Accessibility of mental healthcare services to members of the LGBTQIA+ Community in rural South Africa

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Declaration

I, Danilo Harkers, hereby declare that the dissertation I herewith submit for the Master of Health Systems Studies Degree, 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.

Danilo Harkers

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Dedication

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Abstract

South Africa, with its diverse population and complex socio-political history, has a high incidence of mental health conditions. The country's burden of mental health conditions is closely linked to inequality, poverty, and limited access to mental healthcare services. These disparities are particularly pronounced for members of the lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual and other identities (LGBTQIA+) community residing in rural contexts.

In response to this issue, this study aimed to explore and describe barriers to and facilitators of access to mental healthcare services as perceived by LGBTQIA+ individuals living in Namaqualand through the lens of the Socio-Ecological Model (SEM). The SEM illustrates how multiple factors across the individual, interpersonal, organisational/community, and societal levels influence an individual's health behaviour.

This study, grounded in the constructivist paradigm, explored the lived experiences of LGBTQIA+ while accessing mental healthcare services. Guided by a relativist ontology and a subjectivist epistemology, the research employed a qualitative case in which semi-structured interviews were conducted with eleven purposively selected participants. The sample size was guided by the principle of data saturation rather than the generalisability of the study's findings. The data were subsequently analysed thematically using the SEM as an analytical framework. Barriers and facilitators of mental healthcare access were categorised across the SEM's four levels, with sub-themes emerging inductively from the data.

Participants highlighted various mental healthcare needs within their community, including the pressing need for comprehensive mental healthcare services that are LGBTQIA+ affirming and increased community sensitisation on LGBTQIA+ rights, particularly in rural and conservative communities like Namaqualand. Barriers to mental healthcare access were identified across all levels of the SEM. At the individual level, barriers included internalised stigma, identity conflict, substance use, and limited mental health literacy. Interpersonally, a lack of support from family and friends increased isolation and limited help-seeking behaviour. Mental healthcare access was further influenced by systemic and structural inequalities at the organisational level, where limitations in the public health sector, such as shortages of healthcare professionals, inadequate facilities and discrimination against the LGBTQIA+ community, acted as barriers. Finally, stigma and unsupportive cultural norms, especially within Namaqualand's Coloured communities, emerged as barriers at the societal level.

Facilitators of access included individual-level factors, such as mental health literacy and positive health-seeking attitudes. At the interpersonal level, support from family and friends acted as an enabler to mental healthcare access. Organisational facilitators included access to private healthcare for those who could afford it, and unexpected support from faith-based organisations. The data did not show any societal-level factors that acted as enablers for mental healthcare access.

The participants recommended establishing integrated healthcare facilities that cater to both mental and physical health, increasing mental health sensitisation, culturally competent training for healthcare workers and establishing LGBTQIA+ support groups in Namaqualand.

The study highlights that access to mental healthcare services for LGBTQIA+ individuals in Namaqualand is influenced by complex, multi-level factors. To address the challenges, comprehensive and intersectional strategies are needed that take into account the overlapping influences of gender identity, socioeconomic status, culture, and geography on mental healthcare access. Drawing on the SEM, it is evident that there is a need for culturally competent, LGBTQIA+-affirming services, community education, and systemic reform to improve mental healthcare access in Namaqualand. Lessons learnt from this research could potentially inform strategies to improve access to mental healthcare services in other rural areas of the Northern Cape province in South Africa.

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List of Acronyms

CMHAP	Comprehensive Mental Health Action Plan
CRPD	Convention on the Rights of Persons with Disabilities
DOH	Department of Health
HCW	Healthcare workers
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual and other identities not listed
mhGAP	Mental Health Gap Action Programme
PHC	Primary healthcare
SADAG	South African Depression and Anxiety Group
SDG	Sustainable Development Goals
SEM	Socio-Ecological Model
SMW	Sexual minority women
UN	United Nations
US	United States
WHO	World Health Organisation
NGOs	Nongovernmental organizations

Definitions of Key Words

LGBTQIA+

LGBTQIA+ is an umbrella term referring to a diverse group of sexual orientations, gender identities, and sex characteristics that differ from heterosexual and/or cisgender norms. (Lewis & Reynolds, 2021). In the context of this study, LGBTQIA+ referred to individuals whose sexual orientation or gender identity is not heterosexual and/or cisgender.

Mental health condition

Mental health condition is an umbrella term that includes mental disorders and psychosocial disabilities, as well as other mental states that involve significant distress, impaired functioning, or risk of self-harm (WHO, 2025a). In the context of this study, this definition was used to describe mental illness, mental disorders, mental disabilities and all other associated mental disturbances.

Access

Levesque et al. (2013) defined access as “the opportunity to identify healthcare needs, to seek healthcare services, to reach, to obtain or use healthcare services and to actually have the need for services fulfilled” (p. 8). In the context of this study, access referred to the ability of communities or individuals to use and benefit from services available to them.

Barrier

A barrier is any factor, internal and/or external, that prevents an individual or group from accessing resources or services (Shoesmith et al., 2021). In the context of this study, a barrier was anything that impeded access to mental healthcare services.

Facilitator

A facilitator is something that enables, supports, or promotes progress or access to services (Shoesmith et al., 2021). In the context of this study, a facilitator refers to any factor that promotes or enables access to mental healthcare services.

Transgender

Transgender is the term used to describe people whose gender identity, gender expression, or gender role is not in line with the sex they were assigned at birth (Joseph et al., 2017). In the context of this study, transgender referred to people whose gender expression does not correlate with their sex.

Mental Healthcare Services

Mental healthcare services are seen as the effective provision of treatment for individuals experiencing mental health conditions or psychological distress (World Health Organisation [WHO], n.d. a). In the context of this study, mental healthcare services referred specifically to services aimed at promoting, protecting, and restoring the mental well-being of individuals and communities.

Mental Health

Mental health is a state of mental well-being in which people can cope with the stresses of life, realise their abilities, learn and work well, and contribute to their community, not merely the absence of mental disorders (WHO, n.d. a). Galderisi et al. (2015) further argue that this definition allows for a more holistic view of mental health, emphasising well-being, positive emotions, social functioning, and personal resources. In the context of this study, mental health was seen as a state of mental well-being and the absence of any condition that impedes such well-being.

Healthcare Workers

According to the WHO (2022a), health workers are all people engaged in work actions whose primary intent is to improve health, including doctors, nurses, midwives, public health professionals, and others. In the context of this study, healthcare workers referred to people who work in the healthcare sector whose primary goal is improving the health of the community, who have not been specifically trained in mental healthcare.

Mental Healthcare Workers

A mental healthcare provider is someone who provides mental healthcare services to mental healthcare users and includes professionals that are specifically trained and registered to provide mental healthcare (South African Government, 2002). In the context of this study, this definition was used to describe mental healthcare workers.

Stigma

Stigma is a set of negative beliefs, attitudes, or judgments directed at a person or group that involves labelling, exclusion and stereotyping often leading to discrimination (Link and Phelan, 2001). In the context of this study, this definition was used to describe Stigma.

Discrimination

Discrimination is the unequal treatment of otherwise similar individuals due to their membership in a socially defined category (ie gender, race, sexuality etc.) (Fibbi et al,. 2021) In the context of this study, this definition was used to describe discrimination.

CHAPTER 1: BACKGROUND OF THE STUDY

1.1 Introduction

South Africa faces a mental health crisis because, according to the disability-adjusted life years(DALYs), a measure that combines years of life lost due to premature death, with years lived with disability, mental health accounts for 13.8% of the total disease burden, higher than HIV at 11.8% and musculoskeletal disorders at 10.4%(South African Department of Health, 2023). Additionally, although updated nationally representative diagnostic prevalence data is limited, available evidence suggests that mental health conditions are prevalent in South Africa. The South African Stress and Health (SASH) study reported a lifetime prevalence of 30.3% for any mental health condition (Herman et al., 2009), and a more recent national survey, using validated screening instruments, has found that between 17% and 25.7% of adults experience clinically significant symptoms of common mental health conditions, including depression and anxiety (Craig et al, 2022).The country's burden of mental health conditions is closely linked to inequality, poverty, and limited access to mental healthcare services (Evans-Lacko et al., 2018; Gordon et al., 2020). This limitation to access is exacerbated by a stark divide between the well-resourced private sector and the underfunded public sector (Barber et al., 2018; Young, 2016).

These disparities are particularly pronounced for members of the LGBTQIA+ community residing in rural contexts. LGBTQIA+ individuals experience higher rates of mental health conditions than their heterosexual and cisgender peers, largely due to chronic stigma, discrimination, and structural inequities (Bränström et al., 2024). Müller & Daskilewicz (2018) conducted a study in Kenya and South Africa, they found that mental health conditions such as depression and anxiety have higher rates among LGBTQ individuals than the general population. Considering this pervasive issue, there is a need to investigate the barriers and facilitators of access to mental healthcare services as perceived by LGBTQIA+ individuals living in under-resourced regions such as Namaqualand.

This chapter focuses on the background of the study, which includes a brief description of the mental health burden on health systems globally and locally. It further examines the interplay between LGBTQIA+ identity and mental health internationally and locally. The theoretical framework that guides the study is briefly discussed, followed by the problem statement, the research question, the aim, and the objectives. Thereafter, the research methodology and the significance of the study are provided. The chapter concludes with an orientation to the structure of the dissertation.

1.2 Background

1.2.1 Mental health: A global concern

Health is defined as a state of overall physical, social, and mental well-being and is not merely the absence of disease (WHO, 2013). Mental health which is a crucial component of overall health can be described as a “dynamic state of internal equilibrium” and not only a psychological state of well-being or the absence of a mental health condition (Galderisi et al., 2015). WHO (n.d. b) further defines mental health as “a state of mental well-being that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community”. Mental health influences individuals, communities, and the human population at large. It affects people’s ability to build and maintain relationships, as well as to recognise and express emotions appropriately (WHO, 2013). According to Galderisi et al. (2015), its impact is far-reaching and surpasses personal struggles, shaping societal dynamics, economic productivity, and healthcare systems.

McGrath et al. (2023) estimates that 50% of all people will experience some sort of mental health condition during their lifetime, furthermore approximately 970 million people, about 1 in 8 globally, live with a mental health condition (WHO, 2022b). Depression and anxiety disorders alone affect more than a hundred million people worldwide (James et al., 2018). Mental health conditions are a major factor in suicide rates, with more than 700,000 people committing suicide every year (WHO, 2025b).

The prevalence of mental health conditions has surged globally, with diverse factors contributing to this phenomenon (Steel et al., 2014). Galderisi et al. (2015) maintain that increasing stressors such as social isolation, economic volatility, and environmental difficulties have exacerbated mental health conditions. Most mental health conditions develop because of the economic, physical and social environments. Risk factors for mental health conditions are closely linked to social inequalities, the greater the inequality; the higher the risk of developing a mental health condition (WHO & Calouste Gulbenkian Foundation, 2014) Therefore, social determinants such as poverty, conflict, low education levels and natural disasters are key drivers of the high burden of mental health conditions in low- and middle-income countries (Patel, 2007; Rathod et al., 2017). Since most of the world's population resides in these regions, addressing mental health is a pressing global concern (Rathod et al., 2017).

Mental health conditions have a major impact on economies worldwide. The World Economic Forum (2011) projects that healthcare costs, lost productivity and social care expenses due to mental health conditions could cost the global economy up to $6 trillion by 2030. The burden is further exacerbated by the stigma surrounding mental health. Stigma leads to underreporting and underdiagnoses, which, Corrigan et al. (2014) argue, hamper effective support and treatment.

The importance of mental health is emphasised in the 17 Sustainable Development Goals (SDGs), all of which are inextricably linked to mental health. SDG 3 specifically refers to mental health, aiming to reduce premature mortality from non-communicable diseases by one third, through prevention and treatment as well as the promotion of mental health and well-being (United Nations, 2015; WHO, 2022b). This highlights mental health as a global priority (Lund et al., 2018; Gordon et al., 2020; United Nations, 2015).

Mental healthcare, although increasingly recognised as a crucial component of overall well-being, continues to receive fewer resources than physical healthcare (Becker & Kleinman, 2013; Patel, 2014). Many mental health conditions can be effectively treated at relatively low cost; however, health systems remain chronically under-resourced, and treatment gaps persist. Furthermore, WHO (2022b) reported that when mental healthcare is delivered, it is often of poor quality.

Research shows that people with mental health conditions face greater challenges accessing healthcare services compared to those seeking care for physical conditions (Corscadden et al., 2018; Vergunst et al., 2017). Difficulties in accessing mental healthcare services stem from several factors, including stigma, inequities due to demographics or geographical location, poor infrastructure and inadequate healthcare policies (Davies et al., 2021; Docrat et al., 2019; Moroz et al., 2020; Priester et al., 2016).

The COVID-19 pandemic significantly impacted global mental health (Campion et al., 2020). Pre-existing barriers to mental healthcare access were exacerbated (Egede et al., 2020; Summers-Gabr., 2020), while new challenges emerged, such as the shift of resources to combat the pandemic, restrictions on movement, and the fear of infection (Egede et al., 2020; Vadivel et al., 2021). The interconnected nature of our world today means that mental health conditions can have a global impact on relationships, productivity, and the overall functioning of society.

1.2.2 Mental health in Africa

Across the African continent, mental health challenges are compounded by a severe shortage of resources and a widespread lack of awareness and policy focus (Sankoh et al., 2018; WHO, 2022c). The burden of mental health is widespread, with more than 116 million people estimated to have been living with a mental health condition even before the COVID-19 pandemic (WHO, 2022c). The escalating prevalence of mental health conditions, especially among children and adolescents, is exacerbated by the lack of standalone mental health policies in most African countries (Sankoh et al., 2018; WHO, 2022c). Another challenge to mental healthcare in Africa is funding. Limited financial resources have a detrimental effect on initiatives to increase the number of mental health professionals on the continent. There are fewer than two mental health professionals for every 100,000 individuals, which directly influences access to quality mental healthcare (WHO, 2022c).

In particular, the high rate of mental health conditions in the sub-Saharan Africa region is intensified by the confluence of socio-economic challenges, high levels of HIV/AIDS and related stigma, and poor accessibility to healthcare services. Mental health conditions and substance use disorders are two of the leading causes of disability in sub-Saharan Africa; however, the mental healthcare resources that are available are often limited to tertiary psychiatric facilities, which treat those with acute psychoses (Charlson et al., 2014; Jörns-Presentati et al., 2021).

1.2.2.1 Mental Health in South Africa

South Africa, with its diverse population and history of socio-political challenges, is not immune to the global landscape when it comes to mental health. Mental health conditions ranks among the highest non-communicable diseases when it comes to burden of disease in South Africa (South African Department of Health, 2023). Some studies suggest that as many as 25.7 % of South Africans will suffer from mental health conditions such as depression and anxiety in their lifetime (Craig et al, 2022), and, according to a nationally representative cross-sectional population-based household survey, up to 47% of the population experiences some sort of psychological distress (Ramlagan et al., 2025).

Mental health conditions such as depression and anxiety are commonly diagnosed, and the country has one of the highest rates of suicide globally (South African Depression and Anxiety Group [SADAG], 2019; Statistics South Africa, 2017). Furthermore, the HIV/AIDS epidemic also has a major psychological impact, leaving many people with the challenge of dealing with a chronic disease and the mental health conditions that come with it (Freeman et al., 2007).

Following the global trend and as is the case in many African countries, South Africa’s burden of mental health conditions is closely linked to inequality, poverty and limited access to mental healthcare services. According to Sulla et al. (2022), South Africa is the most unequal country in the world, and it is often the most disadvantaged in society who bear the brunt of the mental health crises (Burns, 2015). Individuals who suffer from mental health conditions are often more likely to face challenges such as higher healthcare costs, discrimination and decreased economic mobility (Evans-Lacko et al., 2018; Gordon et al., 2020).

The Mental Healthcare Act (2002) and the National Mental Health Policy Framework and Strategic Plan 2013-2020 were introduced to alleviate the burden and ensure universal access to mental healthcare services. However, factors such as weak health information systems, mismanagement and lack of expertise in mental healthcare affect access to mental health services (Docrat et al., 2019; Lund et al., 2012; South African Department of Health, 2013; South African Government, 2002). Mental health institutions are usually short-staffed and underfunded. Worldwide, the average number of mental healthcare workers is less than 15 per 100,000 population, with substantial differences between high-income countries at 67.2 per 100,000 population and low-income and middle-income countries ranging between 1.1-2.4 per 100,000 population (WHO, 2025a). The ratio in South Africa is much lower than the global average, with less than 1 psychiatrist/psychologist per 100,000 population (Docrat et al., 2019). This scarcity of skilled mental health professionals has led to increased waiting times and inadequate care (Docrat et al., 2019; Petersen et al., 2012).

To compound the issue, mental health is formally included in national health policies and PHC frameworks, however integration at the PHC level remains limited and resources remain concentrated at specialist and hospital care levels (van Rensburg & Brooke-Sumner, 2025). Issues such as a lack of training, lack of resources both physical and human as well a lack of clear policy directive from management to patient facing staff has hindered the of integration of mental healthcare into PHC (Hlongwa & Sibiya, 2019). This limits mental health access to rural or underserved communities.

1.2.3 LGBTQIA+ and mental health care

Inequalities and disparities in access to health care are particularly pronounced for members of the LGBTQIA+ community (Keuroghlian et al., 2017). Individuals within this group frequently encounter discrimination, stigmatisation, and social exclusion, elevating their risk of developing mental health conditions such as depression, anxiety, and suicidal ideation (Silveri et al., 2022). Consequently, understanding their specific mental healthcare needs and experiences when accessing mental healthcare services is crucial for providing equitable care (Rees et al., 2021).

There has been an improvement in social acceptance for the LGBTQIA+ community, however, even in countries that are more open to the LGBTQIA+ community, stigma and discrimination continues to contribute to mental health inequalities and disparities within the LGBTQIA+ community (Frankis, 2025). Valentine and Shipherd's (2018) systematic review of 77 American studies, which focused on social stress and mental health among transgender and gender non-conforming people, found that stigma and discrimination contributed to mental health conditions within this population. Similarly, a scoping review by Kidd et al. (2016) identified that LGBT individuals were at a higher risk of developing severe mental health conditions, which was linked to their exposure to discrimination. In addition, they found that when mental healthcare services were available, they were often inadequate and delivered in stigmatising ways due to biases towards sexual orientation or gender identity.

Structural heterosexism, homophobia, biphobia, and transphobia that are embedded throughout society reinforce the social exclusion of the LGBTQIA+ community, rendering their needs invisible within healthcare systems (Giannou & Ioakimidis, 2020). This leads to a lack of confidence in the health system and increases concerns about how they will be treated when accessing services (Giannou & Ioakimidis, 2020; Maltempi et al., 2024). LGBTQIA+ people have faced systemic pathologisation in healthcare settings, with their identities historically treated as conditions warranting medical or even legal oversight. According to the Cambridge University Press (n.d.), pathologisation is “the act of unfairly or wrongly considering something or someone as a problem, especially a medical problem”. This further perpetuates the cycle and increased risk of developing mental health conditions within this community (Giannou & Ioakimidis, 2020; Maltempi et al., 2024; Rees et al., 2021).

1.2.4 LGBTQIA+ mental health in the African context

In various African countries, being a part of the LGBTQIA+ community is considered taboo, and it is also criminalised (Alozie et al., 2017; Lyonga, 2023). As a result, discrimination, stigma, and in some instances, violence against LGBTQIA+ individuals are widespread (Mogotsi et al., 2024). Living in such an unaccepting environment can contribute to an increase in mental health conditions, which includes conditions such as suicidal ideation, depression, and anxiety (Mogotsi et al., 2024; Shaikh et al., 2024).

After conducting an integrative literature review, Moagi et al. (2021) reported that LGBTQIA+ individuals often experience emotional distress, victimisation, and barriers when accessing healthcare services due to societal discrimination and stigmatisation. Mogotsi et al. (2024) found comparable results in their study that explored the multifaceted experiences of LGBTQIA+ people in African countries within legal, health, and educational sectors, as well as the broader society. They reported that LGBTQIA+ activities are expressly prohibited by the constitutions of Ghana, Namibia, Kenya, and Uganda, and could result in lengthy prison sentences.

Kenya, for example, punishes consenting same-sex activity with up to 14 years in prison, adding to widespread shame and social marginalisation (Harper et al., 2021; Mogotsi et al., 2024). Similarly, Mogotsi et al. (2024) state that Uganda's Anti-Homosexuality Act sets harsh penalties, including life sentences, for specific same-sex conduct, thus increasing the marginalisation of the LGBTQIA+ community. By having these legal frameworks in place, these countries legitimise social discrimination and inhibit access to crucial services for the LGBTQIA+ community, which, in turn, perpetuates the cycle of distress within this population (Harper et al., 2021; Mogotsi et al., 2024).

Harper et al. (2021) conducted a cross-sectional survey to explore the mental health challenges and needs among sexual and gender minority people in western Kenya, they found that 11% of their participants experienced clinically significant levels of psychological distress which could be linked to the hostile legal and social environment. Additionally, these mental health challenges are often made worse by experiences of violence, which include sexual and physical abuse, all of which are widespread in the LGBTQIA+ community throughout the continent (Harper et al., 2021; Mogotsi et al., 2024).

Even when LGBTQIA+ individuals experience mental health conditions, factors such as financial constraints, discriminatory attitudes among healthcare providers, and a fear of exposure deter many of them from seeking appropriate care (Harper et al., 2021; Mogotsi et al., 2024). The harsh anti-LGBTQIA+ laws in Uganda have led to the shutting down of clinics that catered to the LGBTQIA+ community, thereby further limiting their access to mental healthcare (Mogotsi et al., 2024).

Moreover, Mogotsi et al. (2024) and Harper et al. (2021) contend that since being part of the LGBTQIA+ community is considered illegal, many people do not disclose their sexual orientation or gender identity to health care providers, which results in inadequate or inappropriate care. Not only do these challenges exacerbate existing mental health conditions, but they also add to the under-reporting and mismanagement of mental conditions in this population.

Navigating the intersection of LGBTQIA+ rights and mental health in Africa presents a complex landscape. Yet, some regions are more progressive. For example, LGBTQIA+ rights are recognised and protected in South Africa, and the Constitution explicitly forbids discrimination based on gender or sexual orientation (Eslen-Ziya et al., 2015). Furthermore, same sex marriages are legalised in the country (Mogotsi et al., 2024).

Although South Africa has one of the most progressive constitutions in the world, discrimination and stigma remain widespread, and the South African LGBTQIA+ community face similar barriers to mental healthcare access as those across the globe (Eslen-Ziya et al., 2015; Müller, 2017; Victor & Nel, 2016). Homophobic and transphobic beliefs are common, leading to social exclusion and violence against LGBTQIA+ people, which has a severe impact on their mental health (Müller, 2017; Victor & Nel, 2016).

A national survey on the mental health of university students in South Africa found that the prevalence of mental health conditions was higher in gender non-conforming and sexual minority students compared to their heterosexual peers. Structural challenges, perceived need, and attitudinal factors were identified as barriers to mental healthcare access. As such, only a fraction of students with mental health conditions obtained suitable treatment (Bantjes et al. 2023). Moreover, LGBTQIA+ individuals often fear discrimination at healthcare settings which discourages them from accessing much needed care (Moagi et al., 2021). These challenges contribute to the underutilisation of the available mental healthcare resources and amplify the existing disparities.

1.2.5 Mental healthcare services in South Africa

The South African healthcare system is characterised by a stark divide between the well-resourced private sector and the underfunded public sector. Despite serving only 16% of the population, the private sector accounts for approximately 43% of healthcare expenditure (Barber et al., 2018). A shortage of physical and human resources, insufficient funding, and a lack of adequately trained healthcare workers negatively affect service delivery in the public health sector (Docrat et al., 2019; Petersen et al., 2016).

South Africa spends approximately 5% of the national budget for health on mental health, and the majority of this is spent on psychiatric hospitals rather than community-based healthcare (Docrat et al., 2019; Shisana et al., 2024). This is disproportionate to other illnesses such as HIV and TB which receive up to 37% of the national health budget (National Department of Health, 2023; Wolvaardt et al 2025). Since underprivileged and rural communities are dependent on the public healthcare sector, this disproportionate allocation of funds affects them at a higher rate (Bateman, 2015; Burns, 2010). According to De Kock and Pillay (2017), only around 30% of the public health facilities that provide mental healthcare employ clinical psychologists, while some lack psychiatrists altogether, exacerbating the already dire situation.

In contrast, the private healthcare sector in South Africa is better resourced, has higher appropriate staffing ratios, offers efficient access, and more comprehensive services (Barber et al., 2018; Young, 2016). This difference between the public and private sector has resulted in a two-tiered system in which the majority of the population is unable to access quality healthcare, and those who cannot afford private health insurance are more likely to experience poorly managed mental health conditions or go completely untreated (Docrat et al., 2019; Petersen et al., 2016; Young, 2016).

The effects of these structural inequalities are worse for LGBTQIA+ individuals as, they are faced with unique barriers when accessing mental healthcare. LGBTQIA+ individuals often feel stigmatised and discriminated against; they also report that healthcare practitioners pathologise their behaviour, especially in the public healthcare sector (Müller, 2017). Furthermore, this lack of cultural awareness from healthcare providers leads to a misunderstanding of LGBTQIA+ experiences and discourages people from seeking care (Ford et al., 2024; Müller, 2017).

Additionally, LGBTQIA+ individuals are at a higher risk of developing mental health conditions, including depression and anxiety, due to the psychosocial stress of discrimination, exclusion, and violence (Moagi et al., 2021; Silveri et al., 2022). However, little is being done to provide affirming services tailored to their needs at public institutions (Müller, 2017; Spencer et al., 2017). Rural clinics rarely provide targeted mental health outreach or culturally competent care for their LGBTQIA+ population (Müller, 2017; Spencer et al., 2017). This absence of LGBTQIA+ specific services, such as safe spaces or inclusive psychoeducation, further isolates the

LGBTQIA+ community and reinforces cycles of healthcare avoidance and mental health deterioration (Silveri et al., 2022).

1.3 Theoretical Framework

This study applied the Social Ecological Model (SEM) to explore and describe the perceptions of members of the LGBTQIA+ community regarding access to mental healthcare services. The SEM is underpinned by the understanding that health behaviours are affected by numerous factors and on different levels (i.e. Individual, Intrapersonal, Community and Societal), as well as the interaction between these levels (McCloskey et al., 2011). The SEM was developed in the 1980s by Urie Bronfenbrenner as a conceptual theory to understand human development. It has also been used to identify factors contributing to health-related behaviours (Kilanowski, 2017). The Model has evolved, and different versions are available. This study followed the CDC four-level model, as outlined by McCloskey et al. (2011), which includes the individual, interpersonal/relationships, organisational/community, and societal levels. This framework was used to describe barriers and facilitators that LGBTQIA+ individuals perceived or experienced when accessing mental healthcare services. The SEM was applied as follows in the research:

- Individual level: The study explored how personal factors such as age, education, knowledge and attitudes act as barriers or facilitators to accessing mental health care services.
- Interpersonal/relationships: The focus was on relationships that could act as barriers or facilitators to accessing mental health care services.
- Organisational/community level: The study explored health systems factors such as the accessibility of mental healthcare services and healthcare providers’ attitudes towards mental healthcare and LGBTQIA+ individuals.
- Societal level: The study examined cultural and societal norms, as well as policies that could influence access to mental healthcare services.

The theoretical framework is described in more detail in Chapter 3.

1.4 Statement of the Problem

LGBTQIA+ individuals are faced with significant stigma, discrimination, and marginalisation, which contribute to poorer mental health outcomes when compared to the general population (Moagi et al., 2021; Salerno et al., 2020). Many South African LGBTQIA+ individuals are confronted with challenges when trying to access healthcare, which include widespread ignorance and a lack of knowledge among healthcare providers concerning the specific needs of this community (Currin et al., 2020; Gahagan & Subirana-Malaret, 2018). These challenges are exacerbated by the stark disparities between South Africa's public and private healthcare sectors, particularly in rural areas where resources are scarce, and services are often insufficient (Barber et al., 2018; Bateman, 2015; Petersen et al., 2016; Young, 2016). Considering the limited availability of mental healthcare services in South Africa's public health sector, it is essential to understand the unique experiences of LGBTQIA+ individuals residing in rural communities. Therefore, this research proposed to explore the perceptions of access to mental healthcare services for members of the LGBTQIA+ in a rural community in South Africa.

1.5 Research Question, Aim and Objectives

1.5.1 Research question

This study addressed the following research question: *What are the barriers to and facilitators of access to mental healthcare services as perceived by LGBTQIA+ people living in Namaqualand?*

1.5.2 Research aim

The study used the SEM to explore and describe the perceptions of members of the LGBTQIA+ community regarding barriers to and facilitators of access to mental healthcare services within their community.

1.5.3 Research objectives

The research objectives of this study were:

- To describe the mental healthcare needs of the LGBTQIA+ community in Namaqualand.
- To explore the perceptions of the LGBTQIA+ community in Namaqualand regarding barriers to mental healthcare access within their community.
- To explore the perceptions of the LGBTQIA+ community in Namaqualand regarding facilitators to mental healthcare access within their community.

1.6 Research Methodology

The researcher followed a qualitative approach, specifically using the case study design to effectively address the research problem and objectives (Yin, 2013; Yin, 2017). Furthermore, by approaching the research from an interpretivist stance, the researcher was able to gain insight into the lived experiences of the participants (Al-Ababneh, 2020; Priya, 2020; Rahi, 2017). The qualitative case study design engages in the in-depth exploration of real-life phenomena within a specific context; therefore, the study explored mental healthcare access from the perspective of members of the LGBTQIA+ community holistically and within context. The Socio Ecological Model (SEM) was used as the theoretical framework to explore how LGBTQIA+ individuals interacted with their significant others, families and friends, different organisations, communities, and within the context of mental healthcare provision.

A purposive sampling method was used to select LGBTQIA+ individuals who reside in the Nama-Khoi municipality. A total of 11 participants took part in this study. The purpose of this sample size was to reach saturation rather than the generalisability of findings (Rahimi & Khatooni, 2024). Data was collected using semi-structured interviews with the participants. Ethical clearance was granted by the University of the Free State's General/Human Research Ethics Committee (GHREC). The relevant research methodology is discussed in more detail in Chapter 3.

1.7 Significance of the Study

The findings from this study contribute to the corpus of knowledge on LGBTQIA+ individuals' access to mental health services in rural communities. This information will be shared with the Northern Cape Department of Health and other key stakeholders and could potentially inform interventions to improve mental healthcare service provision for LGBTQIA+ individuals.

1.8 Structure of the Dissertation

Chapter 1 provides the background to the study, which includes the burden of mental health on health systems globally and locally, the mental healthcare needs of the LGBTQIA+ community in the global context, the mental healthcare needs of the LGBTQIA+ community in the African context and the mental healthcare services in South Africa. The chapter also provides an overview of the theoretical framework, the research problem, the aim and objectives, the study setting, the research methodology, and the significance of the study.

Chapter 2 explores key factors affecting mental healthcare access for the LGBTQIA+ community through the lens of the SEM. The chapter addresses the global, regional, and local impacts of mental health conditions, examines the intersection of mental health and the LGBTQIA+ community, reviews international policies and frameworks for mental healthcare, and considers the state of mental health services in South Africa. Additionally, it presents the conceptual framework underpinning the study, the SEM, adapted from Bronfenbrenner's human development theory. The chapter outlines the origins of SEM, describes its four key constructs, and reviews how SEM has been used in related research. The SEM framework was used to illustrate that mental healthcare barriers are influenced by multiple factors across individual, interpersonal, community, and policy levels. Additionally, this chapter explores strategies for enhancing mental healthcare access for the LGBTQIA+ community and ended with a concluding summary.

Chapter 3 delineates the philosophical framework that served as the foundation of the study. The philosophical underpinnings are followed by an expansion of the research methodology, focusing on the research design and methods used to explore the barriers and enablers of access to mental healthcare services in Namaqualand from the perspectives of members of the LGBTQIA+ community. The research methods describe the target population, setting, sampling procedure, research instrument development, participant recruitment, data collection, and data analysis. The chapter concludes with a presentation of the ethical considerations, clearance and study approval process, and an explanation of the trustworthiness and rigour of the study findings, and finally, reflexivity.

Chapter 4 highlights the findings of this study and explores its significance in the context of the objectives of the study. It provides an overview of the qualitative data gathered from semi-structured interviews. These findings are structured according to the SEM, which contextualises the barriers to and facilitators of access to mental healthcare services for members of the LGBTQIA+ community. Contextualisation is applied to all SEM levels, including the individual, interpersonal, community, and societal levels. The chapter also discusses the findings in relation to the existing literature and the SEM.

Chapter 5 expounds the study's limitations, makes recommendations directly derived from the findings, and draws conclusions based on an evaluation of the entire research study.

1.9 Conclusion

This chapter (1) addressed the study's background and rationale, focusing on the mental health burden on local and global health systems, as well the mental healthcare needs of the LGBTQIA+ community in the global context and African context, mental health challenges for LGBTQIA+ individuals in Africa, mental healthcare services and LGBTQIA+ rights and mental health in South Africa, disparities in access to mental healthcare services between rural and urban areas in South Africa and facilitators to mental health care for the LGBTQIA+ community. Furthermore, the theoretical framework, problem statement, research question, aim, and objectives were discussed. Following this, the research methodology, significance of the subject, and dissertation structure of the study were provided. The next chapter (2) meticulously outlines the key elements that contribute to mental health care access for the LGBTQIA+ population and presents the conceptual framework underpinning the study, the SEM.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

One in every eight people worldwide lives with a mental health condition (WHO, 2022b). Mental health conditions manifest as notable disruptions in a person's cognitive processes, regulation of emotions or conduct, typically leading to distress or impairment in crucial areas of functioning (WHO, 2022b). Despite the prioritisation of overall health on the global health agenda, disparities persist when it comes to mental health and the resources, human and non-human, allocated to it (Patel et al., 2025; Shan et al., 2025). Furthermore, individuals with mental health conditions experience more difficulties when trying to access healthcare services compared to those who do not have a mental health condition (Corscadden et al., 2018; Vergunst et al., 2017).

Geographical location, financial constraints and other socio-economic factors have a significant impact on access to mental healthcare services, especially for low-income and rural communities. Individuals in under-resourced communities are often left without access to these essential services because of these barriers (Docrat et al., 2019; Lund et al., 2012). In addition, low-income and rural communities face other challenges, such as inadequate facilities and healthcare workers who are not equipped to deal with mental health conditions (Matsea et al., 2018; Van Spijker et al., 2019). Stigma and discrimination also act as a barrier to access, as cultural beliefs surrounding mental health conditions can discourage individuals from seeking help, especially in communities that have experienced systemic bias from the healthcare sector (Matsea et al., 2018; Thornicroft et al., 1993; Van Spijker et al., 2019).

Although access to mental healthcare is a basic human right, for many people who suffer from mental health conditions or symptoms thereof, it is still unattainable due to challenges, including poverty, limited access to healthcare, and other social inequalities (Carbonell et al., 2020). Mezzina et al. (2022) conducted a conceptual analysis which highlighted how COVID-19 exacerbated existing social and mental health inequalities, especially for vulnerable populations. They found that vulnerable populations, which include members of the LGBTQIA+ community, are at an increased risk for mental health conditions and are confronted with interconnected challenges that make access to mental healthcare even more difficult. These individuals are at a higher risk of illnesses and are less likely to have personal or societal resources to deal with the mental health consequences.

