant gaps still exist in the preparation of 2culturally competent practitioners in both education and health service delivery.	This systematic review has identified important issues that need to be addressed to ensure that undergraduate students and health practitioners possess the appropriate knowledge, skills, attitudes and values necessary to meet the distinct health needs of LGBT+ people	barriers included student and staff negative attitudes including preconceptions and biases about LGBT+ peoplestereotypical beliefs gendered values and an acceptance of the prevailing heteronormative practices and policies	
Number 8 Shortall, Chris, 2019.	"Teaching and Evaluation/Assessment Requirements for LGBTQI2S+ Health and Wellness: A Call to Include LGBTQI2S+ Content in Canadian	Quantitative Descriptive	Undergraduate to Postgraduate. Investigation on what information on sexuality and gender identity health and wellness exists in Canadian English baccalaureate	The heteronormative didactic approaches suggests that LGBTI people have not been identified as a population with specific health and wellness concerns outside of a framework of	nurses are uniquely positioned to significantly contribute to promoting health equity, justice, and wellbeing due to their large numbers in the	contributes to developing culturally sensitivity and should be informed by the latest evidence. In areas of the areas of gender expression, gender confirming	Respondents indicated they would like to know specifically how to teach about heterosexism, cisgenderism, and relational practice		limited views of sexuality and gender identity may result in substandard care, while an anti-oppressive critical framework of intersectionality suggests that all social determinants	exploring educational competencies for known LGBTQI2S+ health and wellness issues

	English Baccalaureate Nursing Curricula /		nursing programmes and related policy?	sexually transmitted blood borne infections	workforce and influence on direct patient care	surgery, intersex, and or transitioning; only 29% saw the need for increasing content in these areas.	for creating safe spaces, as well as how to talk about LGBTQI2S+ health and wellness issues outside of the entrenched discourse on safer Sex/STBBIs/HIV.		of health impact the issues faced by LGBTQ	
Number 9 White, B.P., Abuelezam, N.A., Dwyer, A.A. and Fontenot, H.B., 2020.	A sexual health course for advanced practice registered nurses: effect on preparedness, comfort, and confidence in delivering comprehensive care. Nurse Education Today, 92, p.104506.	Quantitative Descriptive	Graduate Nurses – post basic – Specialised. graduate students in improving nurses' knowledge, preparedness, comfort, and confidence in delivering comprehensive, culturally in formed sexual healthcare.	Explore intersectionality and disparities associated with elderly, adolescents, sexual and gender minorities, racial/ethnic minorities, persons with a history of sexual trauma, and persons with disabilities/comorbidities.	It is imperative that healthcare providers address sexual health disparities and learn to deliver competent sexual healthcare for diverse patient population Registered nurses (RNs) and advance practice registered nurses (APRNs) play a key role in addressing the sexual health needs of both low- and high-risk populations	Teaching methods included didactic guest lectures from content experts, clinical role-playing scenarios, videos, in-depth case studies, online discussions, small group discussions and reflective exercises examining personal biases, as well as strengths, weaknesses, opportunities, and threats (SWOT analysis) for providing optimal care.	Nurse educators should be mindful to include a diverse range of topics (including social determinants of health) and methods of content delivery in their sexual health curricula.	It is imperative that healthcare providers address sexual health disparities and learn to deliver competent sexual healthcare for diverse patient population Registered nurses (RNs) and advance practice registered nurses (APRNs) play a key role in addressing the sexual health needs of both low- and high-risk populations	Little focus on examining sexual health disparities and evaluate the impact of sociocultural, economic, and political influences on sexual health care, including health care for minority populations	Both the intervention and control groups had high baseline knowledge scores suggesting that students enrolled in this graduate nursing program have received adequate training in the objective, clinically-based information related to sexual healthcare (i.e. HIV/STI transmission, pregnancy risk, etc.). No significant changes in objective sexual health clinical knowledge were observed pre-post course. However, students taking the course exhibited increased perceived preparedness, comfort, and confidence in applying sexual health course content in practice