Furthermore, a narrative review by Silveri et al. (2022), which summarised existing research on mental health barriers, specifically in the LGBTQIA+ community, found that they are more likely to have a mental health condition in their lifetime when compared to heterosexual people.

Inequities in the healthcare system promote disparities in access and quality of care for vulnerable populations (Carbonell et al., 2020; Mezzina et al. 2022), while historical injustices, such as discriminatory policies and practices, continue to influence resource allocation and maintain the gaps in healthcare access (Feagin & Bennefield, 2014; Gee & Ford, 2011; Yearby, 2018). Structural biases within healthcare systems exacerbate these difficulties, resulting in disparities in treatment and outcomes for marginalised groups (Bailey et al., 2017; Hardeman et al., 2016; Williams & Mohammed, 2013). Without addressing these systemic imbalances, efforts to enhance access to mental healthcare treatments will fall short of producing substantial and long-term results. Improving mental health on a global scale requires a holistic approach that encompasses socio-economic and cultural factors, as well as healthcare. To reduce the burden of mental health conditions on the global health system, an all-inclusive approach that considers policy, legislation, resources, education, cultural norms and all other relevant determinants of health is required (Becker & Kleinman, 2013; Freeman, 2022; Rathod et al., 2017).

This chapter synthesises current literature on mental health and explores how members of the LGBTQIA+ community experience the accessibility of mental healthcare services in rural settings. It focuses specifically on international policy and frameworks for mental healthcare, mental healthcare in South Africa, disparities in access to mental healthcare services between rural and urban areas in South Africa, and mental health and the LGBTQIA+ community. The chapter concludes with a discussion of the SEM as a conceptual framework for describing barriers to, and enablers of, access to mental healthcare services.

2.2 International Policy and Frameworks for Mental Healthcare

The frequency of mental health conditions globally has resulted in the development of numerous international frameworks to promote mental well-being, ensure access to mental health treatments, and combat stigma. These frameworks reflect a shift from isolated treatment models towards more comprehensive, rights-based approaches aimed at integrating mental healthcare into general health services. The WHO Comprehensive Mental Health Action Plan (CMHAP) exemplifies this approach, emphasising the need for a coordinated international effort to enhance mental healthcare services. This includes ensuring quality care, preventing mental health conditions, promoting mental health, and upholding human rights (WHO, 2021). The CMHAP further highlights the need to integrate mental health into PHC and to reduce stigma; to make treatments more accessible, particularly in low-resource settings. According to WHO (2021), a key aspect of the CMHAP's commitment to human rights is its aim to end abuses in mental health institutions, which has been a historical issue in many countries.

The Sustainable Development Goals (SDGs) aim to address global challenges and create a better, more sustainable future for all (United Nations, 2015). Furthermore, mental health is such a crucial component of sustainable development that it is included in the UN's SDGs, specifically the goal of achieving Good Health and Well-being (Gordon et al., 2020; United Nations, 2015). SDG 3: Good Health and Well-being aims to reduce premature mortality from non-communicable diseases, including mental health conditions, by promoting well-being and preventing substance abuse (United Nations, 2015). The integration of mental health into the SDG framework is significant, as it recognises mental health as a global health priority that requires equal attention to physical health with widespread socio-economic implications if left unaddressed. Mental Health is not only linked to SDG 3, but it has an intricate interdependence with other SDGs, influencing and being influenced by them. An example of this would be SDG1: No Poverty; poverty is a significant risk factor for mental health conditions, which in turn could lead to economic difficulties, perpetuating the cycle of poverty and inequality. Therefore, investing in mental health leads to better health, economic growth, and social stability, creating a ripple effect that could accelerate progress toward several SDGs (WHO, 2022b).

Another framework highlighting the importance of mental healthcare is the Convention on the Rights of Persons with Disabilities (CRPD). The CRPD calls for the protection of the rights of individuals with disabilities, including those with mental health conditions. The right to integrated, accessible mental health services in general healthcare settings is a fundamental principle of this framework (United Nations, 2006). With an emphasis on autonomy, informed consent, and anti-discrimination, the CRPD promotes a human rights-based approach that prioritises the dignity and self-determination of people with mental health conditions. This framework emphasises shifting away from institutionalised care toward community-based support systems, enhancing both accessibility and quality of care.

Accessibility poses a significant barrier to mental healthcare. As a result, the WHO launched the Mental Health Gap Action Programme (mhGAP) to improve accessibility (WHO, 2008). This program aims to support, especially, low- and middle-income countries to integrate mental health services within PHC. mhGAP focuses on mental, neurological, and substance use conditions, providing resources to upscale services and to train healthcare providers. This framework further emphasises building local capacity, thereby enabling countries to overcome resource constraints. The Programme also aims to empower non-specialists in mental healthcare, thus helping to close the treatment gap, making mental health services more widely accessible.

These frameworks collectively promote a paradigm shift in mental healthcare, foregrounding human rights, integration, and preventive approaches. The demand for accessible, integrated mental healthcare services is highlighted by these frameworks, which emphasise stigma reduction, high-quality care, and the recognition of mental health as crucial to sustainable development. By prioritising human rights, building local capacity, and fostering collaboration, these policies provide a pathway to a more effective and inclusive mental healthcare system globally.

2.3 Mental Healthcare in South Africa

South Africa is not immune to the global landscape when it comes to mental health conditions, as it represents a substantial burden of disease in the country (South African Department of Health, 2023). Despite mental health conditions being ranked high on the burden of disease in the country, the vast majority of people with mental health conditions lack access to the treatment they require (Lund et al., 2012; South

African Department of Health, 2013; South African Department of Health, 2023). The disparity is more evident when it comes to individuals of lower socio-economic status (Evans-Lacko et al., 2018; Gordon et al., 2020). This situation is aggravated by the fact that South Africa has one of the highest inequality rates in the world (Sulla et al., 2022), with socio-economically disadvantaged individuals discriminated against at every access point of the healthcare system. According to Gordon et al. (2020), socio-economically disadvantaged people in South Africa have a poorer expected health outcome than those who are not disadvantaged financially.

Access to mental healthcare services in South Africa is an extremely complex and challenging issue. The Mental Healthcare Act was promulgated in 2004 to ensure that all mental healthcare users have access to adequate mental healthcare services without discrimination based on their mental health status (South African Government, 2002). However, due to various factors, including weak health information systems, a lack of human resources for mental health, and a limited budget for mental health services outside of specialised service centres, the policy’s contents have failed to actualise (Docrat et al., 2019; Shisana et al., 2024; Vergunst, 2018).

Another policy that makes provision for LGBTQIA+ individuals and mental health in South Africa is the National LGBTI HIV Plan (2017–2022). It recognises that stigma and discrimination contribute to poor mental health outcomes for LGBTQIA+ people and links stigma to mental health condition, but it does not explicitly state how mental health services should be integrated into HIV service delivery, it simply states that mental health care will be provided by health care workers and peer educators (South African National AIDS Council, 2017). Research has shown that stigma and discrimination in healthcare settings contribute to avoidance of care and poorer mental health outcomes in the LGBTQIA+ community, thus hampering access to healthcare services (Luvuno et al., 2019; Moagi et al., 2020). Additionally, studies on HIV in South Africa have also shown that mental health conditions can act as a barrier to adherence and effective treatment for people with HIV, highlighting the need for better integration of mental health and HIV services (Marinda et al., 2022). This suggests that even though mental health is a component of the National LGBTI HIV Plan, the implementation lacks clear strategies to address mental health needs for LGBTI groups.

The government released its latest Mental Health Policy Framework and Strategic plan 2023-2030 in 2023, three years after the lapse of the previous edition. The updated Mental Health Policy Framework and Strategic Plan recognises that there are shortcomings, such as a lack of policy implementation, a lack of adequately trained staff, and underfunding of mental health services (South African Department of Health, 2023). The Plan proposes actions to improve mental health in South Africa, which include better financing of mental healthcare, better integration of mental healthcare into general healthcare, improving pathways to care, and strengthening healthcare across all provinces. It considers the shortcomings and the current state of mental health in South Africa. Yet, the efficacy of its implementation remains to be seen.

A study by Morar et al. (2024) that reviewed the state of mental health in South Africa found that even though there was official recognition of mental health, increased awareness, and policy changes, the implementation of these measures remains inadequate. In essence, they found that there was a gap between what is intended on paper and what is implemented in practice. In a separate study on the status of South Africa's mental healthcare system, Sorsdahl et al. (2023) had similar findings. Specifically, in relation to how well policy and legislation have translated into services and care, they discovered a vast treatment gap. Many individuals in need of treatment do not receive it due to obstacles, including resource constraints, inconsistent policy implementation, and skewed distribution of specialised mental healthcare services.

Given its long-lasting impact, Apartheid is another important factor that must be considered in the context of South Africa's mental health and its healthcare system (Das-Munshi et al., 2016; Harriman et al., 2021; Maphumulo & Bhengu, 2019). During Apartheid, people of colour experienced racism, violence, unjust treatment, and poverty, causing severe trauma. The South African healthcare system, as with most aspects of society, was divided along racial lines, with the white minority having access to the best resources. The current healthcare system represents a structural legacy of this era of injustice, with racial inequalities persisting in access, distribution, and outcomes (Das-Munshi et al., 2016). Therefore, the provision of mental healthcare must acknowledge historical injustices, alongside ongoing social and economic challenges, to ensure services that are comprehensive and equitable (Das-Munshi et al., 2016; Harriman et al., 2021).

The healthcare system in South Africa is divided into two sectors: public and private. The public sector serves the majority of the population, as most individuals are unable to afford care in private healthcare facilities (Docrat et al., 2019; Maphumulo & Bhengu, 2019). As a result, the public sector is overburdened, limiting access to quality healthcare (Docrat et al., 2019; Lund et al.,2012). Furthermore, only about 5% of the total public health budget expenditure is allocated to mental health, with disparities in the distribution of these funds between the provinces (Docrat et al., 2019). Although the public mental health system does provide services, it remains severely strained and is unable to meet the overwhelming demand. Underfunding, inadequate facilities, and lengthy waiting times all contribute to a system that is ill-equipped to meet the population's mental health needs. Despite the implementation of numerous strategies to improve the state of affairs, it remains a persistent challenge in the healthcare system (Docrat et al., 2019; Lund et al., 2012)

Moreover, the shortage of appropriately trained mental healthcare workers, including but not limited to psychiatrists, psychologists, occupational therapists, and social workers, is evident across the country (Docrat et al., 2019; Vergunst, 2018). However, it is predominantly seen in rural areas, thus exacerbating inequalities in access between urban and rural areas. A stark example of mismanagement and lack of expertise, as pointed out by Durojaye and Agaba (2018) and Dhai (2018), is the Life Esidimeni tragedy. In this instance, the Gauteng Department of Health transferred individuals suffering from mental health conditions to facilities that were ill-equipped to manage their specific conditions, contrary to expert advice. More than 100 patients died following this transfer from a specialised mental healthcare facility to various Nongovernmental organizations (NGOs) and other hospitals that lacked the necessary resources and expertise. This decision was in direct conflict with the national mental healthcare framework (Dhai, 2018; Durojaye & Agaba, 2018; Ferlito & Dhai, 2018).

Further significant barriers to accessing mental healthcare in South Africa include stigma and a lack of public awareness around mental health (Davies et al., 2021; South African Department of Health, 2013). The stigma surrounding mental health is a profound barrier. Many South Africans are reluctant to seek help because of their fear of discrimination and social exclusion (Eksteen et al., 2017; Harriman et al., 2021; Myers et al., 2019; Semrau et al., 2015). Monnapula-Mazabane and Petersen (2023) conducted a study in a provincial psychiatric hospital in the North-West Province. The study was aimed at understanding the nature and context of mental health stigma among those living with mental health conditions and the effects on their caregivers. It was found that participants who suffered from mental health conditions reported experiences of stigma from their own families and communities. Furthermore, caregivers reported that they withheld the patient's diagnosis from the community out of fear of being stigmatised, and this fear of stigma carried the risk of negatively affecting the patients' treatment-seeking. A culture of silence is perpetuated by this stigma, which impedes open dialogue about mental health.

2.4 Disparities in Access to Mental Healthcare Services between Rural and Urban Areas in South Africa

South Africa has noteworthy disparities in mental healthcare accessibility, especially between rural and urban areas. Rural areas are often faced with systemic challenges, which are further compounded for marginalised groups, such as the LGBTQIA+ community. Mental healthcare services are often more prevalent in urban areas as opposed to rural areas, thus making it difficult to access and receive proper mental healthcare in rural settings, as services are in short supply and often not culturally sensitive, especially to the LGBTQIA+ individuals (De Kock & Pillay, 2016; Maria et al., 2025). A severe shortage of mental healthcare workers in South Africa exists, especially in rural areas. The national ratio of psychiatrists is 1.53 per 100,000. However, in rural areas, it drops to as low as 0.03 psychiatrists per 100,000 people (Janse van Rensburg et al., 2022). The distribution of mental health nurses follows a similar pattern, with a national rate of 9.7 per 100,000, but only 0.68 per 100,000 in rural settings (De Kock & Pillay, 2016). De Kock and Pillay (2016) assert that even when the facilities are available, they are not always appropriately staffed, with 96 % of rural mental health facilities not having psychiatrists, 81% not having mental health medical doctors, 64% not having clinical psychologists, and 61% of the facilities do not have mental health nurses on staff.

Challenges in accessing mental healthcare for rural populations are further compounded by geographical and logistical barriers. Individuals who reside in urban areas are on average approximately 2 km from the nearest healthcare facility, whereas those in rural areas could be over 5 km away. Added to this, the limited transport options available make it very difficult for people living in rural areas to access mental healthcare. Furthermore, understaffing and inadequate resources often plague rural healthcare facilities, thus limiting the scope of services that are available (Lehohla, 2011).

LGBTQIA+ individuals in rural areas are faced with additional challenges, such as discriminatory attitudes among healthcare providers. Rural communities tend to have traditional or conservative views, which lead LGBTQIA+ individuals to experience moral judgment, refusal of care, and occasional subjection to religious interventions aimed at changing their sexual orientation or gender identity (Müller, 2017).

As a result of these experiences, LGBTQIA+ individuals choose not to seek care when needed, resulting in poorer mental health outcomes. Additionally, healthcare workers, especially in rural areas, are not always equipped to deal with the specific health needs of the LGBTQIA+ community. This lack of affirming care exposure and training for healthcare workers leads to inadequate care for LGBTQIA+ individuals. Moreover, Luvuno et al. (2019) argue that the dearth of targeted health policies and data collection on LGBTQIA+ healthcare hinders the development of effective interventions.

2.5 Mental Health and the LGBTQIA+ Community

2.5.1 LGBTQIA+ and rights

The United Nations (UN) has been at the forefront of the promotion of LGBTQIA+ rights. The UN argues that the protection of LGBTQIA+ individuals from discrimination and violence does not call for new standards or human rights laws. Instead, they maintain that countries are already legally required to protect the human rights of LGBTQIA+ individuals under the existing frameworks, in line with the Universal Declaration of Human Rights (Office of the High Commissioner for Human Rights, n.d.). However, the absence of a ratified international policy or treaty that specifically protects LGBTQIA+ communities from abuses has resulted in different approaches to the situation in different countries (Langlois, 2018; Lee & Ostergard, 2017). Given the global landscape and the human rights abuses being faced by the LGBTQIA+ community, it could be argued that they are not recognised as a vulnerable group in society (Arora et al., 2022; Edenborg, 2023).

In fact, there has been a global increase in anti-LGBTQIA+ rhetoric by many countries, such as Uganda and Russia, ratifying anti-LGBTQIA+ laws (Ayoub & Stoeckl, 2024). These laws, in essence, criminalise being part of the LGBTQIA+ community, which is in direct contradiction with basic human rights (Anabtawi, 2022; Edenborg, 2023; Langlois, 2018; Lee & Ostergard, 2017). Many countries ban same-sex partnerships, including Lebanon and Russia, often using religious or cultural beliefs as justification for these bans. These regulations not only make it more difficult for LGBTQIA+ people to live freely and autonomously, but they also foster a culture of fear and persecution. In some cases, an individual’s sexual orientation or gender identity can lead to incarceration, violence, or even death (Anabtawi, 2022; Lee & Ostergard, 2017).

LGBTQIA+ rights violations manifest in the form of insufficient legal protections against discrimination. In some countries, there is a lack of inclusive anti-discrimination laws that explicitly address gender identity or sexual orientation. This lack of relevant legislation leaves LGBTQIA+ individuals exposed to discrimination in many areas of their lives, including employment, housing, and education (Anabtawi, 2022; Lee & Ostergard, 2017). Many countries do not have policies that recognise or respect gender identity, which results in problems with acquiring identification documents that display a person’s true gender (da Luz Scherf et al., 2022; Lee & Ostergard, 2017). People who identify as part of the LGBTQIA+ community face social, legal, and institutional challenges that infringe upon their basic human rights (Kum, 2017; Salerno et al., 2020).

Transgender people often experience the most violations of their rights because of additional challenges such as a lack of legal recognition and access to healthcare (da Luz Scherf et al., 2022). This not only infringes on their right to self-determination but also increases transgender individuals’ vulnerability to discrimination and violence. LGBTQIA+ rights violations occur and persist around the world, reflecting a worrying trend of marginalisation and discrimination. Since reclaiming the presidency in 2025, Donald Trump and his administration have overturned various LGBTQIA+ protections, such as preventing gender affirming care in youth and reinstating a ban on trans people in the United States (US) military (Gavulic et al., 2025). Furthermore, the administration also cut funding for LGBTQIA+ specific mental healthcare services (AP News, 2025). These changes implemented by the Trump administration are expected to have far-reaching effects on the LGBTQIA+ community in America and globally

(Them.us, 2025). Societal attitudes towards the LGBTQIA+ community are crucial in preventing rights violations. Prejudice and a lack of understanding within society contribute to an unreceptive environment that supports discrimination and violence (Ayhan et al., 2020; Burton et al., 2021; Ekmekci, 2017).

South Africa is renowned for having one of the most progressive constitutions, which upholds the rights of the LGBTQIA+ community. Despite this, the lived reality for the LGBTQIA+ community, especially in rural areas, is not always aligned with these legal protections (Joseph, 2013). Traditional beliefs and religious norms are predominant in these communities and tend to stigmatise non-heteronormative identities.

Even with these inclusive laws, social acceptance of gender-diverse people is low (Joseph, 2013). Policy and practice are not always integrated, and this disconnect creates an exclusionary environment for the LGBTQIA+ community.

The stigma experienced by LGBTQIA+ individuals in rural areas has a direct impact on their mental health. Chronic exposure to discrimination and isolation puts them at a disproportionately higher risk for developing mental health conditions (Moagi et al., 2021; Silveri et al., 2022). Additional factors, including internalised homophobia and the pressure to conform to societal gender norms, also contribute to their psychological distress (Newcomb & Mustanski, 2010). These challenges are amplified in situations where LGBTQIA+ individuals are rejected by their families and communities, as they are left with little to no support and fewer spaces to express their identities (Crockett et al., 2022; Zimmerman et al., 2015).

The lack of affirming mental health services is another issue that impacts the mental health of LGBTQIA+ individuals in rural areas. According to Muller and Hughes (2016), LGBTQIA+ individuals in Southern Africa are uncomfortable with discussing their sexual orientation or gender identity with healthcare providers. The researchers also noted that LGBTQIA+ individuals experienced discrimination from healthcare workers. This culturally insensitive treatment of individuals might lead to mistrust and poor experiences within the healthcare system, which could discourage individuals from seeking necessary care (Müller , 2017). Additionally, when the services are available, they are under-resourced, and healthcare workers are not sufficiently trained to attend to the mental health needs of the LGBTQIA+ community (Kidd et al., 2016).

2.5.2 Vulnerability

The concept of vulnerability relates to extrinsic economic, societal, and cultural factors that must be addressed to protect the human dignity and rights of individuals belonging to specific groups (Ekmekci, 2017; Shivayogi, 2013). Many of the challenges that the LGBTQIA+ community face are externally imposed and beyond their control. Their vulnerability is multi-faceted, stemming from a combination of social, legal, economic, and health-related factors (Salerno et al., 2020).

As a result, the LGBTQIA+ community is recognised as a vulnerable population, experiencing disadvantages in terms of health and determinants of health (Ekmekci, 2017). This marginalisation leads to poorer health outcomes when compared to heterosexual individuals (Moagi et al., 2021; Salerno et al., 2020). Given their status as a vulnerable group, concerted efforts are necessary to safeguard the human rights of LGBTQIA+ individuals (Arora et al., 2022; Langlois, 2018).

2.5.3 Discrimination and stigmatisation

Members of the LGBTQIA+ community experience disparities across multiple aspects of life, including education, employment, healthcare, and social participation. Society often regards heterosexuality as the traditional norm, whereas homosexuality is frequently perceived as deviant or nonconforming. This results in discrimination and rejection of the LGBTQIA+ community (Sibanyoni et al., 2023; Taskiran Eskici et al., 2021). This discrimination, often termed homophobia, refers to negative attitudes, feelings, and behaviours towards sexual variation and people who identify as part of this community (Ventriglio et al., 2021). As a result, LGBTQIA+ individuals may be exposed to threats, harassment, and abuse (Sibanyoni et al., 2023).

Stigmatisation further marginalises LGBTQIA+ individuals who experience higher levels of poverty, homelessness, and unemployment when compared to their non-LBGTQIA+ counterparts (Kum, 2017; Salerno et al., 2020). In the workplace, LGBTQIA+ people have typically been the focus of prejudice and discrimination. Due to their sexual orientation, they may face stigmatisation, violence, diminished work prospects, job offers, and promotions, among other forms of discrimination and prejudice. An online survey conducted in Portugal investigating the impact of psychological distress on occupational well-being found that LGBTQIA+ individuals received harassment from all levels within the workplace, whether it be from colleagues or management (Pereira et al., 2022). This discrimination persists despite anti-discrimination protections as Beatriz and Pereira (2023) found that Portuguese LGBTQIA+ workers still experienced discrimination based on sexual orientation and gender identity, highlighting the need for more legal, institutional, and social support to ensure a safe workplace for LGBTQIA + individuals.

Similarly, a Turkish survey among nursing students found that male students had more negative attitudes towards LGBT individuals, indicating the need to raise awareness among nurses to provide better access to healthcare services (Özdemir & Erenoğlu, 2022). Research indicates that stigma and discrimination can have detrimental effects on the health of LGBTQIA+ individuals. Discrimination and stigmatisation not only hinder personal development, but they also perpetuate the cycle of exclusion and poverty, further compounding the vulnerability of LGBTQIA+ individuals (Ayhan et al., 2020; Burton et al., 2021 Ekmekci, 2017).

2.5.4 Mental health impact of rights violations and discrimination

Violations of LGBTQIA+ rights have a profound impact that extends beyond individual suffering. Discrimination against this vulnerable community impedes societal growth, perpetuates negative stereotypes, and reinforces destructive norms. It also hampers the development of inclusive societies where diversity is celebrated, which limits the possibility of social cohesion and mutual understanding (Ayoub & Stoeckl, 2024).

Social exclusion, discrimination, victimisation, and poverty are key determinants of mental health (Bostwick et al., 2014; da Luz Scherf et al., 2022; Kidd et al., 2016; Nowaskie & Sowinski, 2019). LGBTQIA+ individuals experience these factors at a disproportionate rate when compared to their heterosexual counterparts. A scoping review by Kidd et al. (2016), identified an increased risk for severe mental health conditions within this population, consistent with research indicating higher rates of mental health conditions among LGBTQIA+ individuals (Nowaskie & Sowinski, 2019; Quinn et al., 2015).

Access to healthcare presents a significant challenge for LGBTQIA+ people. Quinn et al. (2015) note that they face unique barriers in healthcare settings. A 2019 US study found that primary care providers lacked the necessary knowledge and cultural competency regarding LGBTQIA+, resulting in negative attitudes and biases as well as inconsistencies in clinical practice (Nowaskie & Sowinski, 2019). In South Africa, Stevens (2012) investigated transgender access to sexual health services and found that most respondents believed healthcare practitioners displayed discriminatory or hostile behaviour when attending to them.

This lack of cultural competency and biases impedes access to healthcare for LGBTQIA+ individuals, which could, in turn, exacerbate mental health conditions (Nowaskie & Sowinski, 2019).

Economic circumstances, particularly poverty, also adversely affect mental health. Badgett et al. (2019) interviewed approximately 500,000 participants across 35 US states from 2014 to 2017 and found that members of the LGBTQIA+ community were more likely to live in poverty than the rest of the population. Kinitz et al. (2022) in a systematic review of Canadian studies that focused on LGBTQIA+ health and poverty, identified that the intersection between LGBTQIA+ health and poverty generates distinct forms of discrimination. These unique challenges result in reduced access to healthcare and poorer overall health outcomes.

Interpersonal and social support further influence mental health outcomes. Rejection from family members due to gender identity or sexual orientation is linked to higher rates of anxiety, depression, and suicidal ideation (McConnell et al., 2016; Ryan et al., 2010). A longitudinal study conducted in Chicago, US, found that LGBT adolescents with low or no family support demonstrated more psychological distress than those with more family support (McConnell et al., 2016). Similarly, a scoping review by McDonald (2018) reported that LGBTQIA+ youth face disproportionate rates of mental health conditions compared to their heterosexual peers, and that a lack of social support or low social support was linked to higher levels of mental health conditions, alcohol or drug misuse, and low self-esteem. Although this study focused on youth, it could be postulated that the effects of low social support could be carried over into adulthood. Having the support of friends and romantic partners often acts as a buffer against the effects that stigma and discrimination have on mental health (Cavarra et al., 2025; Watson et al., 2019). Addressing these challenges requires a holistic approach that encompasses legal reforms, education, advocacy, and the promotion of inclusive societal attitudes.

Stressors related to identity exploration during early adulthood, along with milestones such as getting married and starting a family, can further increase stress and substance use within the LGBTQIA+ community (Goffnett & Goldbach, 2020). Several studies have examined the relationship between transgender-related discrimination and substance use outcomes. For example, Wolfe et al. (2021) found that transgender individuals in Massachusetts and Rhode Island, who experienced discrimination, were more likely to engage in frequent substance abuse and develop substance use disorders. Similarly, Reisner et al. (2015) found that more than a quarter of their 2,578 transgender participants used substances as a coping mechanism in response to stigma encountered in healthcare settings. This is further compounded by habitual substance abuse as a coping mechanism, whereby individuals continue to use substances regardless of the stressor (Felner et al., 2020). Orchard (2023) supports these findings, indicating that problematic substance use is more prevalent in the LGBTQIA+ community than in the general population.

Finally, a systematic review by Maltempi et al. (2024) found that stigma is associated with poorer physical and mental health outcomes, risky behaviour, and healthcare avoidance. They further discovered that stigma led to negative health behaviours such as substance abuse highlighting the cyclical interaction between societal, structural, and individual stressors that reinforce the vulnerability of LGBTQIA+ individuals.

2.6 Conceptual Framework

The study adopted the SEM to explore and describe the perceptions of members of the LGBTQIA+ community regarding access to mental healthcare services within their community. The SEM was developed in the 1980s by Urie Bronfenbrenner as a conceptual theory to understand human development. It was selected for this study as it is also used to identify factors contributing to health-related behaviours (Kilanowski, 2017). The SEM views health as broad, and it considers many factors, from intra-personal factors (e.g., physiology) to macro-level factors (e.g., politics) that might influence the health of an individual or population (Clinical and Translational Science Awards Consortium Community Engagement Key Function Committee Task Force [CTSA Consortium Task Force], 2011; Wold & Mittelmark, 2018).

2.6.1 The historical background of the SEM

The SEM has its origins in ecological theories of human development, most notably those proposed by psychologist Urie Bronfenbrenner in the 1970s. Bronfenbrenner's Ecological Systems Theory argued that human behaviour is influenced by different layers of environmental factors, which he categorised into microsystems (immediate environments such as family and school), mesosystems (interactions between microsystems), exosystems (external factors that influence the individual indirectly) andmacrosystems (cultural and societal norms) (Bronfenbrenner, 1977).

McLeroy et al. (1988) expanded on Bronfenbrenner’s work and formalised the theory (i.e., the Socio-Ecological Model, SEM) in the 1980s, proposing that health-seeking behaviour is influenced by both internal and external environmental factors. The factors are based on five levels, including individual, interpersonal, organisational, community, and policy that shape behavioural and health outcomes. The SEM gained prominence in public health, where it was utilised to address complicated topics such as chronic illness prevention, sexual health, and substance abuse. Where traditional models focus entirely on individual risk factors, the SEM examines the various levels of influence on an individual’s behaviour and development. It is underpinned by the understanding that health behaviours are affected by numerous factors and on different levels (individual, intrapersonal, community, societal, and policy), as well as the interaction between these levels (CTSA Consortium Task Force, 2011; Kilanowski, 2017; Wold & Mittelmark, 2018). The SEM provides researchers with a framework to explore how broader social determinants of health, such as poverty, education, and access to healthcare, impacted health and health-seeking behaviour (Stokols, 1996).

As the SEM developed, it started bringing in more specific references to policy and environmental factors. Thus, acknowledging the impact that legislation, social norms, and public health infrastructure have on individual behaviour (Golden & Earp, 2012). In part, this shift towards incorporating policy in the model was driven by the increasing use of the SEM in policy research, where individual behaviour change was inadequate without supportive environmental changes (Sallis et al., 2006). The SEM is applied across a wide range of disciplines and is commonly used in developing health promotion strategies that address issues such as substance abuse and mental health (Golden & Earp, 2012; Thaivalappil et al., 2024).

The SEM has evolved from its beginnings in Bronfenbrenner's ecological theory of human development to become a widely used framework for addressing complex social and health issues. Through recognizing and exploring the interaction between individual, interpersonal, organisational, community, and policy factors, the SEM has allowed researchers to develop more comprehensive intervention strategies. Its application across fields such as public health and education demonstrates its flexibility in addressing both individual behaviour and broader societal influences (Golden & Earp, 2012; Stokols, 1996).

2.6.2 Constructs of the SEM

The SEM examines individuals and their relationships with people, organisations, and their community at large. The model comprises five levels, namely Individual, Interpersonal, Organisational, Community, and Policy. However, this study followed the CDC four-level model, which includes the Individual, Interpersonal /relationships, Organisational/ community, and Societal levels, for health promotion when describing barriers and facilitators that LGBTQIA+ individuals may perceive or experience when accessing mental healthcare services (CTSA Consortium Task Force, 2011). These constructs provide a multidimensional approach to the understanding of barriers and facilitators regarding access to mental healthcare services for LGBTQIA+ persons in their communities. This section delves into each level.

Figure 2.1: Adapted SEM with examples of factors that could influence access to mental healthcare (CTSA Consortium Task Force, 2011)

2.6.2.1 Individual level

The individual level of the SEM focuses on personal factors such as knowledge, attitudes, beliefs, skills, and biological issues (Nyambe et al., 2016). This level is usually examined to gauge how personal traits affect behaviour and health outcomes. In this study, the individual level referred to personal factors such as age, education, knowledge, and attitudes that act as barriers or facilitators to accessing mental healthcare services. Burns (2011) argues that individual factors such as literacy, race, socio-economic status, and gender all impact the accessibility of mental healthcare. Whitehorne-Smith et al. (2024) used the SEM to explore the barriers and enablers of public healthcare access for people with comorbid serious mental and chronic physical illnesses in Jamaica. Their participants reported that individual factors, including gender, education level, beliefs, and the lived experiences of health services, all had an impact on healthcare access.

Factors such as attitudes, beliefs, knowledge, expectations, and other personal factors all have an influence on whether they will access mental health services. Crockett et al. (2022) employed the SEM to explore mental health seeking and experiences among LGBTQIA+ university students in Chile. They determined that individual factors, such as attitudes or knowledge regarding mental healthcare, such as negative presumptions about mental healthcare, confidence in the available services, negative experiences with services, ignorance on how to access online therapy, uncertainty about when to seek help, or fear that the professional will downplay their issues, all acted as barriers to seeking mental healthcare.

2.6.2.2 Interpersonal/relationship level

The interpersonal level of SEM comprises social relationships, including those with family, friends, peers, and co-workers. These relationships have a major influence on people's health and well-being (McLeroy et al., 1988). Important social relationships, such as a significant other, could have an impact on whether and when a person seeks help for physical or mental health conditions (McLeroy et al., 1988; Ngwenya et al., 2020). In this study, the factors at the interpersonal level include relationships with friends, family, and significant others. For example, Whitehorne-Smith et al. (2024) found in a Jamaican study that participants experienced interpersonal stigma, which stems from societal attitudes and beliefs that result in discrimination and social isolation. This discrimination negatively impacted the participants' ability to seek and engage with healthcare services due to the fear of judgement from their family members and the community (Whitehorne-Smith et al., 2024). On the interpersonal level, family, friends, and other significant people exert considerable influence on an individual’s decision to access mental healthcare services. As was discovered by Crockett et al. (2022), it was often family members, friends, or partners who recommended and encouraged the participants to seek mental health help when they noticed the participants were distressed.

2.6.2.3 Organisational/community level

The organisational/community level is concerned with institutions and organisations that individuals interact with on a daily or regular basis. This includes workplaces, schools, clinics, and so forth (Sallis et al., 2015). These organisations can have a significant impact on the health and health-related behaviour of their members. Organisations often also mirror social norms and values; thus, they can exert a positive or negative influence on their members’ health. Additionally, they offer a platform that promotes social support and behavioral change (McLeroy et al., 1988). In this study, the organisational/community level included issues such as accessibility of mental healthcare services and healthcare providers’ attitudes towards the LGBTQIA+ community and/or mental health.

Using the SEM model, Boutilier et al. (2024) conducted a study on barriers and facilitators to seeking inpatient psychiatric care among transgender and nonbinary people. They found factors at the organisational/community level, such as having access to community networks and organisations that acted as a pathway to improved access to mental healthcare services, reduced the need for inpatient care. It also served to build trust between individuals and the mental health system. This highlights the importance of NGO’s and other community organisations in driving access to mental healthcare services. In a separate study, Nic Giolla Easpaig et al. (2022) performed a systematic review of the health and healthcare of rural LGBTQIA+ people in the UK, USA, Canada, Australia, and New Zealand. The researchers found that most of the studies reported that interactions between the rural LGBTQIA+ community and healthcare providers were marked by discrimination, stigma, and degradation, whether explicit or implicit. Concern and fear of negative interactions with healthcare providers were cited as a barrier to healthcare access.

2.6.2.4 Societal level

The societal level examines how broader societal factors, such as cultural and societal norms, influence health outcomes (CTSA Consortium Task Force, 2011). According to United Nations Children's Fund (2021), societal norms are made up of practices, expectations, and shared beliefs that mould behaviours within society. These norms can sometimes lead to discrimination. Stigmatisation and discrimination can have an impact on health behaviour and can act as a barrier to seeking help (Matsea et al., 2018; Thornicroft et al., 1993; Van Spijker et al., 2019).

An American study that aimed to understand how stigma impacts mental health concerns and treatment in rural, low-income populations found that the stigma surrounding mental health conditions was often driven by perceptions of weakness or faking, which acts as a barrier for individuals who are seeking help (Crumb et al., 2019). Additionally, Mitchell et al. (2023) assert that norms that marginalise certain groups, such as LGBTQIA+ individuals, contribute to mental health inequalities by exacerbating discrimination and exclusion.

Discriminatory public policies in any sector, whether in employment, education, or healthcare, aggravate the situation by limiting opportunities and reinforcing social inequities (Yearby, 2024). Even when public policies are in place, the implementation might not be sufficient. Marais and Petersen (2015) found that the Mental Health Policy Framework, even though it is aligned with the WHO Mental Health Action plan, would be difficult to implement. Issues such as low prioritisation and stigmatisation of mental health conditions, weak managerial and planning capacity to develop and the implementation of mental healthcare plans at the provincial and district level, and no dedicated mental health budget were a few of the impediments noted. In this study, the societal level focused on factors such as cultural and societal norms, as well as policy that may influence access to mental healthcare services.

2.6.3 Application of the SEM to describe barriers to and facilitators of accessing mental healthcare services for LGBTQIA+ individuals

The SEM has been applied to various qualitative mental health-related research studies. It has also been used to explore the accessibility of mental healthcare. A summary of previous studies that have used the SEM to address health-related challenges, more specifically, addressing barriers to accessing mental healthcare, as well as mental healthcare for the LGBTQIA+ community, follows:

- Boutilier et al. (2024) used a socio-ecological framework to explore the barriers and facilitators influencing transgender and nonbinary people's access to inpatient psychiatric care in America. The researchers collected data through semi-structured interviews with transgender and nonbinary patients who were admitted to psychiatric hospitals. Using thematic analysis within a modified social-ecological model, the researchers identified barriers and enablers across three levels. Firstly, with individual-level factors, participants expressed distrust toward the mental healthcare system, feelings of unsafety, loss of autonomy during treatment, tendencies to downplay their mental health needs, and a sense of responsibility to others. Secondly, with interpersonal level factors, themes included insufficient support for their transgender or nonbinary identity, a lack of knowledge about these identities among mental healthcare workers, and the importance of allyship in care. Lastly, with structural level factors, barriers included the carceral nature of some inpatient settings, financial burdens, and limited availability of non-profit treatment options. The study concluded that transgender and nonbinary individuals face numerous obstacles to accessing equitable inpatient psychiatric care.

- Mitra and Globerman (2014) conducted a study that explored healthcare utilisation among the LGBTQIA+ populations, emphasising the impact of discrimination on delaying or avoiding care. The study used the SEM to examine how personal experiences with healthcare providers, their attitudes, and the anticipated discrimination affected care-seeking behaviours. The researchers found that at the organisational/community level, when healthcare providers have open attitudes, access to healthcare for LGBTQIA+ individuals is improved.

- Bettis et al. (2025) carried out a study in the Southeastern US that aimed to describe the experiences of parents of LGBTQIA+ youth in relation to navigating services for their children. The data were collected through semi-structured focus groups. The researchers used the SEM to contextualise their findings and the parents' recommendations for improving LGBTQ + youth and family mental healthcare services. The study confirmed that there is a demand for affirming and accessible mental health resources for LGBTQ + youth and families in the Southeastern U.S.

- Zimmerman et al. (2015) conducted a study in the US that studied the effects of rejection and support from family on the health outcomes of sexual minority women (SMW). Using the SEM, the researchers found that family rejection was linked to poor health outcomes, while community connectedness and being openly out to family and the community were protective factors. The study emphasises how crucial supportive social and community environments are for fostering the mental health of SMWs.

- Crockett et al. (2022) used the SEM to explore the barriers and facilitators influencing mental health help-seeking among LGBTQIA+ university students in Chile. Barriers such as difficulties in recognising mental distress, fear of discrimination, lack of social support, and concerns about non-affirming professionals were noted. They also found that personal acknowledgment of mental health needs, supportive social networks, and affordable services acted as facilitators. Some of the participants preferred healthcare workers who were familiar with LGBTQIA+ issues, while others preferred individuals who were part of the LGBTQIA+ community. The study highlights the need for more inclusive and accessible mental health services tailored to LGBT+ students' experiences.

2.6.4 Strengths of the SEM

The SEM acknowledges that individual behaviours are influenced on multiple levels, including personal, social, and environmental factors. This allows researchers to develop comprehensive interventions. Stokols (1992,1996) argues that these interventions are most effective when at least two of these factors are targeted simultaneously. The SEM is comprehensive and, as such, it is particularly effective in addressing public health challenges because it addresses personal behaviours, environmental factors, and policies at the same time (Golden & Earp, 2012).

Another strength of the model's comprehensiveness is the fact that it encourages multi-level interventions, which have been proven to be more effective than individual interventions (Stokols, 1992). The SEM's unique consideration of the interaction between factors across the different levels ensures an increased likelihood that interventions would be sustainable and have a lasting impact (Stokols, 1992). The SEM is flexible and can be customised to address the needs of different populations, making it a valuable tool for developing interventions.

Additionally, the model focuses on policies and the physical environment, factors which are often overlooked by individualistic approaches. These factors can have significant effects on health behaviours and are critical for creating sustainable change and improving health outcomes at a societal level (Golden & Earp, 2012; Sallis et al., 2006).

2.6.5 Limitations of the SEM

The SEM is very comprehensive, which in certain cases could be viewed as a limitation. Addressing multiple levels simultaneously is a complex task and requires coordination across different sectors and with different stakeholders, which can be difficult in practice (Eriksson et al., 2018). Added to this, the precise impact of these interventions remains challenging to pinpoint due to difficulties in isolating the specific contribution of each level to the overall outcome. It becomes extremely challenging to assess the efficacy of the interventions using the SEM since different factors interact with one another at different levels (McLeroy et al., 1988). A notable drawback of the model is that there are no guidelines on how to identify the most significant factors that influence behaviour at each level.

This ambiguity introduces potential uncertainty regarding the focus for intervention development. As a result, practitioners could encounter difficulties in determining where to focus their efforts to achieve the biggest impact (Stokols, 1996).

Unlike other models, the SEM emphasizes the importance of environmental and policy influences; however, some critics contend that it underestimates the role of individual agency. Individuals may make decisions that contradict broader social and environmental influences, which suggests that personal motivation and decision-making also play a major role in behaviour change (Stokols, 1996). Golden and Earp (2012) suggest that an overemphasis on external factors may inadvertently disregard personal responsibility and empowerment, which are essential for sustainable behaviour change.

2.7 Barriers to Accessing Mental Healthcare Services Across the SEM Levels

The research on LGBTQIA+ access to mental health services is limited; therefore, this section introduces barriers experienced in accessing mental health services in general, although it highlights when a study specifically refers to the LGBTQIA+ community.

2.7.1 Individual level

The LGBTQIA+ community faces many challenges when trying to access the healthcare system. On the individual level of the SEM, these barriers in accessing mental healthcare services stem from several barriers including, but not limited to, a lack of knowledge of where to find help, language barriers, stigma attached to mental health issues and inequities as a result of demographics and geographical location (Moroz et al., 2020; Priester et al., 2016).

A study in Chile applied the SEM to examine mental health help-seeking behaviours and experiences with mental health services among LGBTQIA+ university students. They identified certain personal factors on the individual level impeding students' access to health services. Findings revealed several barriers, such as students' negative assumptions about mental health services or distrust in the quality of the services. Others were unsure about when to seek help or how to access online therapy.

Additionally, academic demands created time constraints, while psychological factors like low energy and motivation further discouraged help-seeking (Crockett et al., 2022).

Similarly, low levels of mental health literacy related to the LGBTQIA+ experience act as a barrier to mental healthcare access. Members of the LGBTQIA+ community are often unaware of available affirming services or how to navigate health systems. A study by Ho et al. (2024) aimed at examining the enablers, barriers, and unmet needs experiences of LGBT+ individuals in accessing mental healthcare services in Malaysia found that LGBTQIA+ individuals usually lacked knowledge about where or how to access culturally competent mental healthcare. The study identified their lack of knowledge as a barrier to access.

Furthermore, people living in underserved and rural communities are also faced with similar barriers, which include a lack of knowledge of mental health conditions, ignorance about when or where to access mental healthcare services, as well as the fear of discrimination. A study conducted in two rural towns in South Africa found that there is a lack of mental health awareness and understanding among community members in rural South Africa, which acts as a barrier to accessing mental healthcare services. In addition to the lack of awareness, the study also uncovered that these communities often stigmatise people with mental health conditions. The stigma would be internalised and act as a barrier to mental healthcare access (Benjamin et al., 2021).

In a study conducted in southern California, researchers interviewed mental health workers that work for a health and welfare agency serving predominantly low-income Latin families. The researchers found that some of the most pronounced barriers to accessing mental healthcare for these underserved people were attitudes, including stigmatised beliefs about help-seeking and the lack of awareness with regards to local mental healthcare services (Torres Sanchez et al., 2022).

Boutilier et al. (2024) found that their transgender and non-binary participants described lived experience and loss of autonomy as barriers to access to mental healthcare services. Participants reported that they were reluctant to access the mental healthcare system again due to negative past experiences.

This finding is supported by Brown et al. (2016) who discovered that members of the LGBTQIA+ community are less likely to seek help because of the perception that they might be harassed or misunderstood due to their sexual orientation. Jessani et al (2024) conducted a systematic review on healthcare access and barriers to utilisation among transgender and gender diverse people in Africa. In most of the studies they reviewed, negative past experiences were found to act as a barrier to accessing healthcare services.

The fear of disclosing one's sexual identity or mental health status can also act as a barrier to mental healthcare. Brooks et al. (2018) performed a systematic review with the aim of understanding the barriers and facilitators experienced by LGBT adults in healthcare settings with regards to sexual orientation disclosure. They found that in some cases participants had concerns that breaches in patient–provider confidentiality would lead to non-clinical staff, their family and friends, or the wider community finding out about their sexual orientation and therefore they decided not to disclose. This non-disclosure therefore limits access to professional care and social support. This is in line with Gonçalves et al. (2025) who undertook a scoping review on literature in relation to barriers and facilitators to mental healthcare access and engagement for LGBTQA+ people with psychosis. According to their findings, LGBTQIA+ people often had fears about involuntary disclosure of their identity and confidentiality in healthcare settings, which acted as a psychological barrier that impacted these individuals' willingness to engage with services.

Internalised homophobia, which could be described as an internalisation of societal homophobic attitudes, can also act as a barrier to accessing mental healthcare (Chard et al., 2015). It includes the internalisation of negative attitudes that conflict with the persons sexuality and could lead to hatred and disgust with oneself (Chard et al., 2015; Newcomb and Mustanski, 2010). This process may cause discomfort with one's own sexual orientation and subsequently, extreme stress, repression of one's own desires, mental health conditions, and a higher risk of suicide (Chard et al., 2015; Newcomb & Mustanski, 2010; Ventriglio et al., 2021). LGBTQIA+ individuals who experience internalised homophobia often do not disclose their sexuality to their healthcare providers. This non-disclosure stems from a fear of embarrassment or other more serious reactions from healthcare providers (Dodds et al., 2005). Gonçalves et al. (2025) found that LGBTQIA+ individuals, especially those diagnosed with psychosis, often internalise the negative attitudes that society has towards their sexual or gender identities, which in turn breaks down self-esteem and exacerbates feelings of shame and fear related to seeking mental healthcare. This internalised stigma can increase avoidance behaviours, ultimately preventing individuals from disclosing their symptoms or identity-related concerns to healthcare providers.

Socio economic status and affordability could also be seen as a barrier to healthcare access for members of the LGBTQIA+ community. Research conducted in the US among older LGBTQIA+ people of colour indicates that unemployment rates and homelessness is higher in the LGBTQIA+ community when compared to the heterosexual community (Kum, 2017). In a study that discusses the broader experiences of LGBTQIA+ youth during the COVID-19 pandemic, drawing on studies and data from various contexts, primarily within the US, Salerno et al. (2020) affirmed that LGBTQIA+ youth face many socio-economic inequities. For example, Homelessness rates were found to be disproportionately high among LGBTQIA+ youth, and the pandemic exacerbated the issue. Furthermore, LGBTQIA+ youth people from lower-income backgrounds often had less access to healthcare.

Jessani et al. (2024) performed a systematic review of barriers to healthcare access for transgender and gender diverse populations in Africa, to find that financial constraints such as the inability to afford treatment, medical bills, medication and transportation to and from healthcare facilities limited their access to care. Moreover, Shipherd et al. (2010) conducted a study to examine mental healthcare use and barriers to mental healthcare utilisation among Transgender people in Boston. They found that most of their respondents noted that the cost of mental healthcare was a significant barrier to access.

2.7.2 Interpersonal level/relationship level

Interpersonal factors influence the accessibility of mental healthcare services for members of the LGBTQIA+ community. LGBTQIA+ individuals are often rejected and do not receive support from family members and friends, which could be seen as a significant barrier to accessing mental healthcare services at an interpersonal level (Pate et al., 2024)

Strumpher et al. (2014) conducted a study in the Eastern Cape Province of South Africa to explore the barriers to accessing care by people with mental health conditions from the perspectives of mental health trained nurses. They found that a lack of family support for people with mental health conditions acted as a significant barrier to mental healthcare access.

Close family members also often stigmatise and reject individuals with mental health conditions, which negatively impacts their mental well-being (Adu et al., 2024). Furthermore, even the fear of rejection and discrimination from peers may discourage LGBTQIA+ individuals from seeking mental healthcare (Goldbach & Gibbs, 2017). Peer pressure and the anxiety of being “othered” can prevent people from getting treatment, which could exacerbate the mental health condition (Robinson & Espelage, 2012). This rejection and discrimination by friends and family create a hostile environment that isolates individuals and increases their mistrust of formal services.

Cronin et al. (2025) conducted a study to examine mental health service use and barriers to accessing services in Australia. Transgender and non-binary adults were found to often face invalidation or misunderstanding within the healthcare system and even in their families, compounding experiences of stigma and decreasing their intentions to seek help, thus acting as a barrier to access.

In a review by Wickman et al. (2025), using the SEM to identify healthcare barriers for LGBTQIA youths in the US, it was discovered that having a poor or no support system at home acted as a barrier to healthcare. Furthermore, Crockett et al. (2022) concluded that families often minimise or dismiss the mental health needs of these individuals, which can discourage them from seeking professional help. Higgins et al. (2021) conducted a study amongst young LGBTQIA+ people aged between 14-25 in Ireland. Their study aimed to explore the barriers to accessing mental health services. A significant barrier to mental healthcare access among the participants was a perceived lack of support, coupled with a reluctance to disclose their mental health conditions or sexual orientation and gender identity to family members.

2.7.3 Organisational level/ community level

At the organisational level, the interaction between individuals and organisations in their communities, such as clinics, is examined to determine the impact these organisations have on healthy behaviour (McLeroy et al., 1988). Literature indicates that sexual and gender minorities (LGBTQIA+) have a higher prevalence of poor health outcomes and lower access to healthcare than their heterosexual counterparts (Jackson et al., 2016; Moagi et al., 2021). This might be due to fear of discrimination or ill treatment, as seen in a study conducted in Botswana that explored the factors that could cause mental health challenges in the LGBTQIA+ community. The study found that participants experienced inappropriate treatment when accessing healthcare and, therefore, were less likely to access healthcare facilities (Mangwegape et al., 2024). This phenomenon is echoed by Gahagan and Subirana-Malaret (2018), who state that the LGBTQIA+ community members are less likely to go to PHC facilities out of fear of discrimination.

Negative encounters with healthcare workers are common amongst LGBTQIA+ community members. This ranges from healthcare workers using negative or derogatory statements regarding the patients' lifestyles to refusing treatment (Brown et al.,2016; Duby et al., 2018; Lewis, 2020). In addition to discrimination and stigma, healthcare practitioners might not be trained specifically on how to address LGBTQIA+ health issues (Akinbolue et al., 2022). Jessani et al. (2024) performed a systematic review on healthcare access and barriers to utilisation and found that many healthcare workers within the various healthcare systems in Africa lack basic knowledge about transgender and gender diverse identities, which results in misgendering, refusal of care, or inappropriate treatment. Such experiences not only fail to meet the healthcare needs of LGBTQIA+ individuals but also discourage them from accessing the services again.

The attitudes and clinical practices of healthcare workers play a crucial role in shaping the therapeutic experiences and psychological outcomes of LGBTQIA+ individuals and can act as a barrier to mental healthcare services. Spengler et al. (2016) emphasise that microaggressions in therapy, which are often subtle and unintentional biases, can negatively impact client well-being and undermine the therapeutic relationship. Similarly, broader reviews of health professionals' attitudes reveal that although acceptance of LGBTQIA+ clients has increased, heteronormative assumptions and implicit biases persist, potentially influencing treatment quality and client trust (King, 2015).

Furthermore, it should be noted that the transgender population is one of the most marginalised population groups in South Africa. In a study aimed at evaluating the healthcare inequalities that this population is subjected to, it was found that most of the participants reported that there were transgender-related disparities in the healthcare system, which include discrimination, stigma, exclusionary and culturally incompetent health services, and a limited availability of competent healthcare services (Zambezi & Viljoen, 2024). Bettis et al. (2025) conducted a study to explore the perspectives of parents of LGBTQIA+ youth with mental health service needs in the US Southeast. Their findings were similar, stating that the majority of their participants reported that finding culturally competent mental healthcare providers was very difficult and, as such, acted as a barrier to access for the LGBTQIA+ children.

Gonçalves et al. (2025) aimed to identify barriers and facilitators experienced by LGBTQA+ individuals, across the psychosis spectrum, when seeking help and trying to access mental health support. They found that services tailored to address issues at the intersection of LGBTQIA+ identities and severe mental health conditions, like psychosis, are scarce, exposing a structural gap in specialised mental healthcare services. Correspondingly, Ho et al. (2024) conducted a study to explore how LGBTQIA+ individuals in Malaysia experienced mental healthcare access and their satisfaction with services. They found that the service landscape was fragmented, LGBTQIA+ affirming providers were limited, often centralised in urban areas, and difficult to access without considerable effort and expense. These factors negatively affected access to appropriate care.

Religion or faith-based organisations can also act as a barrier to mental healthcare access at an organisational level/ community level. A systematic review of global literature on the mental health of the religious in the LGBTQIA+ community indicated that even though religion acts as a good social support, it can also harm mental health by increasing anxiety and promoting rejection (Wilkinson & Johnson, 2021). Non-affirming religious environments can lead to increased internalised homophobia within the LGBTQIA+ community. This internalised homophobia in turn prevents individuals from seeking help (Barnes & Meyer, 2012; Gonçalves et al., 2025). In a systematic review on religion, psychiatry, and alternative sexuality by Darmansjah et al. (2019), the findings revealed that religious doctrine can harm LGBTQIA+ individuals. Additionally, when a conflict between religion and sexual orientation exists, it can lead to poor mental health outcomes for these individuals.

A recent Australian study aimed at improving the understanding of the unique service needs and delivery requirements for vulnerable members of the Muslim LGBTIQ+ community revealed a dual discrimination. Participants experienced discrimination from their religious community due to their sexual orientation and faith-based discrimination from the broader community, which made it difficult for them to access a wide range of services, including specialised mental healthcare services (Pallotta-Chiarolli et al., 2021). McCann et al. (2020) demonstrated that discrimination and stigma by religious communities are not exclusive to the Muslim faith. In a systematic review, they examined the relationship between spirituality, religion, and mental health among LGBT+ youth. Analysing studies across diverse religious beliefs, the review found that the negative experiences within religious institutions can impact LGBTQIA+ individuals' willingness to engage in healthy behaviours. Furthermore, when LGBTQIA+ members do overcome these hurdles, religion can still act as a barrier to mental healthcare access.

A scoping review encompassing 70 studies from 25 different countries revealed how negative religious attitudes negatively impact clinical practice towards LGBTQIA+ individuals. The research indicates a strong correlation between religious affiliations, especially within Christian and Muslim traditions, and negative attitudes toward LGBTQIA+ individuals. These negative attitudes can ultimately influence clinical practice in ways that can hinder the delivery of competent, affirming care (Westwood, 2022).

2.7.4 Societal level

Barriers at this level include a lack of funding for mental healthcare, a lack of policies or poorly implemented policies, stigma, and culture, just to mention a few. These barriers are more pronounced in low- and middle-income countries, as mental healthcare is often underfunded and neglected in these countries. The challenges faced by low- and middle-income countries when it comes to the provision of mental healthcare services often stem from inadequate policy development, legislation, resources, and planning (Freeman, 2022; Rathod et al., 2017). In an article that discusses the provision of mental health services in low- and middle-income countries (LMICs). The authors found four major challenges to access to mental healthcare services. Firstly, they found that many of these countries do not have sufficient mental healthcare laws and policies that can effectively guide their mental healthcare services or programs. The second challenge they found was funding; LMICs, especially in Africa, allocate only a small fraction of their health budget to mental healthcare. The third challenge that they identified was the organisation and planning of mental health services. It was found that difficulties in physically accessing facilities, low investment in mental health services, a lack of specialist healthcare practitioners, and resistance to decentralisation, in other words, resources clustered in urban areas, were found to be barriers to access. Lastly, evidence-based interventions and training; it was found that psychotherapeutic interventions were not mainstream, due to a lack of resources and training (Rathod et al., 2017).

The third challenge in the above-mentioned study is important, as a significant part of South Africa’s population (33%) lives in rural areas (World Bank, 2020). Rural communities have less access to healthcare services compared to urban communities; this is often a result of a lack of resources, both human and material (Matsea et al., 2018; Van Spijker et al., 2019). Mental health services are even harder to come by in rural communities, as it is a specialised service that is usually concentrated in urban areas (Matsea et al., 2018; Vergunst, 2018). LGBTQIA+ individuals living in rural areas are faced with a unique set of challenges and experiences. Rosenkrantz et al., (2017) conducted a systematic review of American studies on health and healthcare for rural LGBTQIA+ communities. They found that things such as a lack of transportation, lack of healthcare options and a lack of facilities that have LGBTQIA+ affirming policies acted as barriers to access of quality healthcare. Additionally, a Canadian study found that systemic barriers such as heteronormative assumptions within rural health care settings made LGBTQIA+ individuals feel as if their identities were invisible thus making them avoidant of seeking help (Henriquez & Ahmad, 2021).

Even with the advancement of access to healthcare, such as virtual mental health services, rural communities are still left behind due to factors such as geographic isolation and limited technological infrastructure. Maria et al. (2025) conducted a scoping review of accessibility for rural LGBTIQA+ communities. The review included articles from five countries, including the USA, Thailand, Australia, Brazil, and Canada. They found that infrastructural barriers, such as poor internet connectivity and a lack of privacy at home, restrict rural LGBTQIA+ individuals' ability to use potentially accessible virtual mental health services.

Stigma, discrimination, and cultural variations also have an impact on how mental health conditions are treated, as well as on the accessibility of mental healthcare services. Mental health challenges have major societal implications, which often result in increased healthcare expenditures, reduced workforce productivity, and strained social support structures (Javed et al., 2021). Javed et al. (2021) conducted a study to explore the effects of stigma on mental health in low to middle-income countries. They found that societal stigma towards mental health can lead to poor mental health outcomes, delayed help-seeking, and impaired access to mental healthcare services.

Furthermore, another study by Booth et al. (2024) found that the stigma and shame of mental health are made worse by cultural and traditional factors, especially in conservative societies. The stigma that surrounds mental health conditions continues to be a factor in many cultures, which impedes open conversations and prevents people from looking for much-needed help (Booth et al., 2024; Javed et al., 2021). A study conducted in the Eastern Cape of South Africa that aimed to explore how people with a mental health diagnosis perceived and experienced mental healthcare services in their community found that cultural beliefs inform the understanding of mental health, and they also impact the decision-making around accessing mental healthcare services (Booysen et al., 2021). Another South African study conducted within the Zulu-speaking community in KwaZulu-Natal found that the concept of mental health did not emerge within the culture and was viewed as Western; therefore, it was not recognised in the same vein as physical health (Moonsamy & Gurayah, 2024). This lack of awareness and acceptance increases the burden that mental health has on health systems globally. Mental health also intersects with broader societal problems such as poverty, inequality, and access to education (Javed et al., 2021).

Additionally, the legal landscape of society can also profoundly impact access to mental healthcare services. In countries such as Malaysia, where same-sex sexual activity and gender non-conformity are criminalised, LGBTQAI+ individuals live in fear of legal consequences and therefore do not seek care due to risks of exposure, arrest, or social ostracism (Ho et al., 2024). Similarly, Jessani et al. (2024) found that LGBTQIA+ individuals in many African countries face the same struggles, where legal non-recognition of transgender identities, absence of anti-discrimination laws, and punitive policies create an environment of systemic exclusion and invisibility within healthcare systems.

2.8 Facilitators to Accessing Mental Healthcare Services Across the SEM Levels

The research on LGBTQIA+ access to mental health services is limited; therefore, this section will introduce facilitators to accessing mental health services in general, although it will be highlighted when a study specifically refers to the LGBTQIA+ community.

2.8.1 Individual level

The decision to “come out” as LGBTQIA+ plays a big role in accessing mental healthcare. Disclosing one’s sexual or gender identity provides an opportunity to receive social support and affirming care, which enhances psychological well-being (Russell & Fish, 2016). A study among Chinese LGBTQIA+ people found that disclosure to friends and in social settings such as school and work has a positive effect on mental health outcomes and facilitates access to mental healthcare (Cai et al., 2024). Furthermore, Ruben and Fullerton (2018) conducted a meta-analysis of existing literature and found that the disclosure of sexual orientation to healthcare providers resulted in more positive patient health outcomes. It is highly likely that individuals who are open about their gender or sexual identities with their healthcare providers will receive effective and personalised care.

Through accepting their own sexual or gender identities, LGBTQIA+ individuals reduce internalised stigma, thus promoting psychological well-being, which in turn drives them to seek help when needed (Carvalho & Guiomar, 2022). In a systematic literature review that explored the association between self-acceptance of sexuality and mental health among LGBQ+ individuals, it was revealed that lower self-acceptance was associated with higher levels of psychological distress, while greater self-acceptance was linked to improved psychological well-being (Camp et al., 2020).

Higher levels of self-acceptance leads to lower rates of depression and anxiety and also makes individuals more comfortable discussing their experiences with healthcare workers, which leads to better health outcomes (Camp et al., 2020; Carvalho & Guiomar, 2022) It has also been shown that having a positive attitude towards mental health leads to an increase in the engagement with mental health services, additionally the perceived need for mental healthcare also increased the use of mental health services (Bonabi et al. 2016).

Resilience is also an important facilitator when it comes to mental healthcare access. Not only does it lessen the impact of discrimination, but it also encourages a sense of empowerment, which motivates the individual to access mental health services (De Lira & de Morais, 2018). Ungar and Theron (2020) further state that resilience is not only an individual trait, but a dynamic process shaped by interactions across multiple systems, including family, community, institutions, and broader societal structures. They emphasise that resilience develops when people are able to access resources that help them deal with adversity. They also place emphasis on the fact that context is important, what promotes resilience in one setting might not work in another, and that mental health outcomes improve when systemic barriers such as stigma and discrimination are addressed.

Another facilitator for access to mental healthcare at the individual level is health literacy. Jung et al. 2017 conducted a cross-sectional study in Texas to explore the impact of mental health literacy, stigma, and social support on attitudes toward mental health help-seeking. It was found that people who are aware of mental health issues, their impact, and the services available to them are more likely to recognize the symptoms and to seek help. Understanding healthcare issues empowers people to advocate for themselves and to access healthcare providers who are culturally competent. Similar results were found in an American study, which found that people who recognize the importance of mental health are more proactive when it comes to accessing services, despite the stigma attached to it (Fleary et al., 2022). Furthermore, a study among American university students exploring their attitudes toward help-seeking behavior for mental health issues found that awareness and education in relation to mental health are crucial and that knowledge about mental health helps reduce stigma, increase understanding, and promote help-seeking behaviour (Vidourek & Burbage, 2019).

2.8.2 Interpersonal level/relationship level

Family support is an important facilitator to mental healthcare access for LGBTQIA+ individuals. Studies have shown that family acceptance relates to better health outcomes for LGBTQIA+ individuals and correlates with lower rates of anxiety depression and suicidal ideations in this community (McConnell et al., 2016; Ryan et al., 2010). In a study aimed at examining whether family support acts as a buffer against the negative mental health outcomes associated with LGBTQIA+ status, they found that having family support acted as a protective factor against depressive symptoms, furthermore family support protected against the negative mental health effects associated with being part of the LGBTQIA+ (DelFerro et al. 2024). Additionally, Snapp et al. (2015) found that the support of friends, family, and the community has a positive impact on the mental health outcomes for LGBTQIA+ young adults.

A Canadian study that examined the contribution of parental reactions to their child's identity development and psychological adjustment following their child coming out as gay, lesbian, or bisexual, found that parental support had a positive effect on psychological well-being (D'amico et al., 2015). Ryan et al (2010) identified family acceptance as a buffer against depression, substance abuse, and suicidal ideation among LGBTQIA+ adolescents in the US. The study found that, at the interpersonal level, support and acceptance from family a facilitator of mental well-being and health-seeking behaviour for young people in the LGBTQIA+ community. Furthermore, Ho et al. (2024) found that having the support of family significantly improves the chances that LGBTQIA+ individuals might access mental healthcare services, by fostering an environment where mental health needs are normalised and help-seeking is encouraged. This is in keeping with Katz-Wise et al. (2016), who found that through the affirmation of LGBTQIA+ identities, family members create stable emotional environments, which in turn encourage these individuals to seek help. Additionally, a UK-based qualitative study that looks at how family relationships affect the mental health and well-being of LGBTQIA+ youth found that supporting family environments where autonomy and identity are respected is an important factor in having a positive mental health outcome for LGBTQIA+ youth (McDermott et al., 2021).

Supportive families often provide financial support and can advocate for their LGBTQIA+ family members, thus assisting them to navigate complex health systems (Russell & Fish, 2016). Family support and advocacy are especially important for

LGBTQIA+ youth as they are often dependent on family for finances, resources, and decision-making in relation to healthcare (Simons et al., 2013; Snapp et al., 2015)

Peer support groups are another big factor in promoting mental healthcare access. Maintaining friendships within affirming communities fosters a sense of belonging for LGBTQIA+ individuals. This belonging reduces feelings of isolation and improves help-seeking behavior (Gasteiger et al., 2024). Within these support groups, people often share first-hand advice on how and where to access culturally competent healthcare services, reducing the anxiety that comes with searching for help. They also help to normalise and destigmatise mental health conditions, thus fostering a more positive attitude towards mental health and seeking help (Borthwick et al., 2020). These organisations create and foster safe spaces for people to share their experiences and to access mental health resources. Thus, reducing isolation and promoting mental well-being (Gonçalves et al., 2025).

Peer support systems provide empathetic and relatable support for people with similar experiences and, in so doing, significantly improve mental health outcomes (Breslow et al., 2015; Kates et al., 2018). Romantic relationships also act as a facilitator to mental healthcare for LGBTQIA+ individuals. Being in an established romantic relationship is a known protective factor for mental health among heterosexual adults. Whitton et al. (2018) examined whether this was the case for young sexual minorities; their findings propose that being in a romantic relationship could support mental health for many, but not all, sexual minorities. Through encouraging and supporting their partners to get help, significant others play a big role in providing emotional support (Boutilier et al., 2024).

2.8.3 Organisational level/community level

Integrating mental healthcare into PHC could decrease stigma, improve access to mental healthcare, and improve treatment adherence (Marais & Petersen, 2015). Reiss-Brennan (2014) conducted a study in the USA to examine the impact of mental health integration into primary care. It was found that patients had improved functioning and relationships with their caregivers. Healthcare providers also reported that patients had improved access to mental healthcare. Additionally, Reiss-Brennan et al. (2016) conducted a study to evaluate whether the integration of physical and behavioral health, through the use of integrated team-based primary care, was associated with improvements in service utilisation, quality, and cost of care. They found that when mental healthcare was integrated into primary care, there was an increase in quality of care, a decrease in the number of hospital visits, and a decrease in total cost to their participants. This indicates that integrating mental health into primary care has the potential to improve overall health outcomes. Furthermore, Heredia et al. (2021) conducted a study among LGBTQIA+ individuals who accessed primary care settings in the US. They found that integrating behavioural healthcare into primary care can benefit the LGBTQIA+ community by providing care that is tailored to their specific needs, thus improving access.

Similarly, a South African study aimed at developing a district mental healthcare plan that integrates mental healthcare into chronic care, found that integration allows for holistic, patient-centred care, where patients provide input thereby ensuring that their voices are heard and their needs are met (Petersen et al., 2016). Community-based organisations could also be seen as a facilitator to mental healthcare because they assist in bridging the gap that exists between LGBTQIA+ people and mental health treatments (Fish et al., 2019; Gasteiger et al., 2024). Gasteiger et al. (2024) conducted a scoping review that identified community-based support mechanisms that older sexually and gender diverse individuals used to improve their mental health and well-being. The review emphasized the positive outcomes that such support has, which include increased social connections and improved mental health. They also noted the need for more of these interventions designed specifically for this community.

Furthermore, Fish et al. (2025) conducted a study in the US among LGBTQIA+ community-based organisation staff. The study aimed to explore the facets of youth mental health services offered by LGBTQIA+ community-based organisations in the US. They found that most of the community-based organisations provided some sort of mental healthcare, whether through direct clinical services, peer support, or other modalities. Showing how community-based organisations act as an accessible facilitator of mental healthcare services. Another study conducted in America aimed to analyse LGBTQIA+ Youth Community-Based Programs, found that community-based programs are crucial in the promotion of both physical and mental health. Additionally, they found that more than 80% of the community-based programs offered referrals to psychologists or counsellors who have LGBTQIA+ experience (Allen et al., 2012).

Further underscoring how community-based organisations act as facilitators to mental healthcare.

It was also found that Community and school-based programs are accessible entry points to mental health for the LGBTQIA+ community (Russell & Fish, 2016). Mental health stigma is reduced when services are integrated into trusted community spaces, and in so doing, engagement in these services is increased. A South African study conducted in Ekurhuleni, Gauteng, aimed to explore how peer educators could promote mental healthcare within their communities. The study found that promoting health in trusted community settings, such as churches and community halls, provided safe spaces for individuals to open up, and in so doing, stigma was reduced. Furthermore, the mental health promotion activities bridged the gap between informal and formal mental healthcare and, in so doing, improved mental healthcare access (Vostanis et al., 2025).

Vulnerable groups, such as transgender people and LGBTQIA+ youth, find these services crucial as they often do not have access to mainstream mental health services. Additionally, these support groups provide safe spaces where people can interact with peers, exchange stories, and get referrals to mental healthcare services (Fish et al., 2019). LGBTQIA+ individuals also connect with others in these groups, which reduces social isolation and promotes well-being. Creating and sustaining these networks fosters a culture of care by encouraging mental health discussions and normalising help-seeking behaviors (Fish et al., 2019; Gasteiger et al., 2024). Community-based mental health initiatives have proven effective in providing accessible and culturally relevant care (Larrieta et al., 2023). Organisations that focus on peer support groups in the community are vital enablers in South Africa. Organisations such as the Triangle Project and OUT LGBT Well-being provide mental health services, advocacy, and support for LGBTQIA+ individuals. These groups play a critical role in bridging the gap between the LGBTQIA+ community and the healthcare system, offering resources and support tailored to their needs (Bateman, 2015).

Another form of peer support that can act as a facilitator to mental healthcare is online support groups. A study exploring informal digital peer support among LGBTQ+ young people in Australia found that this support played a big role in mitigating mental health issues for the LGBTQIA+ community, as it provided safe spaces, access to mental healthcare services through the sharing of useful information, and it provided emotional support. It should be noted that the study also found that this informal digital peer support acts as a supplement to professional help and should not replace it (Byron & McDaid, 2025).