										<p>with diverse populations.</p> <p>Upon completing the course, students reported significantly improved comfort in discussing sexual health and confidence in providing sexual health care with a diverse set of patients. Notably, nearly all items assessing comfort improved significantly following course completion.</p> <p>Students in the intervention group also reported significant improvements in their level of confidence in providing care</p>
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ADDENDUM H - GATEKEEPER APPROVAL – HSREC SUBMISSION ONE



Office of the Vice-Rector: Research and Internationalisation
Kantoor van die Viserektor: Navorsing en Internasionalisering

14-Jun-2021

Dear Coetzee, Tyrone Brett TB

UFS GATEKEEPERS AUTHORITIES

Research Project Title:

**STUDENT VOICES ON LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND INTERSEX
INCLUSIVITY IN AN UNDERGRADUATE NURSING PROGRAMME**

We regret to inform you that your request to collect data from students and/or staff members at the University of the Free State for your research project cannot be approved for the following reason/s:

The study is regarding the LGBTQI community and perceptions surrounding this community. This is really sensitive. [we] must admit [we] are concerned about the planned theater performance as this could be experienced as insensitive or uninformed. We are thus inclined to decline this application.

Kind Regards



**PROF RC WITTHUHN
VICE-RECTOR: RESEARCH & INTERNATIONALISATION
CHAIR: SENATE RESEARCH ETHICS COMMITTEE**

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ADDENDUM I - HSREC SUBMISSION TWO



Health Sciences Research Ethics Committee

09-Dec-2021

Dear Mr Tyrone Brett Coetzee

Ethics Clearance: **LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND INTERSEX CONTENT IN NURSING EDUCATION PROGRAMMES: AN INTEGRATIVE REVIEW**

Principal Investigator: Mr Tyrone Brett Coetzee

Department: School of Nursing Department (Bloemfontein Campus)

[Submission Page](#)

APPLICATION APPROVED

Please ensure that you read the whole document

With reference to your application for ethical clearance with the Faculty of Health Sciences, I am pleased to inform you on behalf of the Health Sciences Research Ethics Committee that you have been granted ethical clearance for your project.

Your ethical clearance number, to be used in all correspondence is: **UFS-HSD2021/1655/2501**

The ethical clearance number is valid for research conducted for one year from issuance. Should you require more time to complete this research, please apply for an extension.

We request that any changes that may take place during the course of your research project be submitted to the HSREC for approval to ensure we are kept up to date with your progress and any ethical implications that may arise. This includes any serious adverse events and/or termination of the study.

A progress report should be submitted within one year of approval, and annually for long term studies. A final report should be submitted at the completion of the study.

Research conducted in any Department of Health facility: Researchers are required to sign and return the HSREC approval letters to the provincial Department of Health where they applied. It is also a requirement for researchers to submit electronic copies of their final research findings, and/or make a presentation of their findings and recommendations at departmental research days when and where indicated.

The HSREC functions in compliance with, but not limited to, the following documents and guidelines: The SA National Health Act. No. 61 of 2003; Ethics in Health Research: Principles, Structures and Processes (2015); SA GCP(2006); Declaration of Helsinki; The Belmont Report; The US Office of Human Research Protections 45 CFR 461 (for non-exempt research with human participants conducted or supported by the US Department of Health and Human Services- (HHS), 21 CFR 50, 21 CFR 56; CIOMS; ICH-GCP-E6 Sections 1-4; International Council for Harmonisation (ICH) Harmonised Guideline, Integrated Addendum to ICH E6(R1), Guideline for Good Clinical Practice (GCP) E6(R2), 2016, SAHPRA Guidelines as well as Laws and Regulations with regard to the Control of Medicines, Constitution of the HSREC of the Faculty of Health Sciences.

For any questions or concerns, please feel free to contact HSREC Administration: 051-4017794/5 or email EthicsFHS@ufs.ac.za.