Another facilitator to mental healthcare access is inclusivity. When healthcare providers create inclusive and affirming environments, it is more likely that LGBTQIA+ individuals will access mental healthcare services (Bishop et al, 2022). By showing empathy and respect for diverse sexual identities, healthcare workers build trust with their LGBTQIA+ clients, thus sustaining healthy therapeutic relationships. Furthermore, Alessi et al., (2019) found that affirmative therapeutic practices, which validate and support clients' sexual identities, are positively associated with psychological well-being among LGBTQIA+ clients. LGBTQIA+ individuals are more likely to seek help if they think an organisation is inclusive and supportive. Facilities that show support through visible mediums, such as inclusive signage or pride flags, indicate that it is a safe place where everyone is accepted and respected (Bishop et al., 2022). Reynish et al. (2022) conducted a systematic review on barriers and enablers to mental health help-seeking of the LGBTQIA+ community. They found that inclusivity and having mental healthcare providers who are knowledgeable about the unique needs of the LGBTQIA+ community improve mental health help-seeking behavior, thus facilitating access.

Cultural competence in LGBTQIA+ mental healthcare includes knowledge, awareness, skills, and actions necessary to provide affirmative care to this population (Ojanen et al., 2021). An American study by Ratanashevorn et al. (2024) found that cultural humility (which could be seen as an open mindedness and a willingness to learn and not judge, as well as an openness to critically reflect on one's biases) had a positive impact on counselling alliance (a therapeutic bond, and agreement about goals and tasks in counselling) and counselling outcomes. This study's results also showed that higher cultural humility is associated with higher counselling outcome among LGBTQ+ participants (Ratanashevorn et al., 2024). This is very important, as research has shown, that people are more likely to adhere to treatment and to follow up with treatment, if they feel understood and respected (Bishop et al., 2022) Furthermore a study among sexual minority women in America found that receiving patient centered care and knowing that their healthcare provider is gender affirming beforehand acted as a facilitator to healthcare access (Dawson et al., 2025).

In another American study aimed at exploring the experiences and perspectives of LGBTQIA+ individuals, it was found that even though LGBTQIA+ imagery was an important factor in improving healthcare engagement, gender affirming care was more important (Paschen-Wolff et al., 2024). This underscores the importance of the cultural competence of healthcare workers within this community. Having specialised healthcare, specifically tailored to LGBTQIA+ mental health needs, acts as a facilitator to access mental healthcare. It has also been shown that having dedicated services fosters a sense of belonging and reduces the fear of discrimination (Bishop et al., 2022).

University, school, or the workplace can also act as a facilitator to mental healthcare services for the LGBTQIA+ community. An Australian study among LGBTQIA+ youth found that, their participants who experienced their education or workplace settings as affirming had a better mental health outcome and that affirming educational and workplace environments acted as a mitigating factor in terms of adverse mental health (Amos et al, 2023). Crockett et al. (2022) conducted a study amongst LGBTQIA+ students in Chile and found that the relationship and referral system to mental healthcare by the university and psychologists made it easier for their participants to access mental healthcare.

A review and Meta-analysis focusing on workplace contextual supports for LGBTQAI+ employees in the US revealed that LGBTQIA+ supportive policies, work culture, and work relationships help to decrease psychological strain (Webster et al, 2018). Another study that examined work-related stressors and mental health among LGBTQIA+ workers had mixed results, but some of their findings suggested that working in an affirming environment acts as protective a factor when it comes to mental health, furthermore the authors posit that the benefits of permanent employment, such as health insurance and leave days provide workers with access to mental healthcare (Owens et al., 2022).

Private healthcare can sometimes be perceived as more accessible to the LGBTQIA+ community. Müller et al. (2020) conducted a South African study among healthcare professionals, LGBTQIA+ individuals, and other pertinent stakeholders and found that some participants perceived that LGBTQIA+ individuals are less discriminated against in the private sector and receive better treatment. It should be noted that the study also revealed that there was only a slight difference in the discrimination experienced in the private sector vs the public sector. The perception that LGBTQIA+ individuals will receive better treatment in the private sector could therefore act as a facilitator to mental healthcare access.

2.8.4 Societal level

Despite the numerous challenges associated with accessing mental healthcare services, many facilitators can improve mental healthcare access for LGBTQIA+ individuals. The implementation of anti-discrimination laws and policies that protect LGBTQIA+ rights, for example, the legal recognition of same-sex relationships and gender identity, can reduce stigma and discrimination, thus encouraging LGBTQIA+ individuals to seek mental healthcare (Kealy-Bateman & Pryor, 2015; Teo et al., 2022). Russell and Fish (2016) applied the SEM and found that inclusive policies that prohibit discrimination based on sexual orientation build trust in the health system, create safer environments, and act as a facilitator to healthcare access for the LGBTQIA+ community. Additionally, an improvement in mental health outcomes among the LGBTQIA+ community was observed in countries that implemented marriage equality and anti-discrimination laws (Kealy-Bateman et al., 2015; Teo et al., 2022). Legal protection and supportive public policies are among the most influential facilitators to mental healthcare access for the LGBTQIA+ community. Dawson et al.'s (2025) participants reported that being in a supportive political environment made it easier for them to access healthcare, as they did not have to be concerned about whether healthcare providers would be receptive or not.

Cultural change is driven by advocacy, visibility, and education. These campaigns foster societal acceptance and reduce structural stigma, which is an overarching barrier to mental healthcare. Jessani et al. (2024) argue that societal-level advocacy is critical in regions where gender diverse identities remain marginalised and criminalised, as policy reforms are prerequisite to safe and equitable care access.

2.9 Conclusion

Chapter 2 explored how mental health affects the LGBTQIA+ community. The disproportionate effect on the mental health LGBTQIA+ community was attributed to factors such as stigma and discrimination. It reviewed international policies and frameworks and highlighted how these frameworks aim to alleviate the burden of mental health on the global population, especially the LGBTQIA+ community, noting implementation challenges. Furthermore, the chapter examined mental healthcare access in South Africa, with a focus on accessibility for the LGBTQIA+ community. The study's theoretical framework, the SEM, was also explored, detailing its historical background, key constructs, and its relevance in examining access to mental healthcare. Utilising the SEM, barriers to and enablers of mental healthcare access for LGBTQIA+ individuals were identified across various levels, supported by the existing literature. The next chapter outlines the study's philosophical underpinnings and delves into the research methodology. It discusses research design, data collection methods, and ethical considerations that guided the study.

CHAPTER 3: METHODOLOGY

3.1 Introduction

Chapter 2 explored how mental health affects the LGBTQIA+ community. This chapter aimed to describe the methodology and research design that were used in the processes of data collection and analysis in this study. To do that, it was important to explicate the philosophical paradigm that underpins the choice of a qualitative approach. This was followed by a description of the case study design and the specific methods that were used to explore the barriers and enablers of access to mental healthcare services in Namaqualand from the perspectives of members of the LGBTQIA+ community. This chapter also detailed the targeted population, sampling procedure, research instrument development, participant recruitment strategies, and the role of the researcher in the processes of data collection and analysis. It concluded with a reflection on the ethical principles that guided the study from conceptualisation to data collection, processing, analysis, presentation, and dissemination.

3.2 Research Philosophy

Philosophical underpinnings are crucial to research design as they guide how we study the world. Paradigm, ontology, epistemology, and methods are interrelated concepts that shape research direction and purpose (Creswell, 2013; Guba & Lincoln, 1994; Pretorius, 2024). A paradigm is defined as the overall way of looking at the world. Ontology speaks to what we believe is real, while epistemology is about how we can know and study that reality. Methods are the practical tools and steps we use to collect and analyse information (Creswell, 2013; Guba & Lincoln, 1994).

This study judiciously adopted a constructivist paradigm with a relativist ontology and a subjectivist epistemology to acknowledge that knowledge is co-constructed through experiences and interactions (Guba & Lincoln, 1994). Aligned with this paradigm, the qualitative research method was employed to collect and analyse the information. The philosophical underpinnings of the study are discussed in more detail in the following subsections.

3.2.1 Research paradigm

A research paradigm is a guideline that directs the research; it can be seen as a conceptual lens through which the research is viewed. Guba and Lincoln (1994) describe a paradigm as *"the basic belief system or worldview that guides the investigator, not only in choices but in ontologically and epistemologically fundamental ways*" (p.105). To explore the perceptions of members of the LGBTQIA+ community regarding access to mental healthcare services within their community, the constructivist paradigm was adopted. Guba and Lincoln (1994) posit that the purpose of constructivist research is to create knowledge, together with participants, by reconstructing understanding in order to find deeper shared insights, while remaining open to new perspectives. Pretorius (2024) elaborates further by arguing that constructivist research aims to understand how shared experiences and cultural contexts impact the construction of individual realities. The choice of the constructivist paradigm stems from the belief that the human experience is subjective and that individuals live through different realities that are constructed in various contexts. Constructivism places the emphasis on understanding the person and their view of the world around them, to gain a deeper understanding of their reality (Guba & Lincoln, 1994; Merriam & Tisdell, 2016; Pretorius, 2024) In the current study, the constructivist paradigm underlines the importance of understanding how LGBTQIA+ perceive and experience the factors that influence their access to mental healthcare services within their community.

3.2.2 Ontology

Ontology is the foundation of research; it speaks to the beliefs about reality and is concerned with the essence of the phenomenon being investigated (Cohen et al., 2007; Hussain et al., 2013). It refers to the study of the nature of reality and existence, dealing with what can be known and how entities or phenomena exist. It influences the researcher's perspective on what constitutes reality, shaping the research design and interpretation of the findings (Creswell, 2013; Guba & Lincoln, 1994; Pretorius, 2024). Ontology is paramount in determining the approach to qualitative research, as it guides how researchers conceptualise the phenomena that they are studying (Creswell & Poth, 2018; Rehman & Alharthi, 2016).

In research, there are two main contrasting ontological positions, realist and relativist. Realism, which is often associated with quantitative approaches, puts forward that reality exists apart from human thought and seeks to discover objective truths in quantifiable and observable phenomena (Guba & Lincoln, 1994; Pretorius, 2024) On the other hand, the relativist ontological stance, emphasises the significance of understanding the individual's context-dependent interpretations and experiences, viewing reality as socially constructed and subjective, this perspective is usually aligned with qualitative research (Creswell & Poth, 2018; Pretorius, 2024). These opposing positions have an impact on study design where relativism prioritises an exploratory, interpretative approach, while realism favours structured, quantifiable methods (Guba & Lincoln, 1994; Pretorius, 2024).

This study was undertaken from a relativist ontological position, which adopts the belief that reality is complex and multilayered. It also ascribes to the belief that reality is socially constructed and that different realities can exist at a particular time (Creswell, 2013; Guba & Lincoln, 1994; Pretorius, 2024). The ontology in this study focuses on recognising the fundamental characteristics of factors that influence LGBTQIA+ people’s access to mental healthcare services in their communities. The study aims to shed light on how LGBTQIA+ individuals perceive barriers to and facilitators of mental healthcare access in their communities, considering their personal experiences, social interactions, and broader cultural contexts. For this community, multiple realities exist because individual members of the LGBTQIA+ community have different perceptions of the accessibility of mental healthcare services in Namaqualand. Thus, the perspectives shared by participants are seen as their own interpretation processes and the significance they attach to their lived experiences. This is in direct contrast to realism, that is, the stance that reality is independent of context and exists objectively and outside of human perception (Guba & Lincoln, 1994; Pretorius, 2024).

3.2.3 Epistemology

Epistemology is the study of knowledge, its nature, how it is acquired, how it is constructed, and how it is validated. The focal point of epistemology is to understand what can be seen as valid knowledge and how researchers can verify their claims. It provides a philosophical foundation for the methods, strategies, and assumptions that guide research approaches. Therefore, epistemology is a central factor in differentiating between qualitative and quantitative paradigms, as each paradigm is grounded in its unique understanding and interpretation of the world (Creswell, 2013; Creswell & Poth, 2018).

There are various epistemological positions in research, including the objectivist and subjectivist positions, each of which offers a unique perspective on how knowledge is created and validated (Guba & Lincoln, 1994; Pretorius, 2024). Subjectivist epistemology underscores the subjective meanings that people attach to their experiences; it aims to examine social phenomena within context. It assumes that the researcher and participants are interlinked and that the findings of the research are constructed as the research continues. Furthermore, it posits that knowledge is created through social processes, discourse, and cultural contexts (Guba & Lincoln, 1994; Pretorius, 2024). Within this context, the difference between ontology and epistemology becomes unclear (Guba & Lincoln, 1994).

In this study, the researcher was interested in delving into the subjective experiences of individuals in the LGBTQIA+ community and how they interpret their surroundings. To achieve this aim, a subjectivist position was taken, which highlights how personal perspectives influence how we understand the world around us (Pretorius, 2024). The researcher also considered factors such as culture and social context, which align with the subjectivist principles, where multiple interpretations are recognised as valid (Pretorius, 2024). The way in which LGBTQIA+ individuals perceive barriers and facilitators may differ based on their unique backgrounds and experiences. Therefore, employing the subjectivist epistemology was instrumental in unpacking the diverse factors that shape participants' perspectives. Additionally, the subjectivist epistemology acknowledges the dynamic relationship between researchers and participants, emphasising the importance of meaningful dialogue in gaining deeper insights into participants' viewpoints (Guba & Lincoln, 1994; Pretorius, 2024).

3.2.4 Qualitative methodology

Methodology acts as a guide for conducting research, outlining steps for collecting and analysing data, and drawing conclusions (Cohen et al., 2007; Hussain et al., 2013; Rehman & Alharthi, 2016). When using a qualitative approach, the focus is on human experiences, behaviours, and social phenomena. These phenomena are explored using non-numerical data such as focus groups, interviews, and observations. The emphasis of this method is context, depth, and meaning, rather than broad generalisations (Denzin & Lincoln, 2011).

These methods allow researchers to delve into participants' narratives, revealing how their realities are socially shaped. Additionally, the importance of language and conversation in shaping reality is recognised, as participants expressed barriers and facilitators using their preferred language and, in so doing, further aligning with the relativist ontology of the study.

Furthermore, a qualitative approach was selected using semi-structured interviews that allowed for an exploration of participants' views on accessing mental health services in their community. Qualitative research aims to understand participants' perspectives, perceptions, and behaviours, exploring the underlying reasons and mechanisms rather than quantifying data (Al-Ababneh, 2020; Kivunja & Kuyini, 2017). An essential aspect of qualitative research is prioritising participants' voices and interpretations, understanding social phenomena from their standpoint rather than the researcher's. This approach facilitated capturing the diverse perspectives and experiences of participants regarding access to mental healthcare. The data gathered in qualitative research is extensive, enabling the researcher to grasp participants' experiences and viewpoints through direct quotes and detailed descriptions, which were thematically analysed in alignment with different levels of the SEM framework.

3.3 Research Design and Study Setting

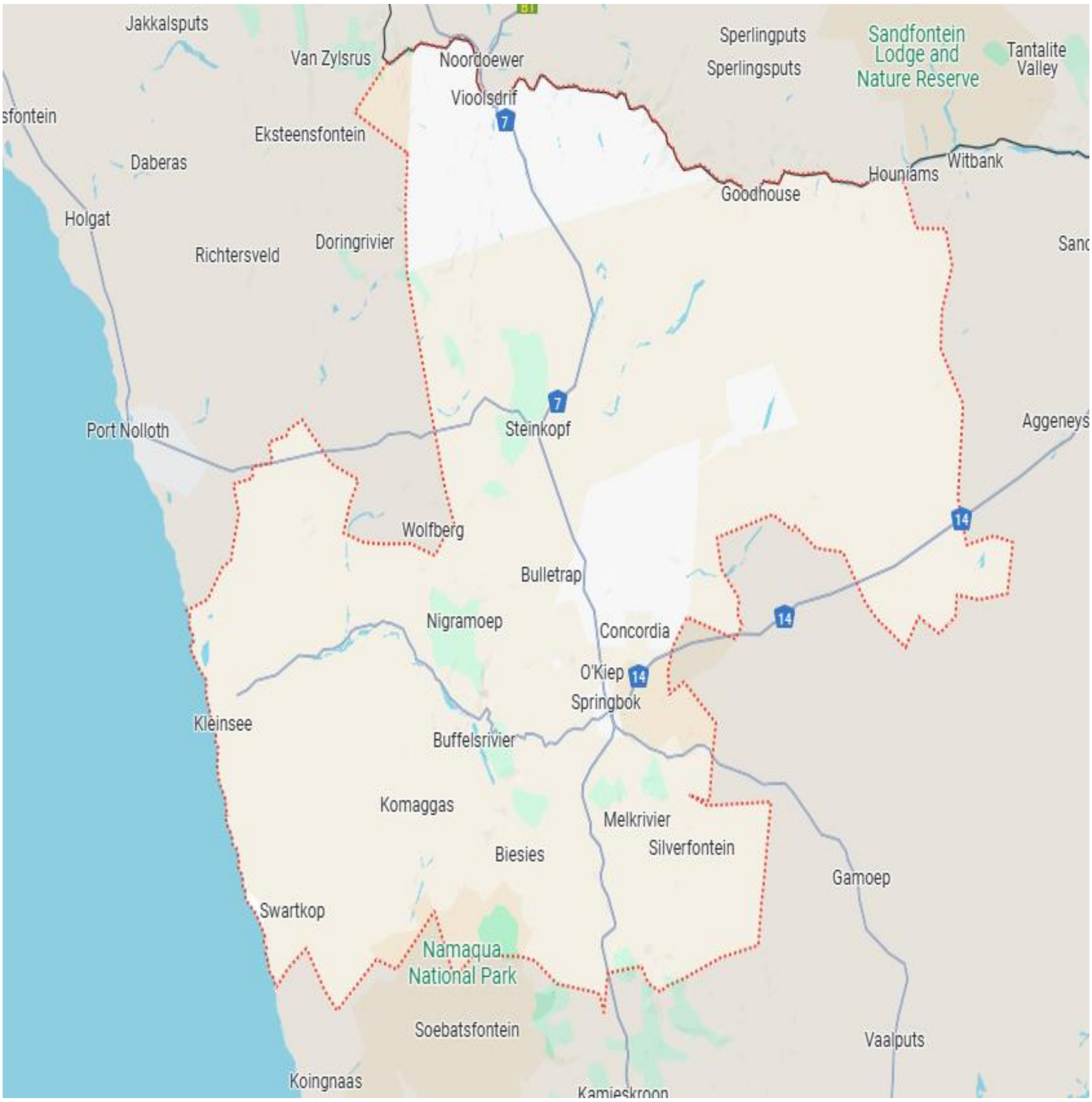
3.3.1 Case study design

The study aimed to explore and describe how members of the LGBTQIA+ community in Namaqualand perceive access to mental healthcare in their community; therefore, a single case study was utilised. According to Yin (2018), a single case study involves an in-depth examination of a contemporary phenomenon in its real-world context and is appropriate when the case provides unique insights. The qualitative approach was deemed appropriate as it allowed for detailed accounts of the LGBTQIA+ community's perceptions of access to mental healthcare services within a specific setting. This design enabled the researcher to focus on a specific case while retaining a real-world, in-context, and holistic perspective of a phenomenon (Yin, 2013; Yin 2018). In this research, the case was the LGBTQIA+ community residing in the Nama-Khoi municipal district in the Northern Cape.

3.3.2 Study setting

The research was undertaken in the Nama-Khoi Municipal area, which forms part of the Namaqualand district, Northern Cape, South Africa (See figure 3.1). The Municipality comprises the communities of Springbok, Steinkopf, Okiep, Rooiwinkel, Concordia, Komaggas, Buffelsrivier, Nababeep, Bulletrap, Vioolsdrift, Goodhouse, Kleinzee, and Carolusberg (Nama-Khoi Municipality, 2019). According to the Nama Khoi Municipality (2019), more than 90 % of the population are Afrikaans-speaking Christians, and most of the households have access to piped water and electricity. Only 32.4% of the population over the age of 20 completed high school education (Statistics South Africa, 2022). While more than 90 % of the population of the Namakwa district has access to healthcare services, 20% of the population reported the quality of the service to be poor (Statistics South Africa, 2018). Residents of the municipality mainly access healthcare through PHC clinics and referral hospitals, a model consistent with South Africa's PHC approach; however, research shows that in rural contexts this model is often constrained by shortages of healthcare professionals, limited resources, and weaknesses in referral and continuity of care, which affect how services are experienced and utilised (Visagie & Schneider, 2014). Furthermore, rural populations face inequities in healthcare access compared to urban populations, with distance, transport costs, and availability of services acting as significant barriers (Ngene et al., 2023). These barriers reflect many of the structural characteristics of rural health systems in South Africa, where healthcare access is shaped by geographic dispersion, long travel distances, and reliance on the public sector for service delivery (Visagie & Schneider, 2014), which residents of the Nama-khoi municipality are all too familiar with.

Figure 3.1: Map of Nama Khoi municipality (Google Maps, 2024)



3.4 Population and Sample

3.4.1 Population

The population for this study was members of the LGBTQIA+ community currently residing in the Nama-Khoi local municipal area.

3.4.2 Sampling

Purposive sampling was used to identify members of the LGBTQIA+ community to participate in the research. Etikan et al. (2016) state that with purposive sampling, the researcher deliberately chooses the participant due to the qualities that the participant has. The inclusion criteria for participants in this study were:

- Adults aged 18 years and older who self-identified as part of the LGBTQIA+ community (See table 3.1).
- Able to express themselves fluently in English or Afrikaans.
- Currently residing in Namaqualand within the Nama Khoi local municipality.
- Members of the LGBTQIA+ community could participate in the study whether they have accessed mental healthcare services or not.

When conducting qualitative research, the focus is on the quality of the data and not necessarily the quantity. The more relevant information that the sample holds, the fewer participants are required (Dworkin, 2012; Malterud et al., 2015). Data collection continued until saturation was reached, with 11 participants partaking in the interviews.

Table 3.1: Participant demographics

Characteristic	**Frequency (n)**
Race	
Coloured	11
Age	
18-25 years	2
25-30 years	6
30-35	1
35- 40	1
40-45 years	1
Sexual Orientation	
Transgender	1
Bisexual	2
Gay	6
Lesbian	2
Highest level of education	
Matric	4
Tertiary	7
Employment status	
Employed	11

3.4.3 Recruitment of participants

Richie Cloete Consultancy, a Northern Cape-based company that works closely with The Triangle Project, an NGO that protects the rights of the LGBTQIA+ community, facilitated access to this specific community and assisted with the recruitment of research participants. A social worker at Richie Cloete Consultancy briefly informed the potential participants about the study (see Appendix A1 and A2 for the recruitment form). People who were interested in participating in the interviews were then asked to propose a time and date that best suited them for the interview. With consent, this information was then shared with the researcher. Richie Cloete Consultancy was also provided with a recruitment poster that included the name and number of the researcher and the social worker, which interested people could contact for more information (see Appendix B1 and B2 for the recruitment poster).

3.5 Data Collection Tool

An interview guide (see Appendix C1 and C2 for the interview guide) was created to facilitate semi-structured interviews with the participants. This guide included demographic questions related to sexual orientation, age, and race, as well as questions regarding barriers and enablers (i.e., at the Four Socio-Ecological Model levels: individual, interpersonal, organisational/community, and societal) that LGBTQIA+ community members in the Namaqualand area perceive to exist or experience when accessing mental healthcare. The interview guide concluded with questions on how to improve access to mental healthcare services for LGBTQIA+ individuals at all levels of the Socio-Ecological Model. The interview guide was made available in English and Afrikaans, which are the most prevalent languages in Namaqualand. To ensure accuracy, both forward and backward translations were carried out by two distinct individuals, one being a native English speaker and the other a native Afrikaans speaker. The researcher then addressed any disparities be the original and translated versions with these individuals before finalising the research instruments. The 11 interviews were conducted in a mixture of English and Afrikaans, and the participants were encouraged to express themselves as best as possible in any of the two languages.

According to Perneger et al. (2015), it is important to perform a pilot test to ensure that the research instrument is understandable to the target audience and that it solicits an appropriate or intended response. Therefore, the interview guide was tested with two individuals, both from the LGBTQIA+ community, with only one residing in Namaqualand, to ensure that the questions were easy to understand and relevant for the research topic. The pilot results showed that the questions were appropriate and understandable. None of the questions were changed from the pilot. These individuals that the pilot was tested on did not form part of the final data collection process for the study due to their personal relationships with the researcher, and their results were excluded from the overall study findings.

3.6 Data Collection

Data collection took place during September 2023. Before the individual semi structured interviews started, the participants were given an information sheet by the researcher that provided details about the study, including the aim of the study, a summary of the interview questions, the expected duration of the interviews, the request to record the interviews, ethical considerations, and how the research findings would be handled and shared. After reading the information sheet, participants were asked to provide signed consent that they were voluntarily participating in the interview and to allow audio recording of the interview. There was no power imbalance between the researcher and the participants as they had no relationship with each other. The interviews were conducted by the researcher in a private office at Richie Cloete Consultancy. The interviews lasted approximately an hour. Participants could choose whether they preferred the interview to be conducted in English or Afrikaans.

3.7 Data Analysis

Data analysis followed a thematic approach involving the grouping of key barriers to and facilitators of access to mental healthcare services by members of the LGBTQIA+ community. Thematic analysis is a process of identifying, analysing, and interpreting patterns of meaning within qualitative data (Clarke & Braun, 2017). As put forth by Clarke et al. (2015), the researcher used thematic analysis as it is flexible and can be applied in most frameworks and contexts. It also allowed the researcher to analyse and cross-reference themes through the whole data set (Alhojailan, 2012). The data were analysed using the six-phase process as described by Braun and Clarke (2006).

3.7.1 Familiarisation with the data

The researcher took steps to understand the data thoroughly. The first step already began during the interviews, by carefully listening to the responses provided. Thereafter, the recorded interviews were transcribed verbatim from the audio recordings. The researcher translated the Afrikaans transcriptions into English for better comprehension and familiarisation with the data. Subsequently, the researcher carefully read and re-read the transcriptions multiple times, highlighting important sections within the text (Braun & Clarke, 2006). Through this process, the researcher actively engaged with the data, identifying relevant text that aligned with the components of the SEM model, including individual, interpersonal, organisational/community, and societal levels. This process of familiarisation with the data was essential for gaining a comprehensive understanding of its scope and depth. (Alhojailan, 2012; Braun & Clarke, 2006)

3.7.2 Generating codes

Both inductive and deductive approaches were used when generating codes. The deductive method involves formulating a hypothesis based on existing theory and then designing research to test it (Alhojailan, 2012; Braun & Clarke, 2006)This method involves researchers actively analysing data in line with their theoretical framework, in this case, the SEM. Inductive analysis, on the other hand, is a more adaptable strategy in which the researcher systematically studies the data and enables codes and concepts to emerge autonomously. In this study, the deductive approach began by systematically organising noteworthy segments of the data based on the SEM levels as a priori themes. Using this approach allowed the researcher to generate codes and subthemes based on the perspectives and experiences of participants.

3.7.3 Searching for themes

The researcher aimed to uncover patterns and connections within and across all interviews by searching for similar codes that could be grouped into themes. A theme encapsulates a significant aspect of the data relevant to a research question, embodying a certain degree of structured response or meaning within the dataset.

(Alhojailan, 2012; Braun & Clarke, 2006) The researcher organised the codes into the predetermined SEM themes to facilitate data processing and organisation.

3.7.4 Reviewing the themes

The researcher undertook a comprehensive review of themes, assessing their alignment both with coded data extracts and the entire dataset. This constant review process served as a validation mechanism, allowing the researcher to meticulously evaluate the coherence of themes and subthemes with the overarching dataset. It provided an opportunity to eliminate data that did not respond to the main objective of the study, to explore participants' perceptions of the accessibility of mental health services for members of the LGBTQIA+ community. For example, narratives about the everyday complexities of romantic relationships as a member of the LGBTQIA+ community within the Nama Khoi district were not included in the coding scheme because the participants did not describe these experiences as relevant to the accessibility of mental health services in their context. Ultimately, this review led to the development of a thematic map, providing a visually coherent representation of the correlation among themes and subthemes (Alhojailan, 2012; Braun & Clarke, 2006)

3.7.5 Defining and naming the themes

This stage involved continuous analysis of the data by the researcher with the support of his supervisors through discussions on coding and analysis. This was aimed at refining the specifics of each theme and the overarching narrative conveyed by the analysis, thereby generating precise definitions and names for each theme. Naming the themes ensured their easy identification and clear distinction, thereby fostering a more structured and organised analysis of the data. Defining the themes required acknowledging unique and shared perspectives on the barriers and facilitators affecting access to mental healthcare services for LGBTQIA+ individuals, and assigning descriptive labels to these themes across each level of the SEM. This approach facilitated a deeper comprehension of the themes, rendering them more meaningful and reflective of the data's depth (Alhojailan, 2012; Braun & Clarke, 2006)

3.7.6 Reporting

In the final step of the analysis, the researcher compiled the findings, which are presented in the next chapter. Researchers need to report data in a manner that aligns with existing theories to mitigate bias. Furthermore, an abductive reasoning approach was used during the reporting as it provides reasonable explanations for complex social phenomena based on participants' experiences and cultural contexts. By using an abductive approach, researchers produce insights that bring together observed realities and theoretical constructs, thus ensuring that findings remain contextually grounded while also contributing to broader knowledge (Bryman, 2016; Tavory & Timmermans, 2014). Therefore, the researcher structured the data presentation according to the objectives of the study and in alignment with the SEM. The data were reported by presenting the subthemes identified from the SEM, along with relevant quotes from the data, to illustrate and support the findings.

3.8 Trustworthiness of the Data

Trustworthiness refers to the level of confidence in the data, interpretations, and methods employed to ensure the study's quality. It comprises four main aspects, namely credibility, transferability, dependability, and confirmability. (Amankwaa, 2016; Schwandt et al., 2007).

3.8.1 Credibility

Credibility refers to the confidence in the truth of the findings and is a critical criterion for assessing the trustworthiness and reliability of the study (Lincoln & Guba, 1985; Schwandt et al., 2007). In this study, credibility was ensured through peer debriefing. Peer debriefing took place through discussion about the research process, analysis, and findings with the study supervisors. This collaborative process consisted of monthly meetings with supervisors. These sessions served as platforms to delve into research findings, interpretations, and methodological approaches, enriching the analytical process and fostering a deeper understanding of the research findings. Adjustments to the themes became necessary after the meetings, indicating a dynamic and iterative refinement process in response to the feedback and insights gained during these collaborative discussions.

3.8.2 Transferability

Transferability refers to how applicable the results of a study are to different situations (Schwandt et al., 2007). Cross-sectional studies gather data at a specific moment, making it challenging to replicate or apply the findings to other groups or contexts.

Moreover, since the data is collected just once, reproducing the findings in the future or extending them to different populations with distinct characteristics or during different time periods might not be feasible. Nevertheless, the study provided thorough details about the research environment, the participants, the method of data collection, and the constraints inherent in this method (Amankwaa, 2016; Mertens,1998; Schwandt et al., 2007). This will allow other researchers to replicate the study.

3.8.3 Dependability

Dependability implies that if the study were replicated with a comparable population and research methodology, comparable results would ensue (Amankwaa, 2016; Schwandt et al., 2007). To ensure this, the researcher created an audit trail of the research process, encompassing data collection and analysis. This allows for transparency of research methods and findings. Initially, transcribed interview data underwent multiple examinations to ensure thorough comprehension. Subsequently, thematic analysis was conducted, structured around the Social-Ecological Model (SEM) levels, to discern barriers to and facilitators of accessing mental healthcare services for LGBTQIA+ community members. Thirdly, procedures for data analysis were meticulously documented to ensure systematic and reliable coding, classification, and interpretation of data, thereby enhancing understanding. The entire research process was extensively reported, enabling future researchers to replicate the study, which could result in similar findings (Amankwaa, 2016; Mertens,1998; Schwandt et al., 2007).

3.8.4 Confirmability

Confirmability refers to the ability of research findings to be validated by another researcher, thereby mitigating research bias. In confirmability, two or more independent individuals concur on the accuracy, relevance, or interpretation of the data, ensuring its objectivity (Cope, 2014; Shenton, 2004). Confirmability was upheld through the guidance and review of the research process by the researcher's supervisors, aiming to diminish bias. The research report encompasses thorough descriptions of the study context, participants, data collection methods, and analysis procedures. This approach enables readers to evaluate the credibility of the findings. Additionally, a thorough record of the research process is maintained, documenting both data collection and analysis stages. This record encompasses the documentation of decisions, selections, and any adjustments made during the study.

3.8.5 Data triangulation

Triangulation is a research technique that uses different theories, methods, or data sources to improve the validity, credibility, and dependability of the findings. By approaching research problems from a variety of perspectives, triangulation decreases biases and provides a more comprehensive understanding of the research problem (Denzin, 2017; Moran-Ellis et al., 2006). Different types of triangulations can be utilised; one of these is data source triangulation. This type of triangulation involves collecting data from various sources, such as different locations, time periods, or participant groups, to provide rich insights and ensure a wide range of perspectives (Fusch et al., 2018; Patton, 2014). Another approach is method triangulation, this approach involves using more than one method, such as using both a qualitative and quantitative approach to examine the same phenomenon and to validate the findings across methodological lenses (Carter et al., 2014; Jick, 1979). Theoretical triangulation uses different theoretical frameworks to interpret the data, which allows researchers to uncover many dimensions of a problem, thus avoiding a one-dimensional conclusion (Carter et al., 2014; Guion et al., 2011). Another form of triangulation that researchers employ is investigator triangulation. When using this method, more than one researcher is required to independently analyse the data. This helps to reduce the potential biases that a single researcher might have.

The final method, unit of analysis triangulation, examines different units, such as individuals, groups, or organisations, to get a more holistic understanding of a phenomenon (Guion et al., 2011; Shih,1998). This study applied the unit of analysis triangulation by selecting participants who self-identified as lesbian, gay, bisexual, and transgender. Since the unit of analysis in this study is the individual, it is important to make use of triangulation to include any differences or similarities in experiences of access to mental healthcare services between lesbian, gay, bisexual, transgender people, etc., for the purpose of capturing the richness and diversity in their perspectives as individuals and as groups. One participant indicated a preference for being identified simply as queer.

3.9 Ethical Considerations

3.9.1 Study approval and ethics clearance

Researchers have a moral obligation to conduct their studies ethically, encompassing the protection of participants, establishment of trust, safeguarding of institutional integrity, and promotion of the integrity of their work (Govil, 2013; Ketefian, 2015). This section outlines the ethical principles that guided the study.

3.9.2 Voluntary participation

Voluntary participation ensures that participants have the autonomy to choose whether to participate, including the right to withdraw from the interviews if they experience discomfort (Govil, 2013; Ketefian, 2015). Participants in this study were duly informed of their right to voluntary participation through the information sheets provided to them.

3.9.3 Informed consent

Informed consent is defined as an ongoing and transparent process. It entails ensuring that participants are thoroughly informed about the nature of the research, including its risks, benefits, expected outcomes, and any available alternatives, before they agree to participate (Govil, 2013; Ketefian, 2015). Moreover, informed consent encompasses informing participants about their right to withdraw from the study at any point without facing any repercussions. To fulfil this requirement, participants were provided with a Participant Information Sheet (See Appendix D1 and D2) prior to the interviews, outlining the study's objectives, data collection methods, ethical considerations, and procedures for handling and processing data. Following this, participants were asked to confirm their understanding and willingness to participate in the study by signing consent forms.

3.9.4 Confidentiality and privacy

Confidentiality is defined as an agreement between the participant and the researcher that restricts access to a participant's information (Govil, 2013; Ketefian, 2015). The researcher guaranteed the participants that any information shared during the interviews would remain confidential. Yet, in cases where participants might pose harm to themselves, the information would be disclosed to pertinent personnel, such as the social workers affiliated with Richie Cloete Consultancy. The confidentiality of the participants' identities and information was also ensured by providing them with pseudonyms, for example, “Respondent 1” and “Town 1”. The researcher refrained from sharing private participant information with any other parties, except for the supervisors who were assisting with the data analysis. Confidentiality measures were further reinforced by storing raw data in a computer protected by a password, accessible only to the researcher. Physical copies of research materials, like consent forms and interview transcripts stripped of identifying details, were securely stored in a locked cabinet and will be destroyed after five years. Additionally, privacy was upheld by conducting interviews in a secluded room at Richie Cloete Consultancy's offices.

3.9.5 Beneficence

The principle of beneficence ensures the participants' well-being and safeguards them from harm during data collection (Govil, 2013; Ketefian, 2015). No harm was anticipated as a result of the study. Nevertheless, arrangements were made to refer participants who experienced psychological distress while recalling painful past events to a social worker at Richie Cloete Consultancy for further assistance. However, throughout the study, there were no instances where participants required such referrals.

3.9.6 Study authorisation

Before the study began, the researcher presented the study proposal to the Centre for Health Systems Research & Development departmental review panel in accordance with the University of the Free State's (UFS) postgraduate research guidelines. The next step involved the proposal being reviewed for scientific merit by the UFS' Faculty of the Humanities Scientific Committee for the Social Sciences. After receiving approval from this committee, the study protocol was submitted to the UFS's General/Human Research Ethics Committee (GHREC) to obtain ethical clearance. Upon meeting all the requirements, the study received ethical clearance with the reference number UFS-HSD2023/0868 (see Appendix E).

3.10 Reflexivity

Reflexivity is an essential concept in qualitative research that relates to the researcher's appreciation of their own impact on the research process and outcomes. It is important for the researcher to critically examine how their own beliefs, biases, and social identities impact not only their interactions with participants but also the interpretation of the data (Bourke, 2014; Finlay, 2002). Reflexivity acknowledges that research is not a linear process, but rather an interaction between the researcher and the participants; therefore, it is fundamental in ensuring trustworthiness and credibility of the findings (Bourke, 2014; Finlay, 2002). Qualitative researchers should continuously reflect on their own positionality and the impact it has on the research, i.e., how their assumptions, experience, and background affect their approach to data collection and analysis (Finlay, 2002; Palaganas et al., 2017). When researchers are reflexive, they can recognise and mitigate potential biases that could skew the interpretation of the data, which in turn improves the trustworthiness of the findings (Finlay, 2002).

In this study, the researcher was mindful of how their personal values could shape interview questions, data interpretation, and findings presentation. To address this, the researcher took precautions. The researcher prioritised transparency and bias reduction. For example, the researcher approached the study with a bias that members of the LGBTQIA+ community in Nama Khoi district are vulnerable. This bias was informed by existing literature that had been conducted in different contexts. However, during the processes of participant recruitment, data collection, and analysis, it became clear to the researcher that other social categories, such as employment status/profession, marital status, and age, can interact with sexual orientation to influence the accessibility of mental healthcare services among members of the LGBTQIA+ community within a rural setting. The researcher committed to being open-minded and respecting participants' perspectives and recommendations.

Additionally, it was essential to consider the values held by the participants themselves. For example, during interviews, the researcher paid attention to participants with strong personal and cultural values regarding mental healthcare, privacy, and stigma, as these could influence their willingness to discuss certain issues related to their mental health and sexual orientation. The researcher also deemed ethical considerations paramount. The researcher evaluated the potential impact of his work on participants and society, aiming to uphold participants' values, privacy, and dignity, and conducting research to inform improvements in mental healthcare services in the Namaqualand area (Bradley et al., 2020; Kivunja & Kuyini, 2017; Mertens, 2007) Reflexivity was further upheld by the researcher through engaging in bracketing sessions with his supervisors.

3.11 Conclusion

This chapter provided an overview of the research paradigm, followed by an examination of the research approach and design, the setting, and the methods utilised. In terms of methodology, a qualitative approach encompassing a case study design was employed. A qualitative approach enabled the researcher to delve deeply into the intricacies of the perspectives of members of the LGBTQIA+ community on the accessibility of mental healthcare services, drawing upon rich qualitative data to gain insights and identify patterns. The paradigm and research design provided a suitable framework for the study, allowing the researcher to explore and describe the barriers to and facilitators of access to mental healthcare services for members of the LGBTQIA+ community in a contextually sensitive manner. The chapter also provided information on the measures taken to ensure the trustworthiness of the data and the ethical principles adhered to. Chapter 4 presented and discussed the findings of the study.

CHAPTER 4: PRESENTATION AND DISCUSSION OF FINDINGS

4.1. Introduction

In the previous chapter, the methodology of the study was discussed. Chapter 4 presents and discusses the findings generated through thematic analysis, as outlined in Chapter 3. The study aimed to explore and describe the perceptions of members of the LGBTQIA+ community regarding barriers to and facilitators of access to mental healthcare services within their community through the lens of the Social Ecological Model (SEM). The specific objectives of the study were to describe mental healthcare needs of the LGBTQIA+ community; to explore the perceptions of the LGBTQIA+ community regarding barriers to mental healthcare access; and to explore the perceptions of the LGBTQIA+ community regarding facilitators to mental healthcare access within their community.

The SEM is underpinned by the understanding that health behaviours are affected by numerous factors and on different levels. Therefore, the themes are structured according to the CDC four level model (individual, interpersonal/relationships, organisational/ community, and societal).

4.2. The Mental Healthcare Needs of the LGBTQIA+ Community

This section described the mental healthcare needs of the LGBTQIA+ community in Namaqualand. Two themes and five sub-themes emerged in response to questions about the participants' mental healthcare needs. The first theme focused on the dire need for comprehensive support systems for the LGBTQIA+ community. The second theme focused on the need for community sensitisation on LGBTQIA+ rights in Namaqualand.

4.2.1 Comprehensive support systems for LGBTQIA+ mental health in Namaqualand (Theme)

This theme was supported by two sub-themes, namely the need for targeted counselling services due to perceptions of a high prevalence of mental health conditions among members of the LGBTQIA+ community, and the need for integrated psychosocial and physical health services to address this problem.

4.2.1.1 Targeted counselling services for members of the LGBTQIA+ community (Sub-Theme)

This sub-theme focused on the participants’ need for mental healthcare services that specifically address the multiple forms of discrimination, stigma, and exclusion that they experience in Namaqualand. One participant qualified this by describing their experience of being in a general state of anxiety while engaged in social activities that are common among young people, such as going to clubs:

> *That's the first thing I want to mention. So, you have that anxiety. I'm literally often scared if, when the club maybe closes in Town 4, and I have to go home because then I know it's going to be a mess outside, or somewhere, I’m going to hear “you’re making a joke out of being a man”, you know they will say those things. So, it creates that fear. The other thing it creates is that it affects your dignity. Do you understand? It breaks down your self-image. (Teacher, transgender, 27)*

For this participant, exposure to transphobia creates a general state of fear, which harms their dignity as a human being. Another participant emphasised that mental healthcare challenges should not be seen as isolated cases, but rather as collective experiences shared across the LGBTQIA+ community:

> *I would say 90% of us all still, who are part of the community, experience mental health issues, no matter how you look at it. I mean, you can get all the support, you can get everything, but you definitely experience some form of unstable mental health in the LGBTQI community because I just feel like, um, there are so many segments that play a role or factors that play a role, like references to the Bible, um, constant references to the Bible, like a man and a man can't be together or a woman and a woman can't be together, and remarks like, "We don't understand you," so all these things affect a person's mental health. (Teacher, transgender, 27)*

These quotes highlight the demand for targeted services where LGBTQIA+ individuals can access counselling for anxiety that is triggered by, amongst others, homophobia. Research has indicated that community-based programs targeted towards the LGBTQIA+ community act as a bridge to mental healthcare services. Paschen-Wolff et al. (2024) conducted a study in the US exploring the experiences of LGBTQIA+ individuals, specifically examining their experiences of discrimination and support related to their sexual orientation and gender identity within treatment and healthcare services. Many of their participants identified the need for targeted services and reported that services specifically tailored for the LGBTQIA+ community could support individuals and provide care that they might not find elsewhere. Furthermore, a scoping review of community-based support mechanisms found that feeling connected improved social support and mental well-being amongst older sexually and gender diverse people (Gasteiger et al., 2024).

Although many participants clearly described the need for targeted counselling services, some of them had never received professional mental healthcare. Research conducted in South Africa and Canada identified that members of the LGBTQIA+ community often do not access healthcare services out of fear of discrimination and unfriendly treatment by the healthcare workers (Duby et al. 2018; Gahagan & Subirana-Malaret, 2018).

When describing the requirements for LGBTQIA+ targeted mental health services, participants emphasised the need for a dedicated facility staffed by professional mental healthcare providers who possess an understanding of the unique challenges faced by LGBTQIA+ individuals in a rural context like Namaqualand. These findings are supported by the following comments:

> *I just feel that it needs to be a physical building, you know? It would make things so much easier at the end of the day. This is just my opinion because I don’t like talking on the phone. I feel it should be face-to-face communication. So, yes, there needs to be a physical building, there needs to be someone there that I can go to, you know? (Social work student/intern, bisexual, 23).*

> *I’m living in Town 4, you see, but you know, you can only go to the church or to the clinic, so it’s not enough. It’s definitely not enough. I just feel that there should be a small facility, maybe, and there should at least be a psychologist available 24/7. You see, when you go to the clinic and pick up a pamphlet about depression or something, you end up being judged. Nowadays, there is so much convenient technology where you can talk to someone anonymously, which helps, but you still literally need to talk to someone. I would say that something definitely needs to be done about mental health. (Social work student/intern, bisexual, 23)*

A recent scoping review on the accessibility of mental healthcare services for members of the LGBTQIA+ community in rural settings globally highlighted limited services, workforce deficiencies, and the cost of travelling to urban areas as significant barriers to access to care (Maria et al. 2025). The inequity in access to mental health services often leads to poorer mental health outcomes for LGBTQIA+ individuals in rural settings when compared to their heterosexual and cisgender counterparts. This supports participants' need for targeted counselling services that are easily accessible to members of the LGBTQIA+ community in Namaqualand.

4.2.1.2 Integrated psycho-social and physical health services for members of the LGBTQIA+ community (Sub-Theme)

Integrating psycho-social and physical health services for the LGBTQIA+ community to provide comprehensive care was identified as a unique need for transgender and transsexual individuals. Integration of these services refers to the provision of basic mental health, psycho-social and physical health services within the primary care setting, this means that trained PHC staff would identify and manage common conditions, refer severe cases to the next level of care, and ensure accessible and affirming care. A participant described the need for integration of services as follows:

> *The transgenders and the transsexuals, they need therapy for their gender conversion, and then they don't necessarily get it, and then it's very difficult for them to eventually transition because they don't usually have access to these services, so if the healthcare system can just be more tolerant, I think that's the right word, towards the community and be more patient and accepting around our community (Intern/graduate student, queer, 25)*

Another participant, who identified as transgender, further elaborated on the importance of integrating psychosocial and biomedical health services. When they sought to initiate their transition, they faced uncertainty regarding available support in Namaqualand, highlighting a gap in locally accessible services. In response, they created an online platform that facilitated connections with individuals worldwide who had undergone similar transition experiences. This underscores the importance of accessible, integrated services and the potential for digital platforms to mitigate barriers in underserved rural contexts. As one participant related:

> *I never understood where I could go, you see, I thought such things (transitioning) only happen in America so, so I created the persona for myself so that I could be seen at the school as Miss without explaining myself, without any medical certificates or anything, but after that, through an experience from other sisters, I found out about the treatment and the psychologist and what you get at clinics and stuff, I didn't know it existed. (Teacher, transgender, 27)*

Research indicates that the integration of psychosocial and biomedical health services at a community-based level improves physical and mental well-being, while also enhancing social connections within the LGBTQIA+ community (Gasteiger et al., 2024). Furthermore, Heredia et al. (2021) highlight that incorporating LGBTQIA+ mental health services into primary care enables healthcare workers to address the multifactorial influences that contribute to and perpetuate psychological distress among LGBTQIA+ clients. They further argue that establishing collaborative partnerships with LGBTQIA+ individuals ensures that their perspectives are incorporated into service provision, potentially leading to innovative and feasible solutions that promote the health of this population. In addition, integrating mental healthcare into primary healthcare has been shown to improve patient functioning, strengthen healthcare worker-patient relationships, and increase access to mental healthcare services (Reiss-Brennan, 2014).

4.2.2 Community Sensitisation on LGBTQIA + Rights in Namaqualand (Theme)

This theme focused on the need for community sensitisation on LGBTQIA+ rights in Namaqualand and was supported by three sub-themes, including disparities in perceptions of homophobia between rural and urban areas, the demand for education on mental health conditions for members of the LGBTQIA+ community, and the longing for acceptance of their sexual and gendered identities by families.

4.2.2.1 Perceptions of homophobia in rural versus urban areas (Sub-Theme)

Namaqualand is perceived as a rural community that is not necessarily open or sensitised to the needs of the LGBTQIA+ population. Several participants reported that LGBTQIA+ individuals often cannot express their identities freely in this context. Participants observed how homophobia remains prevalent in Namaqualand, despite South Africa’s progressive constitution that protects LGBTQIA+ rights. Additionally, an instance of transphobia experienced by a law enforcement officer highlights the broader social challenges faced by LGBTQIA+ individuals and highlights the urgent need for community sensitisation. One participant had the following to say:

> *I just told you, here you can't be yourself, like I said. Now, I have this one guy friend from Town 2, and then one from Town 1 who is a policeman, now he's judged a lot. I think he's busy with transgender (transitioning) or whatever. He's a policeman, (then people will say) yeah, a moffie won't handcuff me you know all these things man and so I feel this doesn't happen in other places because when I see how free people are in Cape Town and how free they are in the specific cities, and then I think, Yoh, can't Namaqualand also become like that because, a gay man doesn't feel he can comfortably walk in the town wearing high heels because then he gets insults or with a skirt or with makeup because he gets insults you see. (Student, bisexual, 22)*

When describing the need for community sensitisation on LGBTQIA+ rights in Namaqualand as a rural community, most participants drew comparisons with the City of Cape Town, an urban Metropolitan Municipality located in the Western Cape Province of South Africa. In contrast to Cape Town, the recognition and protection of LGBTQIA+ rights in Namaqualand lag considerably. One participant illustrated the impact of prevailing homophobia on members of the LGBTQIA+ community in the following quote:

> *I think that specifically rural areas like Namaqualand, LGBTQAI+ is, how should I put it, still very behind. It's terribly far behind, and we're still concerned about what people will think and say, and these things break you down mentally. And if you don't talk about it, it will never come out in the open, and people still think it's an abomination, and you know, you shouldn't touch it. (Events planner/radio host, gay, 36)*

Another participant, who is also a social work student, stated that while members of the LGBTQIA+ communities are encouraged to live their lives openly, homophobia, which is prevalent in their community, can specifically cause depression.

> *They have this thing where they say you have to get out of the closet, and uhm, yeah, people will get broken down by insults that they receive and stuff. So that person will feel like they can't be themselves, for example, if I'm gay, then people*

> *will direct slurs at me, and I know about a few cases where these people will get depressed on another level. like here in Namaqualand. (Social work student/intern, bisexual, 23)*

This image of a mental breakdown as a possible consequence of homophobia within a rural setting is indicative of the need for community sensitisation to address social and cultural norms that drive homophobia in this context.

Studies have shown that rural communities often have conservative views and are less supportive, have less resources and not sensitised to the LGBTQIA+ community (Henriquez & Ahmad, 2021; Rosenkrantz et al., 2017). Previous research has further found that the fear of discrimination and social marginalisation can prevent individuals from engaging fully within their communities (Nic Giolla Easpaig et al., 2022). Consequently, while targeted counselling services are clearly needed in these settings, addressing homophobia at the societal level through community sensitisation on LGBTQIA+ rights is equally essential. Achieving this requires a holistic approach that considers policy frameworks, resource allocation, cultural norms, and other relevant social determinants of health (Becker & Kleinman, 2013; Freeman, 2022; Rathod et al., 2017).

4.2.2.2 Education for members of the LGBTQIA+ community about mental health conditions (Sub-Theme)

Several participants emphasised the need for mental health literacy programmes, focusing on the biomedical causes of mental health conditions. This education should include information about the physical and biological factors that influence brain function and mood. A participant specifically referred to chemical imbalances in the brain, which was reportedly not common knowledge among most members of the LGBTQIA+ community in Namaqualand:

> *Here in Namaqualand, if you say, people will so easily say, oh, I'm so depressed, then I'll ask do you know what that is, and I think they confuse it a lot with stressful situations when in fact it’s not. Everyone experiences stress, but not everyone can say they know what depression is like. My depression previously, where I had no reason, nothing, it just came, everything was good, everything was great, there's no reason, and it was there. So, people need to learn a bit that it's not a, how should I say, a tangible thing that causes it, but it's something in your brain*

> *that's definitely a, I don't want to use the term, there's a screw loose (laughing), but sometimes it feels like there's a screw loose. (Fashion designer, gay, 33)*

A lack of knowledge about mental health can contribute to self-stigma, misconceptions, and dismissive attitudes (Benjamin et al., 2021). Participants reported that some members of their community do not understand what mental health entails and therefore reduce it to stress, which is something that everyone experiences daily. This observation aligns with Benjamin et al.'s (2021) study, which indicated that mental health literacy tends to be low in South Africa's rural communities. The participants also highlighted the need for education to debunk the myth that mental health conditions must be caused by a specific trigger, such as a traumatic experience. These myths often stem from stigmatising beliefs that are held within conservative or rural communities such as Namaqualand. Similarly, a study conducted primarily in the Middle East and North African regions found that the stigma surrounding mental health conditions obstructs open dialogue and prevents individuals from seeking help (Booth et al., 2024).

4.2.2.3 The need for acceptance of LGBTQIA+ identity by families (Sub-Theme)

Closely related to the need for community sensitisation about LGBTQIA+ rights in Namaqualand is the need for acceptance of participants' sexual and gendered identity by immediate family members, particularly parents. One participant, who identified as bisexual, explained that acceptance by families is a critical need for biological male members of the LGBTQIA+ community. Rejection of one's sexual orientation or gender identity within the family structure is perceived to exacerbate negative emotions when individuals are confronted with homophobia at the societal level, especially within a rural context like Namaqualand:

> *Let me tell you, I know now, like most of my friends, especially guys, guys don't get acceptance from their parents. Now you must know if your parents don't accept you, how will the community accept you? How will it come from the community? So, it must be very... I am still lucky that my family accepts it now, but shame I feel so bad for them when I have to see it like that, and then I have to hear hey, you Moffie cunt, you what, you what. Then I think yissie, man, what is that person going through, when people say that to him, but shame man it's... (Student, bisexual, 22)*

The need for acceptance by family is so important that another participant described it as a prerequisite for mental health among members of the LGBTQIA+ community:

> *I just think family acceptance starts at home. If acceptance starts at home, then the child doesn't have a problem having a mental health issue in the first place, you know because, if you can, if I can be insulted in the streets, then my family can be there to help me, so I just feel like the support of family is very important...(Shop Assistant, lesbian, 26)*

Studies conducted across rural and urban settings in America have shown that LGBTQIA+ youth who experience family acceptance tend to have better health outcomes, with such acceptance being linked to lower rates of mental health conditions (McConnell et al., 2016; Ryan et al., 2010). Conversely, rejection from family members negatively affects mental health (Adu et al., 2024; McDonald, 2018). A United Kingdom-based study exploring how family relationships foster, maintain, or harm the mental health and well-being of LGBTQIA+ youth found that mental health is influenced by family relationships in multifaceted ways. The findings suggest that family acceptance resulted in better mental health outcomes while rejection worsened feelings of depression and anxiety (McDermott et al., 2021). Therefore, acceptance by family members is essential to facilitate self-acceptance for young people residing in an environment that can be hostile towards them (Ryan et al., 2010).

This section identified the perceived needs of the LGBTQAI+ community in Namaqualand concerning mental healthcare access. Participants expressed a desire for targeted counselling services, integrated psychosocial and physical health services, and community sensitisation on LGBTQIA+ rights in Namaqualand. This suggests the necessity of a comprehensive, multi-level strategy to address these needs. The following section describes and discusses the participants’ perceptions and experiences of barriers to accessing mental healthcare services in their community.

4.3. Perceptions of the LGBTQIA+ Community on Barriers to Mental Healthcare Access

This section describes and discusses the participants' perceived and experienced barriers to accessing mental healthcare services across four levels: individual, interpersonal, organisational, and societal.

4.3.1 Individual level barriers to accessing mental healthcare services

Individual level barriers refer to personal factors that prevent LGBTQIA+ individuals from seeking mental healthcare services in Namaqualand. Participants identified negative attitudes and a lack of knowledge about mental healthcare services, as well as uncertainty regarding where to access mental healthcare services, as key impediments. These personal level factors are closely interconnected, as a lack of knowledge about mental health conditions can directly influence an individual's attitude towards seeking mental healthcare.

4.3.1.1 Negative attitude towards seeking mental healthcare (Theme)

Participants with expert knowledge concerning the mental healthcare challenges faced by the LGBTQIA+ community in Namaqualand identified two sub-themes, namely internal conflicts related to one's LGBTQIA+ identity, and a preference for alternative coping mechanisms over biomedical approaches to the treatment and care for mental health conditions.

4.3.1.1.1 Internal conflict with LGBTQIA+ identity (Sub-Theme)

Drawing on their professional experience as a social worker, one participant suggested that at a personal level, negative attitudes towards seeking mental healthcare can stem from internalised stigma related to one's LGBTQIA+ identity. In this context, internal stigma can cause conflicting emotions within an individual, which may manifest externally by resisting mental health services that are available due to fear of being labelled as a victim. The following excerpts corroborate this finding:

> *If I can take it from my job, uhm, I work exclusively with victims of violence. Uhm, I had, on one or two occasions, clients who are part of the LGBTI community that were victims of gender-based violence, but they, it was reported but then they'd resist the service or didn't want the service. They didn't want to, I would say, didn't want to identify as a victim, and I understand that because I am part of the*

> *LGBTI community…you, you anyway see yourself as a victim of oppression and everything because you are a member of the LGBTI community. Now this thing happened to you, now you are more of uhm shall I say more of a victim, then you might feel like the whole world is out to get you because you are uhm different, because you get treated differently. (Social worker, gay, 32)*

> *Uhm, but mental health in the LGBTQI community is actually a very sensitive issue, I think, because remember you need to make peace with yourself, but still, you know you are not being accepted. So, the first thing on your mind is suicide, or you have to repent, or you need to fix yourself, because there's something wrong with you in a major way. So, there are many emotions and things that you have to deal with until you accept yourself. (Social worker, gay, 32)*

These insights suggest that when individuals have not fully accepted their identity as a member of the LGBTQIA community, it may become a barrier to seeking mental healthcare when required.

Previous research confirms the finding that unresolved internal conflict and self-stigma related to one's LGBTQIA identity can discourage help-seeking behaviour. A meta-analysis by Newcomb and Mustanski (2010) focusing on internalised homophobia and mental health conditions, found that individuals who experience internalised homophobia have a higher likelihood of also internalising their mental health problems. Similarly, Chard et al. (2015), in a cross-sectional study conducted across seven countries, including South Africa, reported a significant correlation between internalised homophobia and symptoms of depression and anxiety among gay and bisexual men. Furthermore, research indicates that individuals who experience internalised homophobia often do not disclose their mental health struggles and, as a result, do not access mental healthcare services (Ventriglio et al. 2021).

The excerpts above further suggested that internal stigma within the LGBTQIA+ community is directly influenced by perceptions of discrimination, whether real or imagined, at the interpersonal, organisational, and societal levels.

4.3.1.1.2 Alternative coping mechanisms: Substance abuse (Sub-Theme)

Instead of seeking professional mental healthcare when required, some participants indicated that they relied on alternative coping mechanisms at a personal level, such as the use of alcohol and cannabis to numb negative emotions. One participant described how their personal history of substance abuse and depression was triggered by conflicting emotions associated with navigating their sexual and gender identity:

> *A few years back, I had uh, a drug problem at one point and I think it also went hand in hand with the fact that I'm gay and the fact that I was still in the closet and that I didn't know how to express myself. Then I tried these things (drugs) and kind of got lost in it … but when I was trying to get out of those things, I saw that mental health is a big thing because it's not just about changing your environment, it's not just about giving up drugs or cigarettes or whatever, it's also about what's inside you that needs to work together with your body and if that's not right or if you don't know how to handle it, then it will always be a problem. (Personal assistant, gay, 42)*

This personal preference for alternative coping mechanisms was further supported by another participant who described how the use of alcohol or cannabis to numb negative emotions can encourage addiction among some members of the LGBTQIA+ community in Namaqualand:

> *I'm going to smoke weed so I can get rid of what I'm thinking or feeling at the moment, or I'm going to do this or I'm going to do that and then we judge them for that because now they've gone from mental health to addict and a mess, and that's how people are seen in Namaqualand, someone who smokes a bit of weed, who does this and that. Everyone's looking for an escape somewhere, so you don't have to think about that dark cloud, and if reality hits you, but remember, that high is not going to last forever, so when it comes back, those feelings and things you had come back even worse. (Events planner/radio host, gay, 36)*

Explanations provided by participants indicate that they possess some understanding of mental health conditions, as reflected in the use of terms such as ‘breakdown’, ‘bruised tree’, or ‘dark clouds. Despite recognising the intensity of these negative emotions, some participants described a personal preference for alternative coping mechanisms, which, in some cases, led to substance abuse.

The findings from the present study, which demonstrate that some participants rely on alternative coping mechanisms such as alcohol and cannabis to manage negative emotions, align with existing research indicating that members of the LGBTQIA+ community are disproportionately affected by substance use issues. A meta-analysis of American studies by Orchard (2023) demonstrated that LGBTQIA+ individuals experience higher rates of substance use compared to their heterosexual counterparts.

Similarly, research among American transgender individuals found that participants who experienced stigma or discrimination in healthcare settings were more likely to use substances to cope, potentially exacerbating substance use-related conditions. (Reisner et al., 2015). Felner et al.'s (2020) study reported that young American adults, aged between 21-34 years, frequently turned to substances to cope with stressors such as internalised homophobia or the fear of rejection, and for many, substance use became a habitual coping mechanism. The use of substances as a coping mechanism can lead to substance use disorder, which is a mental health condition in itself. In line with this, Wolfe et al. (2021) found that transgender adults exhibited high rates of substance use disorders, which are linked to experiences of discrimination and reliance on substances as a coping mechanism.

These studies collectively illustrate a cycle in which avoidance of professional mental healthcare, prompted by discrimination or stigma, leads to a reliance on substances, potentially resulting in substance use disorders and further mental health conditions. The findings from Namaqualand mirror this pattern, demonstrating how the preference for alternative coping mechanisms can act as a barrier to accessing mental healthcare and exacerbate psychological distress.

4.3.1.2 Lack of knowledge and awareness about mental health (Theme)

At the personal level, lack of knowledge about mental health was identified as an additional barrier to accessing mental healthcare. Two sub-themes describe this theme: a lack of knowledge about mental health conditions and a lack of awareness about the availability of mental healthcare services.

4.3.1.2.1 Lack of knowledge about mental health conditions (Sub-Theme)

Lack of knowledge about mental health conditions was described as a personal factor that can prevent individuals from seeking care. One participant shared the experience of a young relative who, while struggling with conflicts about their sexuality and coping with their parents' divorce, expressed their inability to understand what they were going through, using phrases such as “a black demon was devouring her” in a suicide note:

> *She explained that she doesn't know how to explain what she's going through, but it's very tough, and she can't handle it. Then she told her sisters crap in the letter; it was an intense letter, and no one could get the letter either. So, I wanted to read the letter, and they let me read it, and she, man, she was dealing with demons. I don't know how to put it, there was a black demon that was devouring her, so yeah. (Events planner/radio host, gay, 36)*

These concerns were also raised by another participant, a social worker, who noted that possessing the knowledge and the vocabulary to name feelings is critical and that the lack thereof is a potential barrier to getting support either from family members or healthcare professionals:

> *Yes, if you can call the thing by its name, then you know and then you know why you need help. So, if you don't know, if you can't name it then I don't think you will be able to get help. You can't identify it so its vocabulary, the ignorance yes. If you know what the situation is then you would know where to get help, what the problem is, and what triggers it. So, if you are not aware of it, I don't think you will even look for help or talk about it. (Social Worker, gay, 32)*

The concerns regarding the lack of knowledge about mental health conditions resonate with previous research. A lack of knowledge about mental health conditions leads to avoidance and, as such, acts as a barrier to access (Benjamin et al., 2021). A study by Crockett et al. (2022) among university students in Chile uncovered that individual level factors, such as a lack of knowledge about mental healthcare, as well as the inability to recognise mental distress, served as barriers to accessing healthcare services and delayed help-seeking behaviours. Similarly, a study conducted in the Eastern Cape, South Africa, also found that a lack of knowledge and insight into their conditions amongst people with mental health conditions could act as a barrier and decrease health-seeking behaviours (Strumpher et al. 2014).

4.3.1.2.2 Lack of awareness about the availability of mental healthcare services (Sub-Theme)

Another barrier, at the individual level, was not knowing where to access mental healthcare services. A participant recalled that after receiving an HIV positive diagnosis, they did not know where to go to access support:

> *I also didn't really know who to turn to and ask because... I... what is the name of that one website, uh? Mambo online, it’s also a gay dating site but they always had such ads they sent out regarding uh, men's health, uh mental health, and such things. So, I went to their website, and I tried emailing, but I never got a reply. I tried calling them, too, because I didn't know how to deal with the HIV thing. (Personal assistant, gay, 42)*

While this participant demonstrated a positive attitude towards mental health, they did not know where to go to access such care. This barrier was echoed by another participant, a social worker, who noted that often, members of the LGBTQIA+ community in Namaqualand did not know where to seek mental healthcare:

> *In my community, no, look, we even struggle if we have clients that we see okay, right, it seems...[like they have a mental health condition]. Uhm, look, we can’t diagnose, we can’t say it is like that, but we can see if there are tendencies, then we have to refer to health [referring to the Department of Health]. However, there are so many out here that are walking around and even living on the streets. I can think of two specific people that are here in Town 4 wandering the streets, and they have serious mental issues, but they don’t get the services, uhm, so I don’t think there are any services for us around here. (Social Worker, gay, 32)*

The perspectives shared by participants align with findings from similar research (Crocket et al., 2022; Moroz et al., 2020; Torres-Sanchez et al., 2022) that reported that participants often did not know where or how to access mental healthcare services, which delayed access to care. The rural urban divide was highlighted in a scoping review by Maria et al. (2025), which argued that communities outside of urban areas often lack the awareness of available services thus decreasing the accessibility of such services.

4.3.2 Interpersonal level

The findings indicated that individual and interpersonal level factors intersect to limit access to mental healthcare for members of the LGBTQIA+ community. Some participants reported that their relationships with family members and friends negatively influenced their ability to access mental healthcare. From these accounts, the theme of a lack of relational support towards accessing mental healthcare services was generated.

4.3.2.1 Lack of relational support towards accessing mental healthcare services (Theme)

Relationships with other individuals, such as friends and family, can impact whether members of the LGBTQIA+ community seek mental healthcare or not. When these relationships are not supportive, they can act as a barrier to mental healthcare access. Two sub-themes were identified: a lack of support from family members and a lack of support from friends.

4.3.2.1.1 Lack of support from family (Sub-Theme)

Lack of emotional support from family members, including parents, grandparents, siblings, and cousins, can prevent members of the LGBTQIA+ community from seeking mental healthcare. For participants, this can occur when relatives do not recognise that mental health conditions are real. This concern is captured in the following observations by two of the participants:

> *It is something that is not talked about, but we need to talk about it because my cousin killed herself. We still don't talk about it, to this day we don't talk about it, and she was mentally ill, she was mentally fucked, because she also went through a lot of shit. Her parents got divorced, she was dealing with her sexual orientation, am I straight, am I bisexual? I was there for her; I was so shocked when I heard that she had hanged herself. I was busy with Mr Gay South Africa when I got the call because we were close, and it hit me very hard, the fact that I lost my cousin. I was…ooh, I was very angry at her because, why didn't she talk to me, what was so bad that you had to hang yourself? Given that we spoke every day, that tells me that she didn't even open up to me about what was bothering her. And it was mental health, so we never spoke about it, and we*

> *never will, because it's a taboo in our family, she killed herself and that's it. (Events planner/radio host, gay, 36)*

> *No even to this day, my dad is still emotionally unavailable. Like I can't go and tell them that I'm not feeling well today, they will just say chin up, keep your head high. You can't complain about your feelings. (HR Intern, lesbian, 27)*

The perception that mental health conditions are a "taboo" in the family and that a lack of family support can act as a barrier towards seeking mental healthcare was highlighted in other studies. A study exploring barriers to accessing mental healthcare in the Eastern Cape Province of South Africa by Strumpher et al. (2014) found that a lack of family support acts as a barrier to accessing mental healthcare services by individuals suffering from mental health conditions. Furthermore, some participants believed that their family members expected them to act normally when dealing with emotional trauma. More specifically, research among LGBTQIA+ youth identified that parents frequently minimise the mental health struggles of their children (Crockett et al. (2022), that individuals who do not receive family support experience higher rates of psychological issues than those who do (McConnell et al. 2016), and that family support acted as a buffer against adverse mental health outcomes (DelFerro et al., 2024).

4.3.2.1.1 Lack of support from friends (Sub-Theme)

In addition to a lack of support from family, participants described the absence of support from friends as a barrier to accessing mental healthcare. One participant, who had previously attempted suicide, confided in a friend that they did not want their family to know. The participant reported feeling deeply disappointed and hurt when the friend betrayed their trust by disclosing confidential information about their mental health condition and subsequent hospitalisation to others within their social network. Following this experience, the participant chose not to seek emotional support from friends, who could otherwise serve as an important link to professional help in the absence of family support, and instead preferred to confide in God through prayer. An HR intern (lesbian, 27) had the following to say:

> *I don't trust people. So, I feel that our Creator, I can share everything with Him, I can vent to Him. The reason for this is in the past I have, let me say this friend that supported me, I eventually opened to her, spoke to her about things, vented*

> *to her until one day when we had an argument. Then she turned around and literally shared all my secrets.*

Another participant perceived lack of support from friends when dealing with a mental health condition, in contrast to physical illness.

> *And also, here, people don't take you seriously if you want, like I told you, if you say jeez man I can't go out tonight I don't feel alright, man, it's not physical, it's mentally that I'm not alright, then others will say oh man, that one is depressed again, he's crying, let him just lie down, you see. It's almost like it's just a thing, it's just like having a cold, but in the heart, he'll be alright tomorrow. Tomorrow I must put on a face because I can't be around people and... you understand, hmm, yeah. (Student, bisexual, 22)*

This indicates that within their circle of friends, some participants experienced a lack of support when they shared their emotional problems, which could exacerbate psychological issues. Prior research alludes to similar findings, indicating that social support is a crucial determinant of mental health among LGBTQIA+ individuals. Studies show that a lack of support during adolescence is linked to higher rates of mental health conditions and impedes access to mental healthcare services (Mangwegape et al., 2024; McDonald, 2018). These effects often persist into adulthood, with early social support positively influencing adult adjustment (Snapp et al., 2015). Additionally, the beliefs and attitudes of family, friends, and the wider community shape health-seeking behaviours, with negative perceptions acting as barriers to accessing mental healthcare (Ngwenya et al., 2020). Overall, both the presence of support and the social environment are key determinants of mental health outcomes and service utilisation among LGBTQIA+ populations.