Thank you for submitting this proposal for ethical clearance and we wish you every success with your research.

Yours Sincerely



Prof. A. Shemiff

Chairperson: Health Sciences Research Ethics Committee

Health Sciences Research Ethics Committee

Office of the Dean: Health Sciences

T: +27 (0)51 401 7795/7794 | E: ethicsfhs@ufs.ac.za

IRB 00011992; REC 230408-011; IORG 0010096; FWA 00027947

Block D, Dean's Division, Room D104 | P.O. Box/Posbus 339 (Internal Post Box G40) | Bloemfontein 9300 | South Africa

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ADDENDUM J - SUBSEQUENT SUBMISSION

UNIVERSITY OF THE
FREE STATE
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VRVSTAAT
YUNIVESITHI YA
FREISTATA



UFS·UV
HEALTH SCIENCES
GESONDHEIDSWETENSKAPPE

Health Sciences Research Ethics Committee

05-Sep-2022

Dear Mr Tyrone Brett Coetzee

Ethics Number: UFS-HSD2021/1655-0003

Ethics Clearance: **LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND INTERSEX CONTENT IN NURSING EDUCATION PROGRAMMES: A MIXED METHOD SYSTEMATIC REVIEW.**

Principal Investigator: Mr Tyrone Brett Coetzee

Department: School of Nursing Department (Bloemfontein Campus)

[Submission Page](#)

SUBSEQUENT SUBMISSION APPROVED

With reference to your recent submission for ethical clearance from the Health Sciences Research Ethics Committee, I am pleased to inform you on behalf of the HSREC that you have been granted ethical clearance for your request as stipulated below:

- Title aligned with literature.
- Mixed Method Systematic Review - adopted at research method and design

The HSREC functions in compliance with, but not limited to, the following documents and guidelines: The SA National Health Act No. 61 of 2003; Ethics in Health Research: Principles, Structures and Processes (2015); SA GCP(2020); Declaration of Helsinki; The Belmont Report; The US Office of Human Research Protections 45 CFR 461 (for non-exempt research with human participants conducted or supported by the US Department of Health and Human Services- (HHS), 21 CFR 50, 21 CFR 56; CIOMS; ICH-GCP-E6 Sections 1-4; International Council for Harmonisation (ICH) Harmonised Guideline, Integrated Addendum to ICH E6(R1), Guideline for Good Clinical Practice (GCP) E6(R2), 2016, SAHPRA Guidelines as well as Laws and Regulations with regard to the Control of Medicines, Constitution of the HSREC of the Faculty of Health Sciences.

For any questions or concerns, please feel free to contact HSREC Administration: 051-4017794/5 or email EthicsFHS@ufs.ac.za.

Thank you for submitting this request for ethical clearance and we wish you continued success with your research.

Yours Sincerely

Prof. A. Sherriff
Chairperson : Health Sciences Research Ethics Committee

Health Sciences Research Ethics Committee

Office of the Dean: Health Sciences

T: +27 (0)51 401 7795/7794 | E: ethicsfhs@ufs.ac.za

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ADDENDUM K - TITLE REGISTRATION

Registered Title with – University of the Free State; Health Sciences Research Ethics Committee:

LESBIAN, GAY, BISEXUAL, TRANSGENDER, AND INTERSEX CONTENT IN NURSING EDUCATION PROGRAMMES: A MIXED METHOD SYSTEMATIC REVIEW.

Tyrone TB Coetzee - 2011046139

School of Nursing Department (UFS Main Campus)

Record Number: UFS-HSD2021/1655

Ethics Number: UFS-HSD2021/1655-0003

The HSREC is registered as an institutional review board (IRB) with the Office for Human Research Protections (OHRP) of the USA Department of Health and Human Services:

- IRB organisation identifier: IRB00006240
- Unique Assurance Number: FWA00012784
- Unique Organisation Number: IORG0005187
-

Researcher ORCID Number:



<https://orcid.org/>

0000-0002-1939-1780