4.3.3 Organisational/community level

At the organisational level, health system factors that act as barriers towards accessing mental healthcare services for members of the LGBTQIA+ in Namaqualand were identified. The themes generated include limited mental healthcare services and healthcare workers' negative attitudes towards mental healthcare for LGBTQIA+ individuals.

4.3.3.1 Limited mental healthcare services (Theme)

Five sub-themes illustrate how limited mental healthcare services act as a barrier to access, namely inequality between the public and private sectors, inequality for transgender persons, limited working hours at healthcare facilities, insufficient mental healthcare professionals, and limited mental healthcare facilities in Namaqualand.

4.3.3.1.1 Inequality in access to mental healthcare between the public and private sectors (Sub-Theme)

Participants reported that members of the LGBTQIA+ community access mental healthcare services in the private sector when they are employed and have private medical insurance. However, those without medical insurance reported facing several challenges when accessing care in the public sector, as confirmed in the following excerpts:

> *Yeah, look, the medical practitioners, like the private doctors and stuff have their own practices, they'll probably be able to help you, but I don't think the clinics themselves have such services. I haven't gone to ask yet, so I assume they don't have them, so I don't think there are any such services. (Personal assistant, gay, 42)*

> *I could be lying if I said no, but the reason I'm saying no is because I've never heard of any, and why I am saying this is because when I had to start my transitioning and I had to see a psychologist, I had to come to Springbok Hospital because the psychologist had to write a letter that I'm ready to go on treatment. I had to go to Springbok Hospital, and when I got there, I had to call the psychologist, that's the State psychologist, because the other psychologist would cost money, and I'm not on medical aid. So, this is me who has a degree and works, and I'm not on medical aid. (Teacher, transgender, 27)*

These participants highlighted disparities in the accessibility of mental healthcare services in the public and private sectors in Namaqualand. For those who can afford private medical insurance, mental healthcare is relatively easy to access, although the cost remains high. In contrast, while services may be available in the public sector for free, the waiting period presents a major barrier for clients who need urgent mental healthcare. This reflects a clear inequality in access to mental healthcare services at the organisational level, largely influenced by individuals’ financial means and their ability to afford private health insurance.

This stark contrast between the private and public sectors aligns with previous research by Docrat et al. (2019), which highlighted that the public healthcare sector in South Africa is strained and unable to meet growing service demands. Maphumulo and Bhengu (2019) further attribute this challenge to the unequal distribution of resources, as well as ongoing management and leadership crises in the system. However, the private sector is more resourced and more efficient at providing adequate services to those who can afford them. This disparity between public and private healthcare thus acts as a significant barrier to accessing mental healthcare services, often leading to untreated mental health conditions (Young, 2016).

4.3.3.1.2 Inequality in access to mental healthcare services for transgender persons (Sub-Theme)

The second health systems challenge affecting access to mental healthcare services lies at the intersection of mental and physical healthcare, as described by one participant who identified as transgender:

> *I talked to someone who has been through the journey, but why did I have to talk to someone who has been through the journey? Why isn't there a facility where I can just go and talk to someone who knows what's going on? Because now I have to talk to someone else who has already started the journey and then she said but Respondent 4, you identify as female, you're not gay, that's why and start with your transitioning and everything. Then I said but I want bigger breasts, I don't want a penis anymore, I don't want that anymore. So then I started, there was this little clinic that came, and then the clinic was there for a day, and then they took names, and then we went to Cape Town. All the girls who want to do transitioning you go to Cape Town, you go to the clinic, they do blood tests, HIV tests, everything. You see a psychologist there to see if you're ready, then you go on the pill, the hormone pill. Depending on what your blood count is now, you start on a certain milligram or whatever, then there, you start growing breasts. I got less hair on my face, and everything, and then when I came to V Town, I don't know what happened there, but then I stopped the whole pill thing and just went*

> *on and on, but I was still Miss Respondent 4, and people accepted me. (Teacher, transgender, 27)*

This participant offered a detailed description of the challenges faced when seeking both mental and physical healthcare related to their gender identity in Namaqualand. Transgender individuals in this district are required to travel to Cape Town to access services that support their physiological and psychological needs as they transition. This situation highlights a broader structural inequity within the health system, where specialised and gender-affirming care is concentrated in urban centres, leaving those in rural areas with limited to no access. Consequently, geographical isolation and the centralisation of services act as significant barriers to equitable mental healthcare for transgender individuals. As a result of these barriers, the participant abandoned the process of transitioning after returning to Namaqualand, although they still identify as transgender.

Similar health systems challenges were identified by Müller (2017), who explored the availability, accessibility, acceptability, and quality of healthcare for LGBT individuals in South Africa. It was found that only three tertiary public hospitals in the country provided gender-affirming care, which included hormonal, psychological, and surgical treatment. None of these hospitals was in the Northern Cape Province. Another South African study explored rural transgender individuals' access to healthcare services and found that government services were mainly centralised in urban areas; therefore, individuals residing in informal settlements and rural areas did not have easy access to these services. Furthermore, it was noted that resource allocation in rural areas is markedly low, further exacerbating disparities in access to healthcare services (Zambezi & Viljoen, 2024).

4.3.3.1.3 Limited working hours at public healthcare facilities (Sub-Theme)

Some participants were aware that mental healthcare services were available at public healthcare facilities in their community. However, these services were only accessible during the day as clinics operate between 8:00 and 16:00. One participant elaborated that the hospital was open twenty-four hours a day, seven days a week, but it was located far away from their community, and ambulances always arrive late:

> *That's the thing, that's why I made the example, maybe it's past 5 pm or late at night, then we have to go to the hospital, you see, because we are here in town*

> *4, and maybe there's no transport. The clinic closes at 4. There is no one at the clinic, you see, so it's either you go to the hospital, or you have to um… you have to know someone who can do a session with you, or maybe the priest or someone… Let's say the clinic is closed at 4 p.m. and I have nowhere to go, so that person will just sit there, and no further steps will be taken, which could make the situation worse. (Social work student/intern, bisexual, 23)*

Benjamin et al. (2021) similarly found that mental health services in rural areas of South Africa are often unavailable or located at considerable distances from the communities that they serve, making access particularly challenging for individuals in need.

4.3.3.1.4 Insufficient mental healthcare professionals (Sub-Theme)

The fourth health systems factor identified by participants as a barrier to accessing care was the shortage of mental healthcare professionals in Namaqualand. Two participants expressed their frustration with the lengthy waiting periods, sometimes extending for months, before being able to see a psychologist, as illustrated in the following excerpts:

> *Yes, but it takes a long time, it takes a long time because I know if you have to see a psychologist at a clinic, let's say if the appointment is made, then it's after a month, for heaven's sakes! You need the help now, you can't wait another month, what happens in that month? For heaven's sake, we don't even have a psychologist. We have one person who has to serve the whole of Namaqualand, and that's a psychologist; it isn't even a psychiatrist. For a psychiatrist, you have to go to Upington. (Fashion designer, gay, 33).*

> *I had to wait so long to see a psychologist… It was like 3-4 weeks, it was full, and there is only one psychologist who works here in Namaqualand. So, he is in this place, then he is in that place, then I got a date for the twentieth, so that's another two weeks, but after those two weeks or that month, my well-being is immediately different. I needed a psychologist at that time to tell my story. The readiness mentally was there at that time, now my story is completely different because I waited so long, and it was so disappointing for me. (Teacher, transgender, 27)*

This finding illustrates how limited specialised human resources can hinder access to mental healthcare. Rathod et al. (2017) partly explain this by the finding that low- and middle-income countries, such as South Africa, allocate only a small portion of their healthcare budgets to mental health, and these limited resources are often allocated inefficiently. Such systemic underfunding and misallocation contribute directly to the challenges experienced by participants in accessing timely psychological care. According to Docrat et al. (2019), only about 5 % of South Africa’s national health budget is allocated to mental healthcare. These challenges are even more pronounced in rural areas such as Namaqualand, as mental health is considered a specialised service and is therefore concentrated in urban areas (Vergunst, 2018). Research investigating the number and distribution of mental healthcare providers in rural parts of South Africa identified 0.68 mental health nurses per 100,000 population compared to 9.7 mental health nurses per 100,000 population overall. Furthermore, 64% of rural healthcare facilities did not have psychologists on their staff (De Kock & Pillay, 2016). It was also reported that rural communities had 0.03 psychiatrists per 100,000 population (Janse van Rensburg et al., 2022). This clearly underscores the mental health disparities faced by LGBTQIA+ individuals in rural communities.

4.3.3.1.5 Inadequate mental healthcare facilities (Sub-Theme)

In addition to the shortage of mental healthcare professionals, participants identified inadequate mental healthcare facilities in Namaqualand as a barrier to accessing care. Several participants compared the district to Cape Town, noting that the availability of facilities for LGBTQIA+ individuals requiring in-patient treatment is far more limited in Namaqualand. One participant lamented:

> *No way, not that I know of, I'm dead serious, otherwise, I'm at fault, but I don't know of a specific place in Namaqualand, no, I don’t know of a place like that. … I don't know specifically, but I know L's friend, C he also went through a dark time, but C, well, his parents have money, so they booked him in at a mental healthcare place. Not in Namaqualand because he looked for a place in Namaqualand, but there wasn't one, so he was booked in Cape Town. You see, so unfortunately, Namaqualand doesn’t have. (Event planner/radio host, gay, 36)*

Although all participants resided in Namaqualand, most perceived Cape Town as the ideal location for accessing adequate physical resources to meet the mental healthcare needs of LGBTQIA+ individuals. This contrasts sharply with Namaqualand, where participants reported a lack of in-patient facilities specifically dedicated to mental healthcare.

These findings align with Lehohla (2011), who reported that healthcare facilities are in closer proximity to urban neighbourhoods than to rural areas. Similarly, Benjamin et al. (2021) found that specialised mental healthcare services are scarce in rural South Africa, including in the Northern Cape, mirroring the experiences reported by participants in this study. The lack of mental healthcare facilities makes it difficult for LGBTQIA+ individuals in the Namaqualand community to access essential services, which may result in untreated mental health conditions and further reinforce barriers to care.

4.3.3.2 Negative attitudes of healthcare workers (HCWs) towards mental healthcare & LGBTQIA+ (Theme)

The sub-themes generated under the theme “negative attitude of HCWs” included perceptions of limited knowledge among HCWs, HCW stigmatisation of LGBTQIA+ individuals, and poor service delivery for mental health conditions in Namaqualand.

4.3.3.2.1 Perceived knowledge gaps among healthcare workers on LGBTQIA+ mental health needs (Sub-Theme)

There was a perception among the participants that nurses and lay counsellors, who are predominantly cisgender women, lack training on the unique healthcare needs of LGBTQIA+ individuals. A young participant who identified as non-binary described how nurses and peer educators providing counselling at primary healthcare facilities often fail to understand the physical and psychological needs of LGBTQIA+ community members, as illustrated in the following quotes:

> *I don't really know how they experience it, but what I can say is the clinic sisters, or the nurses, there's a lack of information, a lack of education sometimes, and I'm specifically talking about the sisters, the peer educators, the people who should give the counselling to the clients. There's no counselling services and such things. Rather, there are services, they are just watered down, you see, you do it just because you have to, because its uhm there’s someone who needs to be counselled, then I (the gay person) am there thinking it's a death sentence. (Radio presenter, non-binary, 26)*

> *Theres no uhm…there won't be a sister that knows how to deal with me if I walk in there with tears in my eyes because of something that happened. Hmm, and you must remember, we can't really say, I don't know why gay people don't want to talk about their rapes, it's sad. Like I know about people who have been raped, but they won't talk because who are they going to go and talk to? Definitely not the sisters at the clinic. (Radio presenter, non-binary, 26)*

For this participant, the prospect of seeking mental healthcare at public health facilities in Namaqualand was described as comparable to a "death sentence". This extreme reluctance to seek both mental and physical healthcare, even in extreme circumstances such as rape, appears to stem from the perceived lack of knowledge of healthcare workers regarding the specific mental health needs of LGBTQIA+ individuals.

This finding is consistent with prior research highlighting the knowledge gaps among healthcare providers regarding LGBTQIA+ health needs. Nowaskie and Sowinski (2019) found that healthcare providers in the USA felt uninformed about LGBTQIA+ health needs, clinical management, and referral pathways. Such gaps in knowledge contribute to reluctance among LGBTQIA+ individuals to seek care, particularly following traumatic experiences such as sexual violence. The resulting mistrust can lead to avoidance or delays in accessing health services. Similarly, Müller (2017) found that many LGBTQIA+ individuals in South Africa delay or avoid seeking healthcare because of healthcare worker incompetence or discrimination. Ford et al. (2024) further noted that poor quality of care could potentially be attributed to a lack of cultural competency and understanding among healthcare providers. Whether real or perceived, this lack of knowledge and skills to assist LGBTQIA+ individuals, both physically and psychologically, acts as a barrier towards mental healthcare access and could further exacerbate existing mental health conditions.

Moreover, some participants expressed concern that heterosexual psychologists often lack the cultural competence, lived experience, or sensitivity necessary to fully understand and address the unique psychological and emotional needs of LGBTQIA+ individuals. One participant, who identified as queer, described their subjective experience while seeking care with a psychologist in Namaqualand as follows:

> *I went to the psychologist here too, um, I talked to her, and I just thought she didn't understand 100% what the issues were because she said a homosexual relationship is the same as a what is the word? A heterosexual relationship and I disagree a bit with that, and the fact is that they always want to use religion to apply therapy and keep you, basically, in your lane and that was a bit of a problem for me. (Intern/graduate student, queer, 25)*

The participant also described how the psychologist incorporated religion into therapy, which they considered unprofessional. This perceived disconnect between the client and the psychologist can lead to feelings of misunderstanding, invalidation, and marginalisation within the therapeutic settings, ultimately undermining the effectiveness of mental healthcare for LGBTQIA+ individuals.

Research conducted in other contexts has demonstrated how heteronormative prejudice can infiltrate the relationship between heterosexual therapists and clients who identify as sexual minorities, with negative implications for the psychological well-being of the client (King, 2015). These displays of heteronormative assumptions by therapists have been described by some authors as sexual orientation microaggressions that sexual minorities experience when seeking mental healthcare (Spengler et al., 2016). Also, clients' perceptions of their therapists have been proven to have an impact on the therapeutic relationship. A nation-wide online survey conducted among LGBTQ clients in the USA found that clients' perceptions of LGBTQ affirmative therapy had a strong correlation with the therapeutic relationship and the psychological well-being of the client (Alessi et al., 2019). Therefore, Psychologists who were unconscious of their heteronormative assumptions in a clinical setting were perceived by members of the LGBTQIA+ community in Namaqualand as deterrents in their quest for accessible mental healthcare.

4.3.3.2.2 Perceived unethical conduct by healthcare workers toward LGBTQIA+ mental health needs (Sub-Theme)

Unethical conduct in this context refers to situations where nurses did not take patients' experiences of mental health conditions seriously and therefore did not refer them to psychologists for counselling within the public healthcare system. In addition, failing to keep information confidential also falls under the category of unethical conduct. Such perceived unethical behaviour by healthcare workers in primary healthcare facilities, particularly regarding mental healthcare needs of the LGBTQIA+ individuals, could serve as a deterrent to help-seeking. This finding is corroborated by the following comments:

> *You go to the clinic and say you think you're suffering from depression, they laugh at you, they laugh at you. No, not you! You can't have depression, never, really? That time after I lost my mother, it was the hardest for me because, whether she accepted it [gay identity] on her deathbed or not, she and I were so close, she was my buddy, we're literally best friends. I could share anything with her. When she died, I fell into a dark hole, and I went for help at the clinic. I said, I think I have depression. Oh, for God's sake, that nurse laughed at me. Oh no! not you, Respondent 6. You're so cheerful and lively on the air, and I'm thinking, what the fuck? (Events planner/radio host, gay, 36).*
>
> *Yeah, man, remember I won't always know what she's going through. She, she doesn't talk, you see, but like I told you, I feel they should have referred her to someone because they didn't even advise my aunt, her, and her mom to say, "Look, you need to get help or get her to an institution or something." How do you send someone home who is a danger to themselves, how does that make sense? So now you can see how messed up it is...(Student, bisexual,22).*
>
> *I won’t feel comfortable telling the whole story about what happened last night to the aunty [referring to a cisgender female nurse] who is sitting in front of me, because people hear. We hear our secrets in the streets, you see? You hear other people’s stories literally and for me working in the news space where I hear lots of stories (Gasps) No man! Surely, they can't talk about such things, but then you see them. We're right across from the clinic, then we see them sitting, all of them in a group. Meanwhile a gay guy is committing suicide in the mountain. Here you are all sitting in a group smoking cigarettes and drinking tea. And then for me it’s just like it's frustrating, Then I don't know how to react, then I just say fuck it anyway, let's just get back to work. (Radio presenter, non-binary, 26)*

Research supports the finding that LGBTQIA+ individuals do not access healthcare services because of the unethical treatment by healthcare workers. Duby et al. (2018) found that some LGBTQIA+ participants in the Free State and the North West

Provinces, avoided accessing healthcare services due to discrimination and judgement from healthcare providers. Perceived unprofessional behaviour also included lack of confidentiality, with participants reporting that private conversations were sometimes shared among nurses or with the broader community. This aligns with a systematic review by Brooks et al. (2018) who reported that LGBTQIA+ individuals were not open to disclosing their sexual orientation out of fear that healthcare workers would not keep information confidential and that their friends and family would find out.

4.3.3.2.3 Perceived stigmatisation of transgender persons by healthcare workers (Sub-Theme)

Stigma was identified as another barrier to accessing mental healthcare, specifically for transgender persons accessing treatment in the public healthcare setting. One participant who identified as transgender described experiencing stigma when a doctor attempted to persuade them from proceeding with their gender transition, stating that they were “already so beautiful”:

> *I would say it's stigma because when I got to the hospital and I explained my situation, the doctor told me I'm already so beautiful, it's not necessary to go through all these things, and now you have to see a psychologist, just leave it like that. So, I said no man, I don't feel like that, I want to go for treatment again. I can’t afford treatment with a private doctor, so I have to go through the hospitals. Okay, so let's see you again next week, then we'll look into it again, and then we'll get you a psychologist. So, I feel it was responded to with stigma… It wasn't nice for me because I just felt less worthy, I immediately felt like, If I can make a quick example, you know, marshmallows are white and pink, you immediately feel like a red marshmallow in that white and pink packet, you immediately feel like, wow, you're on one side, people look down on you, I felt too pressed down. I wasn't emotionally well about it, and I told my mom, like, I don't feel like I want to continue with transitioning because the doctors and staff have this type of attitude towards you, and how long do I have to wait for a psychologist and stuff. (Teacher, transgender, 27)*

Although the statement may have been intended as a compliment, when one takes into consideration the unequal power dynamic between the doctor and the client, it becomes evident why this statement had a negative effect on the participant’s self-esteem and ultimately resulted in the discontinuation of the transition process.

The experience shared by the participant resonates with research done by Zambezi and Viljoen (2024), who found that transgender individuals frequently experience both direct and indirect discrimination from HCWs. This demonstrates a lack of sensitivity on the part of HCWs which can be invalidating for the clients. Consequently, negative attitudes among healthcare workers, particularly toward transgender persons, manifest as stigma and serve as a significant barrier to seeking mental healthcare.

4.3.3.2.4 Perceived poor service delivery for mental health conditions in Namaqualand (Sub-Theme)

Several participants used strong, often derogatory, language to describe the poor state of healthcare service delivery in the Northern Cape Province. They indicated that this sub-standard provision has contributed to the sub-optimal level of mental healthcare available in Namaqualand. The following excerpts illustrate the sentiments expressed by two participants:

> *Health in the Northern Cape is shit! That is why they don't have the energy to pay attention to things like mental health because I just sit there to earn my paycheck, there's nothing more. I took an oath to help my fellow man, and then again, the good ones are excluded, some of them are going to try their best, but the rest are there for the paycheck, they don't have time for such things. (Events planner/radio host, gay, 36).*

> *Look, that time I was smoking weed so when they heard I smoked weed, it was just about the weed and stuff. So, I just feel it's because that guy (referring to healthcare provider) couldn't look deeper maybe he could have known what the real problem was, but I quit the weed and I was still sick you know, you understand, that's how I feel… I think I was supposed to see psychologists, but I can't remember if the psychologist came or not. (Shop assistant, lesbian, 26)*

The participant noted that some HCWs either fail to refer clients to the next level of care or do not undertake comprehensive mental health screenings. These could be because HCWs are not sufficiently trained on mental health issues or excessive workloads within the public healthcare sector.

Previous research has shown that there are a limited number of HCWs who are sufficiently trained in mental healthcare, specifically in rural areas (Docrat et al., 2019; Vergunst, 2018). This is in keeping with the broader national trend where underfunding, inadequate facilities, and long waiting times contribute to a healthcare system that is ill-equipped to meet the mental health needs of the country (Docrat et al., 2019; Lund et al., 2012). The sub-optimal level of service delivery for mental health conditions in the Northern Cape, and specifically in Namaqualand, has a compounding effect on members of the LGBTQIA+ community who seek care in the public sector.

4.3.4 Societal level

At the societal level, the perceived barriers to accessing mental healthcare services relate to cultural and societal norms, as well as policies that may negatively influence access to mental healthcare services. The overarching theme that was identified is described as inadequate LGBTQIA+ mental health support systems.

4.3.4.1 Inadequate LGBTQIA+ mental health support systems (Theme)

Inadequate mental health support systems encapsulate the social and cultural factors that act as barriers for LGBTQIA+ individuals seeking mental healthcare services in Namaqualand. Two sub-themes were identified from this theme, namely perceptions of social norms that stigmatise mental health conditions and perceptions of unsupportive cultural norms in Namaqualand's Coloured communities.

4.3.4.1.1 Perceptions of social norms that stigmatise mental health conditions (Sub-Theme)

Several participants identified social norms that stigmatise mental health conditions within the LGBTQIA+ community. Behaviours such as minimising negative emotions, gossiping about mental health conditions, labelling mental health conditions as insanity and the social practice of not talking about one’s feelings were perceived as contributors to mental health stigma. Two participants who identified as lesbian shared their experiences and perceptions of social stigma, as illustrated below:

> *I don't know, I can't really remember what happened that year, but I was just you know, as I said I wasn't okay maybe I was depressed and at our house, at my auntie's house, there’s usually a lot of people who come to visit. They are, I guess I can say they're outsiders, and I’m not talking about the people who live there.*

> *So, then these people would gossip, and stories would go around about Respondent 8 being crazy and stuff and running around and Respondent 8 doing this and that...(Shop assistant, lesbian, 26)*
>
> *Uhm, if you are going to tell them that you have depression, then they will be like, oh it is that guy of yours that's making you feel like that. Or if you have suicidal ideation, then it...It's never a mental health problem. Something else will always get the blame. It's because they grew up like that in those times, you can't be sad, you can't be depressed, you must get up and move forward. (HR intern, lesbian, 27)*

While one participant described their subjective experiences of being labelled as "crazy" by community members because they were dealing with a mental health condition, another highlighted how some people in Namaqualand often dismiss or invalidate the lived experiences of those with mental health conditions. These attitudes and behaviours, rooted in broader social stigma and prevailing community norms, can create barriers towards health-seeking behaviour for members of the LGBTQIA+ community.

This finding correlates with previous research indicating that social stigma surrounding mental health hinders individuals from seeking help or having open conversations about their emotions. Javed et al. (2021) highlight that in low- and middle-income countries, social stigma surrounding mental health has an impact on the perceptions of mental health as well as health-seeking behaviour. This influences not only individuals with mental health conditions but also mental healthcare workers and health systems as a whole. Similarly, research in more conservative settings of Middle Eastern and North African countries also found that stigma is a barrier to mental healthcare access (Booth et al., 2024). These findings resonate with the situation in Namaqualand, where conservative social values encourage silence around emotional distress and discourage mental health-seeking behaviour. Moreover, mental health stigma, in this context, intersects with homophobia and discourages members of the LGBTQIA+ community from seeking mental healthcare. A global systematic review conducted by Maltempi et al. (2024) supported this intersectional perspective, indicating that societal stigma stemming from mental health conditions, sexual orientation, and other sources hurts health-seeking behaviour and mental health as a whole.

4.3.4.1.2 Perceptions of unsupportive cultural norms in Namaqualand's coloured communities (Sub-Theme)

Several participants explained how cultural norms, specifically within Coloured communities in Namaqualand, are unsupportive of mental health. This lack of support ranges from the outright denial that mental health conditions does not exist, to perceptions that cultural norms on mental healthcare-seeking behaviour are shaped by race, with cultural norms in white households being depicted as more supportive than Coloured communities. The intersection between race and cultural norms in the context of lack of support for mental healthcare is elucidated in the quotes below:

> *I can say cultural ways of doing things play a role, not just culture but my understanding, as I can see in movies and such or in my community, is that if maybe you grew up in a white household, then people might say, um, you might need to see a psychologist or something, but in our coloured communities or black communities, they might just say no, this child is showing off, he's fine. Cry if you want to cry or have a beer; our escape is not to go see a psychologist. And you might have mental health issues, so I think culture plays a big role, or rather, your race, I should say. (Teacher, transgender, 27)*

> *In Coloured households, I think mental health issues are, you're either right or you're not (laughing). Mental health doesn't exist, so if you're depressed, you should get up and go to work or do something to get out of that mood, but depression just doesn't exist, and I think that's how it is still seen or how mental health issues are seen…I think I experienced a bit of that with the drug abuse, when I started getting sober, it was something that you know when it feels like it's too hard to get your feet out of bed then you lie there in the dark room for two, three days and it's difficult to get up to bring yourself to just feel normal again because I always said that thing just overwhelmed me and took me over and until I feel better. (Personal assistant, gay, 42)*

Cultural norms shape how different groups perceive and engage with mental health, influencing whether individuals seek mental healthcare services. Booysen et al. (2021) found that in the Eastern Cape, culture plays a significant role in how mental health conditions are understood, expressed, and treated. Likewise, another South African study reported that some cultural groups perceived mental health as a Western or “white” concept and therefore not as important as physical health (Moonsamy & Gurayah, 2024). These studies underscore how culture can negatively impact access to mental healthcare services.

This section has demonstrated how stigma manifests at all four levels, including self-stigma at the individual level, lack of acceptance of LGBTQIA+ identity by families at the interpersonal level, perceived stigma from healthcare workers at the organisational level, and social stigma at the societal level. It has also shown that a single concept can have an impact across all four levels of the SEM, although it is experienced or perceived in different ways by participants. Therefore, SEM levels should be viewed as interconnected rather than individual.

The following section describes and discusses the participants’ perceptions and experiences of facilitators to accessing mental healthcare services in their community.

4.4. Perceptions of the LGBTQIA+ Community on Facilitators to Mental Healthcare Access

Despite numerous challenges to accessing mental healthcare services, the participants also identified several facilitators, which were categorised at the individual, interpersonal, and organisational levels. The participants did not identify any facilitators to access at the societal level.

4.4.1 Individual level

Individual level facilitators refer to personal factors that enable LGBTQIA+ individuals to access mental healthcare services in Namaqualand. These factors include knowledge, attitudes, and beliefs that support access to mental healthcare. Two themes namely knowledge of mental health and Positive attitudes toward the utilization of mental healthcare emerged as facilitators at the individual level.

4.4.1.1 Knowledge and attitudes about mental health (Theme)

Knowledge of mental health encompasses both formal and informal education that participants had about mental health and where to access mental health services. The two sub-themes that were identified are formal and informal education on mental health and knowledge of signs and symptoms of mental health conditions.

4.4.1.1.1 Formal and informal education on mental health (Sub-Theme)

At the individual level, participants described exposure to tertiary education as a facilitator of mental healthcare access, as it provided information about mental healthcare and offered access to services that are easily accessible to students. In contrast, participants who did not have access to university or college education relied on mainstream media and social media as informal sources of mental health information. One participant commented:

> *Most of my friends have also studied, so naturally they would understand, but unfortunately those who haven't studied, it's a bit of a struggle for them to understand what it's really about, but thanks to social media and TV and radio, they are also up to date with what mental health issues are and how you can fall into it or how your mental health can be influenced and the symptoms of mental health. (Intern/graduate student, queer, 25)*

Mental health education, whether gained through informal or formal channels, improves mental health literacy and acts as a facilitator to accessing care. Studies in the UK identified that the higher an individual's mental health literacy, the greater the likelihood that they would seek help (Jung et al., 2017). Additionally, regardless of the stigma attached to mental health, individuals who understood the importance of mental health actively sought help (Fleary et al., 2022).

4.4.1.1.2 Knowledge of signs and symptoms of mental health conditions (Sub-Theme)

Some participants used formal words, like "depression" and "anxiety," to describe their experiences and perceptions of mental health conditions. While others made use of more informal language when describing intense negative emotions, such as "being in a dark hole" or "the inability to get out of bed in the morning". A teacher who identified as transgender explained the importance of knowing the signs and symptoms of mental health conditions as follows:

> *There are, of course, signs and symptoms that you can notice, and words that are usually associated with mental healthcare, like depression and such, which I can link to mental health, but I believe a person will, or I personally will be aware if my mental health isn't okay; my body will give me signs and so on. (Teacher, transgender, 27)*

Another member of the LGBTQIA+ community who is also a social worker in Namaqualand described how knowledge of mental health conditions could act as a facilitator to access care by demystifying common mental health conditions like anxiety and depression in the following words:

> *Yes, if you can call the thing by its name, then you know, and then you know why you need help. So, if you don't know, if you can't name it, then I don't think you will be able to get help. You can't identify it, so it's vocabulary, the ignorance, yes. If you know what the situation is, then you would know where to get help, what the problem is, what triggers it. (Social worker, gay, 32)*

Previous research indicates that more knowledge about mental health increases the likelihood of seeking care. For example, studies in the US found that understanding signs and symptoms of mental health conditions (Jung et al., 2017) and recognising the importance of mental health (Fleary et al., 2022) facilitate access to care. Furthermore, a longitudinal study in Switzerland found a positive correlation between mental health literacy and mental health service use (Bonabi et al., 2016).

4.4.1.*2* Positive attitude towards the utilisation of mental healthcare services(Theme)

Attitudes toward mental health describe participants' attitudes toward the utilisation of mental health services. One participant described how taking medication for depression changed their attitude towards the treatment of mental health conditions. They also used their experience to educate others about mental health, as can be gleaned from the following excerpt:

> *I don't think I've experienced stigma because everyone I come into contact with, I try to explain, this is what it is, that's the difference, that's what the pill does, that's what changes your brain [referring to medical treatment for depression].*

> *So, I try to educate, in my own way, for the people who don't understand. (Fashion designer, gay, 33).*

Another participant described maintaining a positive relationship with their primary healthcare physician, who, in the absence of a mental healthcare provider, offered counselling when needed. Although the doctor was based in Cape Town, the participant continued to keep in contact, valuing the ongoing support they received.

> *It was in 2014 when I was in Cape Town and I was diagnosed with HIV at that time, and I had no one to talk to about it. I came back here and I had no access to any mental health institutions or access to talk to anyone; I didn't even know. I knew [Richie Cloete Consultancy] was here, but I don't think I was comfortable enough at that stage to share it with anyone else. Um, my mom and dad know about it, my brother knows, and a few of my friends. Um, so when I found out or when I was diagnosed with it, was it Men's Health?, I tried calling or sending emails, no one got back to me, so I tried to deal with it myself and went to see the doctor and ever since, I think the doctor has been my counsellor and still is to this day, and I never changed doctors, he's still in Cape Town and I'm here but we're still in contact. (Personal assistant, gay, 42)*

A positive attitude towards mental health and the utilisation of mental healthcare services can facilitate access to care. Bonabi et al. (2016) found that individuals who believe in the effectiveness of treatment and have a positive attitude towards mental health are more likely to use mental healthcare services. Similarly, Vidourek and Burbage (2019) reported that among American university students, a positive attitude towards mental health improves the likelihood that individuals will seek help and that they will support their peers to access appropriate mental healthcare.

4.4.2 Interpersonal level

Facilitators of access to mental healthcare services at the interpersonal level were centred around a single theme, namely relational support. This was reflected in two sub-themes, which included support from family and support from friends.

4.4.2.1 Relational support (Theme)

Participants described that having the support from someone within their social circle, whether it be family or friends, made mental healthcare more accessible. Participants differentiated the support into support from family and support from friends.

4.4.2.1.1 Support from family (Sub-Theme)

Family members in this context extend beyond the nuclear family to encompass grandparents and cousins. Several participants identified their mothers and sometimes their grandparents as the people with whom they felt safe enough to share their feelings with as members of the LGBTQIA+ community. Having support from at least one member of the family could encourage LGBTQIA+ individuals to seek mental healthcare when required, as illustrated in the following quotes:

> *Okay, I have known R.C my whole life, and through my mom as well, so I know for sure that she is the one who will always refer R.C to other people and everything. I think if she wasn't here, I mean she is an unqualified counsellor, but if she had seen that she couldn't help me further, she would have known which place to refer me to. (Social work student/intern, lesbian, 23)*

> *So, mental health is also important, because there were a few cases of self-harm you see and people who have become dependent on substances, and then we usually have these family gatherings every year, and then the WhatsApp group, where we check up on each other. Since my one cousin passed away, she committed suicide, depressive and all of those things, so it has become a thing in our family we must talk to each other, find someone in the family that you are close with and talk. (Social work student/intern, bisexual, 23).*

Another participant was able to access mental healthcare in the public sector through a relative who worked as an HIV counsellor at the PHC facility:

> *I had an uncle who worked at the clinic. He was an AIDS counsellor; he made it his duty to help me with my mental health, you know, and he passed away. (Shop assistant, lesbian, 26)*

This finding aligns with previous studies, which reported that acceptance and emotional support from family members facilitate mental well-being and help-seeking behaviour (Ryan et al. 2010). More specifically that LGBTQIA+ individuals who receive emotional support from their families are more likely to access mental healthcare services (Russel & Fish, 2016). Family support and advocacy are particularly important as they can provide resources and guidance for health-related decisions, as shown in a study among young American adults in the LGBTQIA+ community by Snapp et al. (2015). Similarly, research among adolescents in Los Angeles found that transgender youth have higher life satisfaction if they have family support and that family support acts as a buffer against mental health conditions such as depression (Simons et al. 2013). These findings highlight the important role of family support as a facilitator of mental healthcare access for LGBTQIA+ individuals.

4.4.2.1.2 Support from friends (Sub-Theme)

Apart from the support provided by family members, support from friends was also identified as a facilitator of access to mental health services. Many participants indicated that having a network of supportive friends in the LGBTQIA+ community in Namaqualand acts as a facilitator of access to mental healthcare services. One participant iterated:

> *It was easy because I knew people, because I knew R.C. I had contacts, networking, things like that. So, it made it easier and I knew I needed it, because I couldn't deal. My hair also started to fall out. This beautiful hair had patches. Then I realized no this is not right, and I googled it, you see, read up, understand. Okay my hair is falling out and my nails, you see those little white stripes on your nails, apparently it's signs, insomnia, and what, what. R.C, sounds like something's wrong with me! (Radio presenter, non-binary, 26)*

Support from a network of friends was also reported as critical by young people who had experienced rejection from their nuclear and extended families because of their sexual orientation. One participant describes how reaching out to a friend for support saved her life because she was able to seek help at the hospital in Namaqualand:

> *Mentally, it helped me a lot, because I also had suicidal ideations due to the fact that I was crucified at home…Yes, I did, I reached out to a friend of mine… I was emotionally damaged, but with time I managed to pick up the pieces because I didn't want to be someone that I'm not…I drank pills and I ended up in hospital, I almost died, but by God's grace...yeah and I also slit my wrists… Nobody knew about it, except for one of my friends. Even till this day it's only my friend and my*

> *current partner that knows what I did…I mean my grandparents and parents don't know. (HR Intern, lesbian, 27)*

Boutilier et al. (2024) found that social support from within the LGBTQIA+ community has an impact on the emotional well-being of transgender and nonbinary individuals in the US. Sharing similar experiences encourages openness about mental health and promotes help-seeking. Similarly, Crockett et al. (2022) reported that among LGBTQIA+ students in Chile, friends and partners often played a key role in encouraging participants to seek mental healthcare when they noticed signs of distress. These studies highlight that support from friendship and community networks is a vital facilitator for mental healthcare access for LGBTQIA+ individuals.

4.4.3 Organisational/community level

Facilitators of access to mental healthcare services at the organisational level were centred around a single theme, namely, access to care outside the public health system. It was reflected in two sub-themes, including private medical insurance and faith-based organisations.

4.4.3.1 Access to quality mental healthcare services outside of the Public Healthcare Facilities (Theme)

Most participants had a perception that the private sector provided good quality and easily accessible mental healthcare services for LGBTQIA+ individuals who were in formal employment or belonged to families who had the financial means to pay. Some participants had experienced easy access to mental healthcare services in the private sector, while for others, access was facilitated through faith-based organisations.

4.4.3.1.1 Private Medical Insurance (Sub-Theme)

Participants who are engaged in formal employment had access to private health insurance policies, which facilitated access to health services, including mental healthcare, in the private sector. One participant described how accessing mental healthcare services in the private sector made it possible for them to finally come to terms with depression, which they had struggled with for many years:

> *I went to the General Practitioner(GP) and explained my feelings because at that time I developed anxiety, then they referred me to a psychologist and the psychologist and I worked through a lot of things and we talked about things and*

> *she just put me a bit on the right path in terms of self-acceptance and the identity issues I went through there, so yeah. But here, I would say most of the time you give another version of yourself so they don't necessarily have to see the real you, so it's difficult for them to really impact you, or it makes it easy for you to protect yourself, or in my case, it was like that, to not let them impact you, but it's very easy to also be impacted because even if I have to think back to my school years, someone could just say one bad word and then you feel sad and uncomfortable for a week, and as you get older then you'll actually realize but it was depression at that time, but you didn't realize it yourself at that stage. (Intern/graduate student, queer, 25)*

Young (2016) and Docrat et al. (2019) highlighted the disparities between the private and public healthcare sectors in South Africa, noting that the public sector was underfunded and overburdened while the private sector had better quality of care, better facilities, and better resources, all of which led to better health outcomes for those who can afford them. Furthermore, Müller et al. (2020) highlighted that their participants held the perception that the private sector was more welcoming to the LGBTQIA+ community in South Africa. The study further found that there was only slightly less discrimination within the private sector towards LGBTQIA+ individuals. However, the perception that the private sector is less discriminatory could make it more accessible to the LGBTQIA+ community.

4.4.3.1.2 Faith-based organisations (Sub-Theme)

According to the participants, Namaqualand is a very religious community, and many of the norms are influenced by the church. Two participants described how they perceived and experienced the church and spiritual leaders as facilitators of access to mental healthcare as follows:

> *Okay, as far as I know, the church is definitely there. We have the group that’s there, um, but the social workers, I want to say, they're not so involved from what I know. Yes, the church definitely, and then there’s the clinic, that’s also there, and that’s it. (Social work student/Intern, bisexual, 23).*

> *There are many spiritual leaders who don’t want anything to do with us, but there are a few who are very supportive. Like the father in our church supported me, because many people had a problem with me being so active in all the structures*

> *of our church, they felt like because I was a lesbian, I couldn't take part in the church's activities and stuff like that. I wanted to leave the church; I didn't want anything to do with the church anymore, until the priest reached out to me, and he came to our house to speak to me. (HR Intern, lesbian, 27).*

These views contradict previous research by Darmansjah et al. (2019), who found that religious spaces are usually non-affirming and could have a negative impact on the mental health outcome for LGBTQIA+ individuals. While religious organisations are often perceived as spaces that are dominated by homophobia (McCann et al., 2020; Pallotta-Chiarolli et al., 2021), participants in this study described certain churches and spiritual leaders in Namaqualand as supportive, providing emotional support and faith-based counselling that facilitate access to mental health services. This indicates that at the organisational level, faith-based organisations can play a key role in efforts to promote mental-health seeking behaviours amongst members of the LGBTQIA+ community. This finding aligns with Wilkinson and Johnson's (2021) global systematic review that showed that while rejection by religious communities can cause psychological distress, religious involvement can also serve as a protective factor by fostering social support and emotional resilience.

This section revealed that facilitators to accessing mental healthcare services for the participants were identified at the individual, interpersonal, and organisational levels. Knowing when and where to access mental healthcare services made it easier for participants to access services at an individual level, while having support from friends or family also acted as a facilitator at an interpersonal level. At an organisational level, it was revealed that having access to private healthcare also facilitated mental healthcare access for the participants. In contrast, no facilitators were identified at the societal level, which suggests that there is a potential gap in systemic support for LGBTQIA+ mental health within Namaqualand. It also highlights a need for supportive policies and a culture shift within the community that supports and does not stigmatise LGBTQAI+ mental health.

The following section describes and discusses the participants' recommendations to improve access to mental healthcare services for members of the LGBTQIA+ community.

4.5 Recommendations to Improve Access to Mental Healthcare Services for Members of the LGBTQIA+ Community

This section presents the participants' recommendations to improve LGBTQIA+ individuals' access to mental healthcare services. Although this was not an objective of the study, participants were eager to share their ideas on what can be done to improve access to mental healthcare services for members of the LGBTQIA+ community in Namaqualand. These recommendations included integrated healthcare facilities for LGBTQIA+ mental and physical wellbeing, LGBTQIA+ mental health training for HCWs, rural LGBTQIA+ mental health sensitisation, and support groups for members of the LGBTQIA+ community in Namaqualand*.*

4.5.1 Integrated healthcare facilities for LGBTQIA+ mental and physical wellbeing

Participants reported the need to integrate physical and mental health services within the existing healthcare facilities, with a specific focus on the holistic healthcare needs of the LGBTQIA+ community. They recommended that specialised treatment, such as hormone therapy for transgender individuals, should be included in the services that public healthcare facilities in Namaqualand provide, as illustrated in the excerpts below:

> *I would say to bring in facilities, to bring in facilities that focus on mental health and us who need hormone treatment and such, many times you have to go to Bloemfontein for your things, understand, and it's all the medication and such that helps for those people's mental well-being and everything. (Teacher, transgender, 27)*

> *The transgenders and the transsexuals, they need therapy for their gender conversion, and then they don't necessarily get it, and then it's very difficult for them to eventually transition because they don't usually have access to these services, so if the healthcare system can just be more tolerant, I think that's the right word, towards the community and be more patient and accepting around our community. (Intern/graduate student, queer, 25)*

Previous studies have shown that integrating mental healthcare services into primary healthcare settings can improve access and decrease stigma (Marais & Petersen, 2015). Additionally, an American study conducted by Reiss-Brennan (2014) found that integrating mental healthcare into primary healthcare also improves the functioning of individuals with mental health conditions. Integration improves the quality of care, decreases acute care utilisation, and reduces costs. Petersen et al. (2016) also reported that integrating mental healthcare into primary care leads to holistic patient-centred care, where patients are valued and play a role in their treatment. This allows for ownership and leads to better adherence. Therefore, mental health integration leads to a better overall health outcome.

A further recommendation was to establish a dedicated unit for LGBTQIA+ mental healthcare services at every PHC clinic that has trained staff who deal specifically with LGBTQIA+ related issues. The following excerpts support this recommendation:

> *Specifically, because it’s still so taboo and it’s not something that people talk about, I would say that every clinic should have a, almost like a unit uhm that deals specifically with it, and you know that if you are experiencing one, two and three, you are always depressed, you’re constantly tired, you have anxiety. If you know you must go there to get help and not to the normal clinic where everybody else goes. I think if you know, for example, you are experiencing these types of symptoms, then you go to that specific unit in the clinic. In this way I’d think the service could be made more accessible which would be a good thing. (Social worker, gay, 32)*

> *So, if the government or the healthcare system here in Town 6, for example, could just make a section, I don't want to almost say just for queer individuals, then it's a bit wrong because there are many people who need help, but sections that will treat queer individuals like heterosexuals………Not necessarily just queer people who work there and can go there, but people who have a little more insight into what a queer individual might be going through and their specific health needs. (Intern/graduate student, queer, 25)*

The LGBTQIA+ community are more likely to adhere to treatment and respond better to treatment if they feel understood and respected. This is in keeping with Dawson et al. (2025), who conducted a study among sexual minority women in America. They found that having supportive and culturally competent healthcare workers acted as a facilitator to mental and physical healthcare for their participants. Furthermore, Bishop et al. (2022) conducted a study among LGBTQIA+ individuals in Australia, aimed at exploring the importance of cultural competence in mental healthcare settings. The study found that participants were more likely to seek help if they felt the facility was affirming or welcoming to the LGBTQIA+ community. Therefore, having these services in the community could improve adherence and promote access.

4.5.2 LGBTQIA+ mental health training for healthcare workers

Participants recommended training for all healthcare workers to equip them to provide mental healthcare services for LGBTQIA+ individuals. A participant suggested that the curriculum for students in health services professions should include a focus on the mental healthcare needs of LGBTQIA+:

> *In general, I feel like they need to include LGBTQI+ community's mental health in the curriculum when it comes to studying for nurses, any people doing professional health because I just feel like that part in the curriculum when it comes to healthcare isn't so advanced yet, like you always have to hear that you need to see special people, can’t the special people's part also be part of the general curriculum of health professionals? I think that's where it should start, so then I can easily go to anyone who is a nurse and that person will know how to help me, it must start in the curriculum. (Teacher, transgender, 27)*

Apart from the recommendation for changes to the curriculum, another participant suggested that training should be provided on cultural competency. This would assist in reducing unconscious bias against members of the LGBTQIA+ community and create inclusive spaces where participants do not feel judged by HCWs. As one participant shared:

> *I think the medical fraternity, or nurses and others should receive more training on how to treat these specific people. Uhm, and how they can create a space for people to come and access the service and we as a community should speak about it. So, that we can identify and know that okay, when this happens, you can go there, and which services are available. I think we should talk about it there should be more awareness about when to start looking for help and when it becomes a problem. (Social worker, gay, 32)*

These recommendations are consistent with research, which identified that the healthcare experiences of LGBTQIA+ individuals improved when healthcare workers used inclusive language, created welcoming environments, and had knowledge about the specific needs of LGBTQIA+ patients (Bishop et al., 2022; Ford et al., 2024).

4.5.3 Rural LGBTQIA+ mental health sensitisation

Participants described Namaqualand as a rural community that is more conservative than urban areas like Bloemfontein and Cape Town. Rural communities are often conservative, thus increasing the likelihood that LGBTQIA+ individuals would hide or not disclose their identity to protect themselves and to avoid discrimination and stigma (Maria et al., 2025). One participant recommended that the community should be made more aware of the mental healthcare needs of the LGBTQIA+ community through the engagement of civil society organisations, as well as local radio stations that operate in rural communities in the Northern Cape:

> *I also feel like going out to rural villages and aligning with other organisations that are also part of mental health, and talking about these things, and getting a time slot on the local radio station where mental health is talked about, and where people can share their stories about mental health, because then it will reach a broader spectrum. (Teacher, transgender, 27)*

This recommendation resonates with the findings of Benjamin et al. (2021), who conducted a study in rural South Africa. Their participants suggested that community awareness would decrease the stigma and discrimination around mental health and would also assist in early detection.

Another participant suggested that the Northern Cape Provincial Department of Health has a key role to play in community mobilisation and raising awareness about mental health and promoting health-seeking behaviour for mental health conditions in Namaqualand:

> *I think everybody has a responsibility, especially government departments, because they have the know-how. Specifically, the clinic and health, they deal with it so I think they have a bigger role to play in the awareness of it. Uhm, so that people know, so that people can identify with it or so that people can get the necessary help. (Social worker, gay, 32)*

The Northern Cape Provincial Department of Health can be seen as an extension of the National Department of Health and, as such, should play a major role in community mobilisation, mental health awareness and the implementation of guidelines for mental health services. The National Mental Health Policy Framework and Strategic Plan 2013–2020 and The National Mental Health Policy Framework and Strategic Plan 2023–2030 recognises the department as the main driver for mental health promotion, prevention, and service integration within primary healthcare settings (South African Department of Health, 2013; South African Department of Health, 2023) Furthermore, the Mental Healthcare Act 17 of 2002 compels the department to ensure that care is provided in the least restrictive and most community-oriented settings, highlighting the need for public engagement and awareness (South African Government, 2002). Therefore, as both policy leader and service provider, the National Department of Health, and as an extension, the Northern Cape Provincial Department of Health, is essential in driving community mobilisation and normalising mental healthcare in Namaqualand.

4.5.4 Support groups for members of the LGBTQIA+ community

Several participants recommended the need to establish support groups for members of the LGBTQIA+ community in Namaqualand. They noted that such groups could provide shared spaces to discuss common challenges experienced at individual, interpersonal, organisational, and societal levels. Support groups have been shown to promote access to mental healthcare. For one participant, support groups would provide safe spaces where individuals who felt rejected by families, friends, and communities might find acceptance and affirmation as equal members of society in Namaqualand. The following excerpts support this recommendation:

> *Okay, I think there should be some pressure applied to start up support groups, you know. Maybe also, like, okay, social media is there, but it's not like people are asked every day if they're okay or anything like that, because there are people who express their feelings and everything on their statuses, but I would say definitely support groups. (Social work student/intern, 23)*

> *Yes, create a safe space type of thing where people can talk about it and where they can just know that they are normal, that it's not abnormal to be gay, and that's what many people probably think we're all abnormal, so yes...Exactly to be told every day, to be told things so yes, I just think it was never a choice it will also never be a choice for anyone else. uhm just the fact that it's difficult for them to talk about it, and I think it would be easier if there were uhm support groups or uhm a place where you can go to talk to someone about it. (Personal assistant, gay, 42).*

Support groups can play a major role in the mental health of the LGBTQIA+ community because they have the potential to foster a sense of belonging, provide a safe space for sharing experiences, and provide emotional validation for members. A scoping review by Gasteiger et al. (2024) indicated that support groups have a positive overall outcome that includes increased social connections and improved mental health.

Apart from support groups, a younger participant suggested that social media can also facilitate experience sharing within the LGBTQIA+ community. Research indicated the potential of online peer support in promoting mental health among the LGBTQIA+ community in Australia, as reported by Byron and McDaid (2025). While this was supported by Nic Giolla Easpaig et al. (2022), they cautioned that these approaches should complement in-person care and not replace it. This resonates with participants, both younger and more mature, who supported the creation of in person support groups for members of the LGBTQIA+ community in Namaqualand.

In this section, participants provided recommendations on how to improve mental healthcare access for the LGBTQIA+ community of Namaqualand. These recommendations were insightful and addressed the needs identified by the participants. This suggests that the participants have a clear understanding of the issues affecting access to mental healthcare within their community, and their recommendations would be valuable in guiding practical interventions to address the identified issues.

4.6. Conclusion

This chapter presented and discussed the findings of the study. The research explored the perceptions and experiences of LGBTQIA+ individuals in Namaqualand regarding access to mental healthcare. The data revealed the mental health needs of the LGBTQIA+ community and, by making use of the SEM as a lens, the data revealed a complex interplay of barriers and facilitators across all the levels of the model.

Barriers such as; internalised stigma, identity conflict, substance use, and limited mental health literacy acted as significant individual-level barriers to mental healthcare access. At an interpersonal level, it was revealed that a lack of support from family and friends were barriers to accessing mental healthcare services. Access was further influenced by systemic and structural inequalities at the organisational level, including limitations in the public health sector such as shortages of healthcare professionals, inadequate facilities, and discrimination against the LGBTQIA+ community. Finally, stigma and unsupportive cultural norms, especially within Namaqualand's coloured communities, were identified as barriers at the societal level.

Facilitators included individual-level factors, such as mental health literacy and positive health-seeking attitudes, which were noted as enablers of mental healthcare access. Furthermore, the data showed that support from family and friends also acted as enablers to mental healthcare access at the interpersonal level. At an organisational level, access to private healthcare was seen as a facilitator for those who could afford it and, faith-based organisations also emerged as a facilitator to mental healthcare access in Namaqualand. The data did not show any societal level factors that acted as enablers for mental healthcare access.

Finally, the participants provided practical recommendations on how to improve mental healthcare access for the LGBTQIA+ community in Namaqualand. The recommendations by the participants were related to the needs that they identified emphasising the importance of comprehensive mental healthcare services that are LGBTQIA+-affirming and context specific.

The following chapter (5) provides a comprehensive synthesis of the research findings, followed by the contribution of the study, recommendations, limitations, and the study's conclusion.

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

In the previous chapter (4), the key findings of the study were presented and discussed. Through the use of the SEM as a framework, this study set out to describe the mental healthcare needs of the LGBTQIA+ community and to explore their perceptions of barriers to and facilitators of access to mental healthcare services in Namaqualand. This was achieved using a qualitative single case study design, in which data was collected through semi structured interviews using purposive sampling. The data were analysed thematically to identify key patterns relevant to the research aims

This chapter provides a comprehensive synthesis of research findings followed by a section on the contribution that the research makes to existing knowledge, highlighting its value and implications for practice. Practical recommendations, based on the findings of this research, are provided for healthcare practitioners and key stakeholders in the Northern Cape province of South Africa. The study's limitations are delineated, and the chapter concludes with an integrated summary that drew together the main conclusions and underscores the overall importance and impact of the research.

5.2 Summary of Main Findings

5.2.1 Healthcare needs of the LGBTQIA+ community

This study explored the mental healthcare needs of the LGBTQIA+ community in Namaqualand. Findings highlighted the importance of promoting mental health literacy within the LGBTQIA+ community in Namaqualand to reduce self-stigma and foster self-acceptance. One participant argued that learning more about how factors, such as brain chemistry and hormones in the human body can influence mood and well-being could help challenge misconceptions about mental health that promote self-stigma among members of the LGBTQIA+ community in Namaqualand. In this manner, members of the LGBTQIA+ community in Namaqualand could move toward a more supportive and understanding environment where individuals feel more comfortable reaching out for help when they need it. This finding is supported by prior research, which found that people in some rural communities in South Africa view mental health conditions simply as everyday stress, indicative of low levels of mental health literacy in under-resourced contexts (Benjamin et al., 2021). Participants emphasised the need for education within the LGBTQIA+ community in Namaqualand, which challenges the individual level belief that mental health conditions must result from a specific traumatic event. Similar patterns have been observed internationally, where self-stigma continues to silence open discussions and discourages help-seeking in the context of mental health conditions (Booth et al., 2024).

At the interpersonal level, the need for family acceptance by LGBTQIA+ individuals in Namaqualand, particularly from parents, was emphasised. One bisexual participant noted that support from family is especially crucial for gay and bisexual men, as rejection at home can intensify the emotional impact of facing homophobia in the wider community. Therefore, fostering acceptance within families at the interpersonal level is just as important as community sensitisation in creating a supportive environment for the well-being of LGBTQIA+ individuals in this rural setting. Prior research indicated that family acceptance plays a crucial role in the mental health of LGBTQIA+ youth. Studies from the US, Canada, and the United Kingdom indicate that supportive family relationships are linked to lower rates of depression and anxiety, while family rejection significantly exacerbates mental health outcomes (Adu et al., 2024; McConnell et al., 2016; McDonald, 2018; McDermott et al., 2021; Ryan et al., 2010). These findings suggest that acceptance within the family can promote better mental health and health-seeking behaviours, particularly in environments such as Namaqualand, where members of the LGBTQIA+ community do not feel that they are fully accepted by the community at large.

At the community level, the need for sensitisation on LGBTQIA+ rights through media campaigns, aimed at transforming local myths and misconceptions about LGBTQIA+ and mental health, was discerned. In addition, findings indicated that limited access to LGBTQIA+ affirming services within the public healthcare system in Namaqualand was identified. To effectively address this need, participants recommended two key strategies. First, they recommended the provision of counselling services that are tailored to the mental healthcare needs of the LGBTQIA+ community. Second, they suggested the implementation of community sensitisation programmes with the use of traditional and social media to disseminate information that dispels myths and misconceptions about LGBTQIA+ and mental health. This aligns with findings from a systematic review by Nic Giolla Easpaig et al. (2022). They reported that LGBTQIA+ individuals living in rural areas across the UK, USA, Canada, Australia, and New Zealand often face discrimination, stigma, and dismissive treatment when interacting with healthcare providers. These negative experiences, which can be overt or subtle, create fear and concern about seeking care, making access to health services challenging for rural LGBTQIA+ communities. These findings support the need for targeted LGBTQIA+ affirming mental health services in Namaqualand.

At the societal level, the need to address structural disparities in rural versus urban mental healthcare and societal homophobia through holistic approaches that encompass policy, resources, and social norms was emphasised. Most participants viewed Namaqualand as a rural area where people are not yet fully aware of the needs of the LGBTQIA+ community, particularly in comparison to urban areas like the City of Cape Town. One participant pointed out that although South Africa has a progressive constitution that protects LGBTQIA+ rights, homophobia is still common in Namaqualand. Another story about a law enforcement officer facing transphobia further shows the social challenges LGBTQIA+ people continue to face. The story also highlights how important it is to build greater understanding and acceptance within the community through community sensitisation initiatives.

The present study supports the evidence from a recent review highlighting the challenges faced by LGBTQIA+ individuals in rural areas around the world, when seeking access to mental healthcare services. Services are often limited, there is a lack of trained professionals, and travelling long distances to cities for care can be expensive (Maria et al., 2025). Because of these barriers, LGBTQIA+ individuals in rural communities often experience poorer mental health than their heterosexual and cisgender peers. In South Africa, access to mental healthcare is disproportionate, with rural communities facing far greater challenges than urban areas. These systemic barriers are even more pronounced for marginalised groups like the LGBTQIA+ community in Namaqualand. Mental health services tend to be concentrated in cities like Cape Town, leaving rural areas with limited options that are often difficult to access and not always culturally sensitive to the needs of some LGBTQIA+ individuals (De Kock & Pillay, 2016). This underscores why many participants in this study perceived the need for mental and physical health services in Namaqualand that are designed for, and easily accessible to, the LGBTQIA+ community as important.

5.2.2 Perceptions of the LGBTQIA+ community of barriers and facilitators to mental healthcare access

The barriers and facilitators to mental healthcare access are summarised in Tables 5.1 and 5.2 and described in more detail in the subsequent sections that follow.

Table 5.1: Barriers to mental healthcare services for members of the LGBTQIA+ community in Namaqualand

SEM Levels	Themes	Sub-themes
Individual Level	Negative attitude towards seeking mental healthcare	• Internal conflict with LGBTQIA+ identity • Alternative coping mechanisms: substance abuse
	Lack of knowledge and awareness about mental health	• Lack of knowledge about mental health conditions • Lack of awareness about the availability of mental healthcare services
Interpersonal level	Lack of relational support towards accessing mental healthcare services	• Lack of support from family • Lack of support from friends

Organisational/community level	Limited access to mental healthcare services	• Inequality in access to mental healthcare between the public and private sectors. • Inequality in access to mental healthcare services for transgender persons • Limited working hours at public healthcare facilities • Insufficient mental healthcare professionals • Inadequate mental healthcare facilities
	Negative attitude of healthcare providers towards mental healthcare & LGBTQIA+	• Perceived knowledge gaps among healthcare workers on LGBTQIA+ mental health needs • Perceived unethical conduct by healthcare workers toward LGBTQIA+ mental health needs.

		- Perceived stigmatisation of transgender persons by healthcare workers - Perceived poor service delivery for mental health conditions in Namaqualand
Societal level	Inadequate LGBTQIA+ mental health support systems	- Perceptions of social norms that stigmatise mental health conditions - Perceptions of unsupportive cultural norms in Namaqualand's coloured communities

Table 5.2: Facilitators of mental healthcare services for members of the LGBTQIA+ community in Namaqualand

SEM Levels	Themes	Sub-themes
Individual Level	Knowledge of mental health	• Formal and informal education on mental health • Knowledge of signs and symptoms of mental health conditions
	Positive attitude towards mental healthcare	• Positive attitude towards the utilisation of mental healthcare services
Interpersonal level	Relational support	• Support from family • Support from friends
Organisational/community level	Access to quality mental healthcare services outside of the Public Healthcare Facilities	• Private Medical Insurance • Faith-based organisations

5.2.2.1 Individual level

At the individual level, the research explored how personal factors such as age, education, knowledge, and attitudes act as barriers or facilitators to accessing mental healthcare services. Participants' personal experiences reflected negative attitudes toward and lack of knowledge about mental health as key barriers to accessing mental healthcare services (see table 5.1). More specifically, negative attitudes towards seeking mental healthcare were explained in terms of internal conflict with one's LGBTQIA+ identity and internalised stigma, which acted as barriers to accessing care. This aligns with previous research, which identified that internalised negative attitudes towards one's own sexual or gender identity can exacerbate feelings of shame and fear and hinder mental healthcare-seeking behaviour (Gonçalves et al., 2025). As an alternative to seeking mental healthcare services, some participants used substances such as alcohol or cannabis to cope with negative emotions, which is supported by research conducted in the USA among the LGBTQIA+ community by Reisner et al. (2015) and Felner et al. (2020).

A lack of knowledge about mental health conditions was another key obstacle to accessing mental healthcare, according to the participants(see table 5.1). It was noted that some individuals did not have the vocabulary to correctly describe and explain their feelings, instead resorting to the use of terminology such as “the black demon that was devouring her”. A lack of knowledge about mental health conditions among LGBTQIA+ individuals was also identified by Maria et al. (2025) in a scoping review among rural communities. Additionally, not knowing where to access mental healthcare was also mentioned as a barrier to accessing care, which is also reported in other research findings (Maria et al. 2025).

Some participants reported that possessing knowledge about mental health, acquired through formal and informal sources, acted as a facilitator to accessing mental healthcare services (see table 5.2). Participants who had attended tertiary education facilities reported the dual benefit of increased mental health awareness and access to services that were available for students. Knowledge of mental health condition symptoms was linked to improved access to care across various studies (Bonabi et al., 2016; Fleary et al., 2022; Jung et al., 2017).

5.2.2.2 Interpersonal level

At the interpersonal level, the study explored how relationships with family, peers, and intimate partners could act as barriers or facilitators to accessing mental healthcare services. Having unsupportive families and peer networks stood out as a barrier to accessing mental healthcare services (see table 5.1). More specifically, the perception that mental health was taboo and that family members expected participants to act normally even though they were experiencing mental health issues made participants less likely to seek help. This is in keeping with previous research that identified unsupportive home environments that dismiss or minimise mental health as deterring individuals from seeking care (Crockett et al., 2022; Strumpher et al., 2014). In addition to a lack of family support, a lack of support from peer networks was noted as a barrier to mental healthcare access. Participants expressed that their mental health concerns were not taken seriously or met with the same consideration as physical illness by their peers. Furthermore, they expressed a lack of trust in sharing mental health concerns within their social networks. Research indicates that rejection and inadequate social support networks correlates with increased mental health issues (McDonald 2018). Adversely, it decreases health seeking behaviour and acts as a barrier to mental healthcare access (Mangwegape et al., 2024; Ngwenya et al., 2020).

Several participants reported that having the support of one's family acted as a facilitator to mental healthcare access (see table 5.2). The encouragement and emotional support of even one family member could encourage them take the first step toward seeking mental healthcare. Supportive relationships promote health-seeking behaviour and offer emotional safety. Similarly, Katz-Wise et al. (2016) found that when LGBTQIA+ identities are affirmed by family members it creates stable emotional environments, that encourages LGBTQIA+ people to seek help. Similarly, support from friends was also a strong facilitator to mental healthcare access especially when participants faced rejection from family members. Supportive friendships can provide a crucial bridge to mental healthcare, mirroring the findings of Crockett et al. (2022). Their research indicates that friends or partners often encourage LGBTQIA+ individuals to seek professional help.

5.2.2.3 Organisational/community level

At the organisational/ community level, participants identified health systems factors that influence access to mental healthcare services. Their experiences with healthcare services and providers were predominantly described as hindering access to care. Specifically, participants raised concerns about disparities in access to mental healthcare services between the public and private sector as well as urban and rural areas, inequalities in access for transgender individuals, limited operating hours at public healthcare facilities, insufficient mental healthcare professionals and inadequate mental healthcare facilities(See table 5.1). These factors made it difficult for participants to access mental healthcare. These findings and align with previous research that has indicated that access to mental healthcare is often limited in rural communities as it is seen as specialised and mostly concentrated in urban areas (Bateman, 2015; Ho et al., 2024; Petersen et al., 2016). Even when services are available, issues such as limited staff and a lack of expertise further restrict access to care (De Kock & Pillay, 2016; Janse van Rensburg et al, 2022; Petersen et al., 2016).

Participants also referred to the lack of knowledge and negative attitudes of healthcare workers regarding mental healthcare and the LGBTQIA+ community, which acted as additional barriers to accessing care (see table 5.1). Some participants felt that in certain cases, healthcare workers acted unethically towards LGBTQIA+ individuals and even stigmatised transgender individuals.

Despite these health systems barriers, some participants highlighted the benefit of having access to quality private mental healthcare services (see table 5.2). They explained that having access to medical aid or support from faith-based organisations made it possible for them to access to mental healthcare. This correlate with Young (2016) who found that having access to private healthcare in South Africa leads to better quality of care and overall health outcomes. Other studies have also shown that having access to faith-based organisations could improve mental health outcome as these organisations sometimes act as social support systems for LGBTQIA+ individuals (Wilkinson & Johnson, 2021).

5.2.2.4 Societal level

At the societal level, social norms stigmatising mental health conditions and unsupportive cultural norms within Namaqualand's Coloured communities reinforced institutional exclusion and acted as barriers to mental healthcare (see table 5.1). Societal discrimination and cultural norms that encourage stigmatisation, particularly against mental health and LGBTQIA+ individuals, further impede open discourse and discourage LGBTQIA+ individuals from seeking help (Booth et al., 2024; Booysen et al., 2021; Javed et al., 2021).

The participants did not express any facilitators to mental healthcare access on the societal level. The lack of facilitators at this level reflects the distant and disconnected nature of societal level factors, such as policies and cultural norms, of which the effects are often invisible or intangible. Participants described experiences and perceptions that were informed by their immediate environments, where facilitators like supportive family/friends or access to faith-based organisations were tangible and their effects could be felt by the participants. In contrast, societal-level factors may have been perceived as distant or ineffective, especially when policies intended to improve access were poorly implemented or inconsistently experienced. The lack of societal facilitators therefore suggests that systemic enablers of mental healthcare access for the LGBTQIA+ community remain weak or inaccessible within the context of Namaqualand.

5.2.2.5 Interactions across the socio-ecological levels

The findings reveal that the different levels of the SEM interact to influence whether an individual accesses mental healthcare. For example, a person might have knowledge of when and how to access mental healthcare services and have a supportive family, both of which are facilitators on an individual and interpersonal level. However, negative attitudes from healthcare workers and societal norms that stigmatise mental health and LGBTQIA+ identities, which are organisational/community level and societal level factors, can still discourage them from accessing mental healthcare services.

Furthermore, at the individual level, knowledge about mental health and willingness to seek help may be undermined by rejection from family or friends at the interpersonal level. Conversely, supportive relationships at the interpersonal level could mitigate the effects of societal level stigma. Community-based NGOs or faith-based organisations that affirm LGBTQIA+ identities can serve as buffering mechanisms between marginalised individuals and discriminatory institutional systems.

This highlights the complexity of LGBTQIA+ mental healthcare access in Namaqualand, across all levels of the socio-ecological model. Interventions must target systemic issues, organisational practices, community norms, and broader societal structures, rather than solely focus on individual-level behaviour.

5.2.3 Participants' recommendations to improve access to mental healthcare

The participants offered several suggestions to improve LGBTQIA+ individuals' access to mental healthcare services. They recommended that targeted counselling services should be provided at their local PHC clinics. This suggestion is supported by Fish et al. (2019) and Gasteiger et al. (2024), who maintain that targeted counselling services offer safe, affirming spaces that foster mental well-being and self-acceptance. Targeted counselling has the potential to reduce rates of depression, anxiety, and suicide within the community, ultimately promoting mental health and well-being.

Another recommendation was for healthcare workers to be sufficiently trained on the overall healthcare needs of the LGBTQIA+ community. Healthcare worker sensitivity training ensures respectful, inclusive, and non-discriminatory care. It assists healthcare workers to understand the unique health needs and challenges faced by the LGBTQIA+ community, reduces bias and improves communication, making patients feel safe and valued. Reynish et al. (2022) demonstrated that having access to healthcare workers who are culturally competent and attuned to the needs of the LGBTQIA+ community improves help-seeking behaviour. This fosters better health outcomes and improved trust in the healthcare system.

Furthermore, it was recommended that physical and mental health should be integrated at a PHC level. Combining services improves access, continuity, and quality of care. When psycho-social and physical health services are integrated, it ensures holistic support. Integrating mental healthcare into PHC improves the relationships between healthcare workers and clients, the functioning of the client, and ultimately access to mental healthcare (Reiss-Brennan, 2014). This fosters better overall health outcomes and increased trust in healthcare systems.

Finally, the participants recommended that the community be sensitised regarding LGBTQIA+ mental health. Rural communities are usually under-resourced and have limited access to inclusive mental health services, which increases the risk of untreated mental health conditions. Through sensitising the community by educating and spreading awareness, discrimination is reduced, and acceptance is promoted (Benjamin et al., 2021). As a result, safer environments are created where LGBTQIA+ individuals feel seen, supported, and empowered to seek mental healthcare.

5.3 Recommendations

The practical contributions of this study underscore the complex, interdependent nature of LGBTQIA+ mental healthcare access in a rural setting in South Africa. The findings indicate that change must extend beyond individual behaviour, addressing the relational, organisational, and societal determinants that shape mental health experiences. In line with this, the following section outlines evidence-based recommendations to inform future research. The recommendations are organised according to the SEM levels to ensure that they address the multi-level nature of the identified barriers and facilitators.

5.3.1 Individual level

To support LGBTQIA+ individuals in Namaqualand in accessing mental healthcare, it is essential to enhance personal knowledge and understanding of mental health. Individual members of the LGBTQIA+ community, such as Richie Cloete, should be supported to design and promote educational initiatives that focus on improving mental health literacy, including awareness of biological and psychological factors that influence mood and well-being, particularly among the youth. By increasing their understanding of mental health and mental health conditions, individual members of the LGBTQIA+ community in Namaqualand can better recognise symptoms, reduce self-stigma, and feel more confident in seeking help. Rights-based NGOs operating in rural communities like Namaqualand could also provide guidance on navigating available mental health services and promote self-advocacy skills, empowering LGBTQIA+ individuals to take an active role in their mental healthcare despite systemic and social barriers. The researcher recommends individual level interventions that enhance mental health literacy, reduce stigma, and empower individuals, especially those from marginalised or rural backgrounds in Namaqualand, to identify and access affirming, culturally competent care.

5.3.2 Interpersonal level

At the interpersonal level, support from friends and family plays a crucial role in enhancing mental health outcomes and improving access to mental healthcare services. Having support from family and friends is important for LGBTQIA+ individuals as it brings about a sense of belonging and emotional safety. Experiencing the support of loved ones helps to reduce feelings of isolation, which are common due to stigma or rejection. Having peers who share similar experiences can validate identity and build resilience. Acceptance from family and friends significantly improves mental health and overall well-being (Snapp et al., 2015). Therefore, the researcher recommends that mental health interventions and services integrate social and familial support components to promote engagement. By incorporating family members and close social networks into treatment planning, healthcare workers can promote adherence to care, reduce stigma, and foster a more supportive environment for LGBTQIA+ individuals experiencing mental health difficulties.

Furthermore, increasing mental health literacy among families and communities through education and training initiatives can empower support networks to identify early signs of distress and facilitate timely access to professional services. Healthcare workers, families, friends, and the wider community should therefore recognise social support as a key determinant of mental well-being for the LGBTQIA+ community of Namaqualand.

5.3.3 Organisational/community Level

At the organisational level, the researcher recommends that faith-based organisations in Namaqualand should be identified and supported by LGBTQIA+ rights organisations as potential partners in promoting inclusive mental healthcare. Since the church holds significant social influence within the community, initiatives aimed at improving mental health outcomes for LGBTQIA+ individuals should actively engage spiritual leaders who demonstrate empathy and inclusivity. Training and dialogue opportunities could help equip these leaders with the knowledge and skills to provide affirming, faith-based support that complements formal mental health services. As participants' experiences have shown in this study, compassionate religious figures can play a transformative role in countering stigma by offering both spiritual and emotional guidance when other systems fall short.

5.3.4. Societal level

Cultural norms and practices that are unsupportive and stigmatise mental health are prevalent in Namaqualand. The researcher recommends that context-specific and culturally appropriate approaches, such as public awareness campaigns, should be employed to address this. Public awareness initiatives should be designed to challenge prevailing misconceptions about mental health conditions by leveraging local communication platforms such as community radio and faith-based events to promote mental health literacy and normalise help-seeking behaviours.

These initiatives must be culturally sensitive and promoted in the local language to ensure relevance and resonance. Collaborations between healthcare workers, educators, those living with mental health conditions, and community-based organisations are vital for co-developing interventions that align with existing social structures and values and could help to dismantle negative stereotypes and foster supportive social norms. Ultimately, making Namaqualand a more inclusive and supportive environment for mental well-being. Furthermore, policies such as the National LGBTI HIV Plan (2017–2022) that promote mental healthcare services could be expanded to include all LGBTQIA+ community members and mot only those receiving treatment for HIV/AIDS. Additionally, The South African policies such as the National Mental Health Policy Framework and Strategic Plan 2023-2030, National LGBTI HIV Plan (2017–2022 and others could be expanded to include strategies to address implementation.

These recommendations are intended to guide future investigations, interventions, and initiatives aimed at improving access to mental healthcare services for the LGBTQIA+ community.

5.4 Research Contribution

This qualitative case study contributes practical insights into how LGBTQIA+ individuals in Namaqualand experience and navigate barriers to mental healthcare access. Even though the findings are specific to this context, they supplement and extend existing knowledge and understanding of the challenges that these individuals experience in accessing care, also it reports on the voices of a very neglected population in a disadvantaged geographical area. They further provide tangible recommendations for local stakeholders, including LGBTQIA+, their families, NGOs, and civil society organisations that advocate for the rights of the LGBTQIA+ community, as well as the Northern Cape Provincial Department of Health.

Practical recommendations that could be implemented included:

Families **–** Improving mental health literacy among LGBTQIA+ individuals and their families can lead to reduced internalised stigma by promoting open conversations. Individuals will feel more supported and open to seeking care if families are supportive and affirming (Katz-Wise et al., 2016).

NGOs – NGOs can guide program design and advocacy efforts; potential partnerships between NGOs and faith-based organisations, provide mental health education. The study also identified the importance of community-based organisations in Namaqualand to employ peer-led and family-focused programs. These initiatives play a vital role in strengthening interpersonal support systems and mitigating social isolation (Gasteiger et al., 2024), thereby promoting overall health and resilience.

The Northern Cape Department of Health – The Department can implement comprehensive sensitivity and cultural competency training for healthcare workers in Namaqualand. These types of training are essential to ensure that health services are inclusive, respectful, and responsive to the diverse needs and values of the LGBTQIA+ individuals in the community. Additionally, LGBTQIA+ individuals are more open to accessing services if they know healthcare workers are culturally competent and affirming (Bishop et al., 2022; Dawson et al., 2025). Furthermore, the Department can integrate mental healthcare services into primary healthcare facilities to enhance accessibility. This integration is particularly important for Namaqualand as it is considered a rural and under-resourced area, and mental healthcare services are not readily available. Additionally, this improved accessibility can lead to improved functioning of clients and improved relationships between clients and healthcare workers (Reiss-Brennan, 2014). The Department can also implement equitable health policies to ensure fair distribution of healthcare resources and personnel, especially in areas such as Namaqualand, which are outside of urban centres where mental healthcare is usually concentrated. By addressing the disparities in workforce allocation and service access in Namaqualand, the Department can ensure that the LGBTQIA+ community will have more access to mental healthcare. This will ensure more equitable and sustainable mental health outcomes. It has been observed that low mental healthcare resources correlate to decreased access to mental health (Docrat et al., 2019; Vergunst, 2018).

Recommendations for future studies

Future research on mental health in the LGBTQIA+ could examine whether similar findings emerge in different institutional (Clinical settings) contexts. Future studies could also examine factors that cause or exacerbate mental health conditions for the LGBTQIA+ community in Namaqualand.

5.5 Limitations

While the study offered valuable insights into the barriers and facilitators to mental healthcare access for the LGBTQIA+ community of Namaqualand, it is important to acknowledge certain limitations that may have influenced the findings and their interpretation. These limitations do not detract from the significance of the research but rather provide context for understanding its scope and boundaries. Recognising these constraints also highlights areas for future inquiry and methodological refinement. The limitations of the study include:

- The participants were recruited with the help of an NGO that works with LGBTQIA+ individuals, offering counselling and other LGBTQIA+ specific mental health services. Therefore, the participants were already aware of mental healthcare, and their perspectives may have been quite different from individuals who did not have prior support. The perspectives of the participants may not represent the views of the entire LGBTQIA+ community in Namaqualand, such as those who do not have access to the NGO.
- While data saturation was achieved, the relatively small sample size may limit the transferability of the findings to the broader LGBTQIA+ population or different contexts. The aim with qualitative research is depth rather than breadth; however, the perspectives gained may not fully represent the diversity of experiences within the wider LGBTQIA+ community.
- Participant responses could have been influenced by social desirability bias, where they would respond with answers that they thought were socially acceptable, instead of providing answers that reflect their true perceptions, beliefs, attitudes, or experiences. Consequently, when interpreting the findings, caution should be exercised. Future research could benefit from including objective measures of the barriers to and facilitators of mental healthcare access for the LGBTQIA+.
- The study highlighted a variety of factors that could either facilitate or act as a barrier to accessing mental healthcare across the different levels of the Social Ecological Model (SEM). While this multilayered approach offers a broad and detailed view of what influences access, its complexity can make it hard to design focused interventions. Further research is needed to determine the importance of these factors and how they interact to develop solutions that are tailored to specific situations and needs.

- The focus of the study was on the perceptions of members of the LGBTQIA+ community regarding access to mental healthcare, but it did not include the perceptions of other key stakeholders, such as healthcare professionals. Future research could benefit from exploring the experiences of these key stakeholders, which could provide further valuable insight into the topic under investigation.
- The barriers and facilitators as perceived by the LGBTQIA+ community of Namaqualand offered valuable insights into the specific challenges and opportunities faced by these individuals. However, it should be noted that these perceptions might not be universally applicable. Factors such as geographic location, cultural contexts, dynamics within health systems, and society can influence whether people access mental healthcare services or not. Therefore, these findings should not be generalised to other settings.
- LGBTQIA+ was used as an umbrella term to describe a diverse range of sexual and gender identities in this study. Even though this terminology promotes inclusivity, it can also mask important differences between the distinct identities that it incorporates, which could possibly decrease the specificity and validity of the findings. Using this approach could lead to an overrepresentation of visible groups, for example, gay men, while underrepresenting others, such as intersex people, and in so doing could obscure the disparities in mental health outcomes. Furthermore, combining the different experiences of the different sub-groups could limit the effectiveness of intersectional analysis and overlook the unique psychosocial challenges that they face. Even though the differences between the distinct identities were highlighted at times in the study, future research could benefit from separating the data and using identity-specific approaches to better reflect the intricacies within the LGBTQIA+ community.

5.6 Conclusion to the Study

Guided by the SEM, this study investigated how members of the LGBTQIA+ community in Namaqualand perceived barriers to and facilitators of mental healthcare services in their community. Employing a qualitative case study design, the research addressed its objectives by examining factors operating across multiple ecological levels.

The findings indicated that barriers to mental healthcare access exist at every level of the SEM. At the individual level, a negative attitude towards seeking mental healthcare and a lack of knowledge and awareness about mental health were seen as barriers to mental healthcare access. At the interpersonal level, a lack of relational support from family and friends emerged as barriers to accessing mental healthcare services. At the organisational/community level, limited access to mental healthcare services and a negative attitude of healthcare workers towards mental healthcare and LGBTQIA+ identity were perceived as barriers. Finally, at the societal level, inadequate LGBTQIA+ mental health support systems were highlighted.

Despite these challenges, the study also identified several factors that facilitate access to mental healthcare services. At the individual level, knowledge of mental health and a positive attitude towards the utilisation of healthcare services were perceived as facilitators. At the interpersonal level, support from family and friends was revealed to be a facilitator. At the organisational/community level, access to quality mental healthcare services outside of the public sector was perceived as a facilitator. The data did not identify any facilitators on a societal level.

The study concludes that access to mental healthcare services for LGBTQIA+ individuals in Namaqualand is influenced by complex, multi-level determinants. Drawing on the Socio-Ecological Model, the research identified a need for culturally competent, LGBTQIA+-affirming services, community education, and systemic reform to improve mental healthcare access in Namaqualand, filling a crucial gap in existing research. However, addressing this issue requires comprehensive and intersectional strategies that account for the overlapping influences of gender identity, socioeconomic status, culture, and geography on mental healthcare access. Therefore, the study underscores the importance of adopting multifaceted interventions (individual, interpersonal, organisational/community, and societal) emanating from the findings to develop strategies and interventions specifically targeted at mitigating existing barriers and improving mental healthcare for the LGBTQIA+ community.

References

Adu, J., Oudshoorn, A., Anderson, K., Marshall, C. A., & Stuart, H. (2024). The experiences of familial mental illness stigma among individuals living with mental illnesses. *Journal of Biosocial Science, 56*(5), 809-830.

Akinbolue, D., Raifman, J. R., Day, T., Morgan, A., Mehta, S., Stewart, R. W., & Arrington-Sanders, R. (2022). Qualitative exploration of PCPs' mental health role for LGBT youth in Baltimore: a socio-ecological lens. *Journal of LGBT Youth, 20*(4), 918-939.

Al-Ababneh, M. (2020). Linking ontology, epistemology, and research methodology. *Science & Philosophy, 8*(1), 75-91.

Alessi, E. J., Dillon, F. R., & Van Der Horn, R. (2019). The therapeutic relationship mediates the association between affirmative practice and psychological well-being among lesbian, gay, bisexual, and queer clients. *Psychotherapy, 56*(2), 229.

Alhojailan, M. I. (2012). Thematic analysis: A critical review of its process and evaluation. *West East Journal of Social Sciences, 1*(1), 39-47.

Allen, K. D., Hammack, P. L., & Himes, H. L. (2012). Analysis of GLBTQ youth community-based programs in the United States. *Journal of Homosexuality, 59*(9), 1289-1306.

Alozie, N. O., Thomas, K., & Akpan-Obong, P. (2017). Global liberalization on homosexuality: Explaining the African gap. *The Social Science Journal*, *54*(2), 120-131.

Amankwaa, L. (2016). Creating Protocols for Trustworthiness in Qualitative Research. *Journal of Cultural Diversity, 23*(3).

Amos, N., Hill, A. O., Jones, J., Melendes-Torres, G. J., Carman, M., Lyons, A., & Bourne, A. (2023). Affirming educational and workplace settings are associated with positive mental health and happiness outcomes for LGBTQA+ youth in Australia. *BMC Public Health, 23*(1), 1421.

Anabtawi, S. (2022). Snatching Legal Victory: LGBTQ Rights Activism and Contestation in the Arab World. Ar*ab Law Quarterly, 36*(4-5), 383-421.

AP News. (2025, March 15). Trump administration removing 988 hotline service tailored to LGBTQ+ youth in July. https://apnews.com/article/382342828b381b6a32964f09fe9aa59c

Arora, L., Bhujang, P. M., & Sivakami, M. (2022). Understanding discrimination against LGBTQIA+ patients in Indian hospitals using a human rights perspective: An exploratory qualitative study. *Sexual and Reproductive Health Matters, 29*(2), 2104678.

Ayhan, C. H. B., Bilgin, H., Uluman, O. T., Sukut, O., Yilmas, S., & Buslu, S. (2020). A systematic review of the discrimination against sexual and gender minority in healthcare settings. *International Journal of Health Services, 50*(1), 44-61.

Ayoub, P., & Stoeckl, K. (2024). The global resistance to LGBTIQ rights. *Journal of Democracy, 35*(1), 59-73.

Badgett, M. V., Choi, S. K., & Wilson, B. D. (2019). LGBT poverty in the United States: A study of differences between sexual orientation and gender identity groups. Los Angeles, CA: Williams Institute; 2019. *williamsinstitute. law. ucla. edu/wp-content/uploads/National-LGBT-Poverty-Oct-2019. pdf*.

Bailey, S. D., Krieger, N., Agénor, M., Graves, J., Linos, N., & Bassett, M. T. (2017). Structural racism and health inequities in the USA: Evidence and interventions. *The Lancet, 389*(10077), 1453-1463.

Bantjes, J., Kessler, M. J., Hunt, X., Kessler, R. C., & Stein, D. J. (2023). The Mental Health of University Students in South Africa: Results of the National Student Survey. *Journal of Affective Disorders, 321*, 217-226.

Barber, S. L., Kumar, A., Roubal, T., Colombo, F., & Lorensoni, L. (2018). Harnessing the private health sector by using prices as a policy instrument: lessons learned from South Africa. *Health Policy, 122*(5), 558-564.

Barnes, D. M., & Meyer, I. H. (2012). Religious affiliation, internalised homophobia, and mental health in lesbians, gay men, and bisexuals. *American Journal of Orthopsychiatry, 82*(4), 505.

Bateman, C. (2015). Mental health under-budgeting undermining SA's economy. *South African Medical Journal, 105*(1), 7-8.

Beatris, C., & Pereira, H. (2023). Workplace experiences of LGBTQIA+ individuals in Portugal. *Employee Responsibilities and Rights Journal, 35(*3), 345-367.

Becker, A. E., & Kleinman, A. (2013). Mental Health and the Global Agenda. *New England Journal of Medicine, 369*(1), 66-73. https://doi.org/10.1056/nejmra1110827

Benjamin, F., Vickerman-Delport, S. A, & Roman, N. V. (2021) Mental health care services in rural South Africa: a human capabilities approach, *Social Work in Mental Health, 19*(5), 365-380

Bettis, A. H., Argiros, A., Kittleson, A. R., Sheffer, P., Holladay, M., Cyperski, M. A., ... & Clark, K. A. (2025). Perspectives of Parents of LGBTQ+ Youth with Mental Health Service Needs in the US Southeast: Challenges, Needs, and Recommendations for Improving LGBTQ+ Youth and Family Support. *Evidence-Based Practice in Child and Adolescent Mental Health,* 1-13.

Bishop, J., Crisp, D. A., Grant, J. B., & Schols, B. (2022). "You say you're inclusive, but can you show us?" The importance of cultural competence when working with sexual minorities in a mental health setting. *Journal of Clinical Psychology, 78*(11), 2145-2163.

Bonabi, H., Müller, M., Ajdacic-Gross, V., Eisele, J., Rodgers, S., Seifrits, E., & Rüsch, N. (2016). Mental health literacy, attitudes to help seeking, and perceived need as predictors of mental health service use: A longitudinal study. *The Journal of Nervous and Mental Disease, 204(*4), 321-324.

Booth, W. A., Abuhmida, M., & Anyanwu, F. (2024). Mental health stigma: A conundrum for healthcare practitioners in conservative communities. *Frontiers in Public Health, 12*, 1384521.

Booysen, D., Mahe-Poyo, P., & Grant, R. (2021). The experiences and perceptions of mental health service provision at a primary health centre in the Eastern Cape. *South African Journal of Psychiatry, 27*, 1641.

Borthwick, J., Jaffey, L., & Snell, J. (2020). Exploration of peer support models to support LGBTQ+ people with their mental health. *Centre for Mental Health, 16*.

Bostwick, W. B., Boyd, C. J., Hughes, T. L., West, B. T., & McCabe, S. E. (2014). Discrimination and mental health among lesbian, gay, and bisexual adults in the United States. *The American Journal of Orthopsychiatry, 84*(1), 35–45.

Bourke, B. (2014). Positionality: Reflecting on the research process. *The Qualitative Report, 19*(33), 1-9.

Boutilier, A. J., Clark, K. D., Bosse, J. D., Jackman, K. B., Jewell, J., & Dawson-Rose, C. (2024). Social-ecological barriers and facilitators to seeking inpatient psychiatric care among transgender and nonbinary people: A qualitative descriptive study. *Journal of Advanced Nursing.*

Bradley, S. H., DeVito, N. J., Lloyd, K. E., Richards, G. C., Rombey, T., Wayant, C., & Gill, P. J. (2020). Reducing bias and improving transparency in medical research: a critical overview of the problems, progress and suggested next steps. *Journal of the Royal Society of Medicine, 113*(11), 433-443.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative research in psychology, 3(2), 77-101.

Bränström, R., Hughes, T.L., Pachankis, J.E. (2024). Global LGBTQ Mental Health. In: Hwahng, S.J., Kaufman, M.R. (eds) Global LGBTQ Health. Global LGBTQ Health. Springer, Cham.

Breslow, A. S., Brewster, M. E., Veles, B. L., Wong, S., Geiger, E., & Soderstrom,B. (2015). Resilience and collective action: Exploring buffers against minority stress for transgender individuals. *Psychology of Sexual Orientation and Gender Diversity, 2*(3), 253.

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American psychologist*, *32*(7), 513.

Brooks, H., Llewellyn, C. D., Nadarsynski, T., Pelloso, F. C., Guilherme, F. D. S., Pollard, A., & Jones, C. J. (2018). Sexual orientation disclosure in healthcare: a systematic review. *British Journal of General Practice, 68(*668), e187-e196.

Brown, A., Rice, S. M., Rickwood, D. J., & Parker, A. G. (2016). Systematic review of barriers and facilitators to accessing and engaging with mental healthcare among at-risk young people. *Asia‐Pacific Psychiatry, 8*(1), 3-22.

Bryman, A. (2016). *Social Research Methods.* Oxford University Press.

Burns, J. K. (2010). Mental health services funding and development in KwaSulu-Natal: A tale of inequity and neglect. *South African Medical Journal, 100*(10), 662-666.

Burns, J. K. (2011). The mental health gap in South Africa: A human rights issue. *The Equal Rights Review, 6*(99), 99-113.

Burns, J. K. (2015). Poverty, inequality and a political economy of mental health. *Epidemiology and Psychiatric Sciences, 24*(2), 107-113.

Burton, C. W., Nolasco, K., & Holmes, D. (2021). Queering nursing curricula: Understanding and increasing attention to LGBTQIA+ health needs. *Journal of Professional Nursing, 37*(1),101-107.

Byron, P., & McDaid, L. (2025). Informal digital peer support for mental health: Understanding the digital support practices of LGBTQ+ young people in Australia. *Culture, Health & Sexuality,* 1-18.

Cai, J., Li, H., Guo, F., & Chen, S. (2024). Disclosure to Whom Matters: Association Between Disclosure of Sexual Orientation and Mental Health Among Chinese LGB People. *International Journal of Sexual Health, 36*(4), 553-568.

Cambridge University Press. (n.d.). Pathologise. *Cambridge Dictionary.* https://dictionary.cambridge.org/dictionary/english/pathologise

Camp, J., Vitoratou, S., & Rimes, K. A. (2020). LGBQ+ self-acceptance and its relationship with minority stressors and mental health: A systematic literature review. *Archives of Sexual Behavior, 49*(7), 2353-2373.

Campion, J., Javed, A., Sartorius, N., & Marmot, M. (2020). Addressing the public mental health challenge of COVID-19. *The Lancet Psychiatry, 7*(8), 657–659.

Carbonell, A., Navarro-Péres, J. J., & Mestre, M. V. (2020). Challenges and barriers in mental healthcare systems and their impact on the family: A systematic integrative review. *Health & Social Care in the Community, 28*(5), 1366-1379.

Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J., & Neville, A. J. (2014). The use of triangulation in qualitative research. *Oncology Nursing Forum, 41*(5), 545-547.

Carvalho, S. A., & Guiomar, R. (2022). Self-compassion and mental health in sexual and gender minority people: A systematic review and meta-analysis. *LGBT Health, 9*(5), 287-302.

Cavarra, R., Pepping, C., & Anderson, J. (2025). How Social Support Affirms Identity in LGBQ Adults: A Qualitative Exploration. *Sexuality Research and Social Policy,* 1-16.

Chard, A. N., Finneran, C., Sullivan, P. S., & Stephenson, R. (2015). Experiences of homophobia among gay and bisexual men: results from a cross-sectional study in seven countries. *Culture, Health & Sexuality, 17*(10), 1174-1189.

Charlson, F. J., Diminic, S., Lund, C., Degenhardt, L., & Whiteford, H. A. (2014). Mental and substance use disorders in sub-Saharan Africa: Predictions of epidemiological changes and mental health workforce requirements for the next 40 years. *Plos One, 9*(10), e110208.

Clarke, V., & Braun, V. (2017) Thematic analysis. *The Journal of Positive Psychology*, 12(3), 297-298. https://doi.org/10.1080/17439760.2016.1262613

Clarke, V., Braun, V., & Hayfield, N. (2015). Thematic analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (3rd ed., pp. 222–248). Sage.

Clinical and Translational Science Awards Consortium Community Engagement Key Function Committee Task Force on the Principles of Community Engagement. (2011). *Principles of community engagement* (2nd ed.). Washington, DC: Department of Health and Human Services, National Institutes of Health, Centers for Disease Control and Prevention, Agency for Toxic Substances and Disease Registry, Clinical and Translational Science Awards. http://purl.fdlp.gov/GPO/gpo15486

Cohen, L., Manion, L., & Morrison, K. (2007). *Research Methods in Education* (6th ed.). London: Routledge.

Cope, D. G. (2014). Methods and meanings: credibility and trustworthiness of qualitative research. *Oncology Nursing Forum, 41*(1).

Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental healthcare. *Psychological Science in the Public Interest, 15*(2), 37-70.

Corscadden, L., Callander, E. J., & Topp, S. M. (2018). International comparisons of disparities in access to care for people with mental health conditions. *International Journal of Health Planning and Management, 33*(4), 967-995.

Craig, A., Rochat, T., Naicker, S. N., Mapanga, W., Mtintsilana, A., Dlamini, S. N., … Norris, S. A. (2022). The prevalence of probable depression and probable anxiety, and associations with adverse childhood experiences and socio-demographics: A national survey in South Africa. Frontiers in Public Health, 10, 986531.

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). SAGE.

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). SAGE.

Crockett, M. A., Martínez, V., & Caviedes, P. (2022). Barriers and facilitators to mental health help-seeking and experiences with service use among LGBT+ university students in Chile. *International Journal of Environmental Research and Public Health, 19*(24), 16520.

Cronin, T. J., Pepping, C. A., & Lyons, A. (2025). Mental health service use and barriers to accessing services in a cohort of transgender, gender diverse, and non-binary adults in Australia. *Sexuality Research and Social Policy, 22(*1), 150-163.

Crumb, L., Mingo, T. M., & Crowe, A. (2019). "Get over it and move on": The impact of mental illness stigma in rural, low-income United States populations. *Mental Health & Prevention, 13*, 143-148.

Currin, J. M., Giano, S., & Hubach, R. D. (2020). Interface of Internalised Homophobia and Community Connectedness on Frequency of Doctor's Visits for Rural and Urban MSM in Oklahoma. *Journal of Rural Health,36*(3), 416-422.

D'amico, E., Julien, D., Tremblay, N., & Chartrand, E. (2015). Gay, Lesbian, and Bisexual Youths Coming Out to Their Parents: Parental Reactions and Youths' Outcomes. *Journal of GLBT Family Studies, 11*(5), 411-437.

Da Luz Scherf, E., Alves Lima Sanatta, M. de L., Viana da Silva, M. V., & da Silva, J. E. (2022). Healthcare access by transgender persons in South Africa: Gender-based discrimination, human rights violations, and the role of the African human rights system. *Journal Health and Technology - JHT, 1*(4), e1425.

Darmansjah, D., Kalra, G., & Ventriglio, A. (2019). Religion, psychiatry, and alternate sexuality. *East Asian Archives of Psychiatry, 29*(1), 26-29.

Das-Munshi, J., Lund, C., Mathews, C., Clark, C., Rothon, C., & Stansfeld, S. (2016). Mental health inequalities in adolescents growing up in post-apartheid South Africa: Cross-sectional survey, SHaW study. *PloS One, 11*(5), e0154478.

Davies, T., Roomaney, R., Lund, C., & Sorsdahl, K. (2021). Evaluation of an Advocacy Programme for Mental Healthcare Users in South Africa: A Mixed Methods Study. *Community Mental Health Journal, 58*(4), 720-728

Dawson, C. A., Moulder, A., & Heron, K. E. (2025). Barriers and Facilitators to Accessing Mental and Physical Healthcare Among Sexual Minority Women: A Qualitative Exploration. *International Journal of Environmental Research and Public Health, 22*(6), 965.

De Kock, J. H., & Pillay, B. J. (2016). Mental health nurses in South Africa's public rural primary care settings: A human resource crisis. *Rural and Remote Health, 16*(3), 1-10.

De Kock, J. H., & Pillay, B. J. (2017). A situation analysis of clinical psychology services in South Africa’s public rural primary care settings. *South African Journal of Psychology, 47*(2), 260-270.

De Lira, A. N., & de Morais, N. A. (2018). Resilience in lesbian, gay, and bisexual (LGB) populations: An integrative literature review. *Sexuality Research and Social Policy, 15*(3), 272-282.

DelFerro, J., Whelihan, J., Min, J., Powell, M., DiFiore, G., Gsesh, A., & Wood, S. (2024). The role of family support in moderating mental health outcomes for LGBTQ+ youth in primary care. *JAMA Pediatrics, 178*(9), 914-922.

Denzin, N. K. (2017). *The Research Act: A Theoretical Introduction to Sociological Methods*. Routledge.

Denzin, N. K., & Lincoln, Y. S. (2011). *The Sage Handbook of Qualitative Research* (4th ed.). Sage.

Dhai, A. (2018). The Life Esidimeni tragedy: Moral pathology and an ethical crisis. *South African Medical Journal,108*(5), 382-385.

Docrat, S., Besada, D., Cleary, S., & Lund, C. (2019). Mental health system costs, resources and constraints in South Africa: a national survey. *Health Policy and Planning, 34(*9), 706-719.

Dodds, C., Keogh, P., & Hickson, F. (2005). It makes me sick: heterosexism, homophobia and the health of gay and bisexual men. *Sigma Research., London. https://researchonline.lshtm.ac.uk/id/eprint/1399*

Duby, S., Nkosi, B., Scheibe, A., Brown, B., & Bekker, L. G. (2018). ‘Scared of going to the clinic’: Contextualising healthcare access for men who have sex with men, female sex workers and people who use drugs in two South African cities. *Southern African Journal of HIV Medicine, 19(*1),1-8.

Durojaye, E., & Agaba, D. K. (2018). Contribution of the Health Ombud to accountability: The life Esidimeni tragedy in South Africa. *Health and Human Rights, 20*(2), 161.

Dworkin, S. L. (2012). Sample size policy for qualitative studies using in-depth interviews. *Archives of sexual behavior*, *41*(6), 1319-1320.

Edenborg, E. (2023). ‘Traditional values’ and the narrative of gay rights as modernity: Sexual politics beyond polarisation. *Sexualities, 26*(1-2), 37-53.

Egede, L. E., Ruggiero, K. J., & Frueh, B. C. (2020). Ensuring mental health access for vulnerable populations in COVID era. *Journal of Psychiatric Research, 129*, 147-148.

Ekmekci, P. E. (2017). Do we have a moral responsibility to compensate for vulnerable groups? A discussion on the right to health for LGBT people. *Medicine, Healthcare and Philosophy, 20*, 335-341.

Eksteen, H. C., Becker, P. J., & Lippi, G. (2017). Stigmatisation towards the mentally ill: Perceptions of psychiatrists, pre-clinical and post-clinical rotation medical students. *International Journal of Social Psychiatry, 63*(8), 782-791.

Eriksson, M., Ghasinour, M., & Hammarström, A. (2018). Different uses of Bronfenbrenner’s ecological theory in public mental health research: What is their value for guiding public mental health policy and practice? *Social Theory & Health, 16*, 414-433.

Eslen-Siya, H., McGarry, A., Potgieter, C., & Reygan, F. C. (2015). Equal but separate? LGBTI rights in contemporary South Africa. In *Discursive Governance in Politics, Policy, and the Public Sphere* (pp. 179-189). New York: Palgrave Macmillan US.

Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of Convenience Sampling and Purposive Sampling. *American Journal of Theoretical and Applied Statistics*, *5*(1), 1-4.

Evans-Lacko, S. A. G. S., Aguilar-Gaxiola, S., Al-Hamsawi, A., Alonso, J., Benjet, C., Bruffaerts, R., & Thornicroft, G. (2018). Socio-economic variations in the mental health treatment gap for people with anxiety, mood, and substance use disorders: results from the WHO World Mental Health (WMH) surveys. *Psychological Medicine, 48*(9), 1560-1571.

Feagin, J., & Bennefield, S. (2014). Systemic racism and U.S. health care. Social *Science & Medicine, 103*, 7-14.

Felner, J. K., Wisdom, J. P., Williams, T., Katuska, L., Haley, S. J., Jun, H. J., & Corliss, H. L. (2020). Stress, coping, and context: Examining substance use among LGBTQ young adults with probable substance use disorders. *Psychiatric Services, 71*(2), 112-120.

Ferlito, B. A., & Dhai, A. (2018). The Life Esidimeni tragedy: The courts are also to blame. *South African Medical Journal, 108*(3), 155-156.

Fibbi, R., Midtbøen, A. H., & Simon, P. (2021). Migration and discrimination: IMISCOE short reader. Springer. https://doi.org/10.1007/978-3-030-67281-2

Finlay, L. (2002). “Outing” the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research, 12*(4), 531-545.

Fish, J. N., Moody, R. L., Grossman, A. H., & Russell, S. T. (2019). LGBTQ youth-serving community-based organisations: Who participates and what difference does it make? *Journal of Youth and Adolescence, 48*, 2418-2431.

Fish, J. N., Paceley, M. S., Evans, S., Kosi-Huber, J. A., Phillips, D. R., & Levine, D. S. (2025). Community efforts to support LGBTQ+ youth mental health: Programs objectives, development, and delivery. *Journal of Community Psychology, 53*(2), e70002.

Fleary, S. A., Joseph, P. L., Gonçalves, C., Somogie, J., & Angeles, J. (2022). The relationship between health literacy and mental health attitudes and beliefs. *Health Literacy Research and Practice, 6*(4), e270-e279.

Ford, L. G., Lewis, C., & Volberding, J. L. (2024). The Perceptions and Experiences Among Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Agender Patients of Quality of Care with Healthcare Services. *International Journal of Athletic Therapy and Training, 29*(3), 130-135.

Frankis, J. S. (2025). Understanding the mental health of LGBTQIA+ communities in Western Countries: what can nurses do to help? *Evidence-Based Nursing, 28*(1),1-3.

Freeman, M. (2022). Investing for population mental health in low and middle income countries—where and why? *International Journal of Mental Health Systems, 16*(1), 1-9.

Freeman, M., Nkomo, N., Kafaar, S., & Kelly, K. (2007). Mental disorder in people living with HIV/AIDS in South Africa. *South African Journal of Psychology, 37*(3), 489-500.

Fusch, P., Fusch, G. E., & Ness, L. R. (2018). Denzin's paradigm shift: Revisiting triangulation in qualitative research. *Journal of Sustainable Social Change, 10*(1), 2.

Gahagan, J., & Subirana-Malaret, M. (2018). Improving pathways to primary healthcare among LGBTQ populations and healthcare providers: Key findings from Nova Scotia, Canada. *International Journal for Equity in Health, 17*(1).

Galderisi, S., Heins, A., Kastrup, M., Beeshold, J., & Sartorius, N. (2015). Toward a new definition of mental health. *World Psychiatry: Official Journal of the World Psychiatric Association, 14*(2), 231-233 .

Gasteiger, C., Collens, P., & du Preez, E. (2024). Community-based support to improve mental health and wellbeing in older sexually and gender diverse people: A scoping review. *Aging & Mental Health, 28*(4), 692-700.

Gavulic, K. A., Ferrara, C. F., Aaron, D. G., & Gonzalez, G. (2025, March 31). Presidential powers and LGBTQI+ equity: Advances and rollbacks. Health Affairs Forefront. https://doi.org/10.1377/forefront.20250324.892969

Gee, G. C., & Ford, C. L. (2011). Structural racism and health inequities. *Du Bois Review: Social Science Research on Race, 8*(1), 115-132.

Giannou, D., & Ioakimidis, V. (2020). ‘Neither invisible nor abnormal!’ Exploring the invisibility and pathologisation of LGBT people in the Greek National Health System. *Critical Social Policy, 40*(3), 370-388.

Goffnett, J., & Goldbach, J. (2020). Substance use across the lifespan of the LGBTQ+ population. In *The Routledge Handbook of Social Work and Addictive Behaviors.* Routledge.

Goldbach, J. T., & Gibbs, J. J. (2017). A developmentally informed adaptation of minority stress for sexual minority adolescents. *Journal of Adolescence, 55*, 36-50.

Golden, S. D., & Earp, J. A. L. (2012). Social ecological approaches to individuals and their contexts: twenty years of health education & behavior health promotion interventions. *Health Education & Behavior, 39*(3), 364-372.

Gonçalves, C. C., Waters, S., Quirk, S. E., Haddad, P. M., Lin, A., Williams, L.J., & Yung, A. R. (2025). Barriers and facilitators to mental health care access and engagement for LGBTQA+ people with psychosis: A scoping review. *Psychiatry Research, 343*, 116281.

Gordon, T., Booysen, F., & Mbonigaba, J. (2020). Socio-economic inequalities in the multiple dimensions of access to healthcare: The case of South Africa. *BMC Public Health, 20*(1).

Govil, P. (2013). Ethical considerations in educational research. *International Journal of Advancement in Education and Social Sciences, 1*(2), 17-22.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 105–117). SAGE.

Guion, L. A., Diehl, D. C., & McDonald, D. (2011). *Triangulation: Establishing the validity of qualitative studies.* University of Florida, IFAS Extension.

Hardeman, R. R., Medina, E. M., & Koshimannil, K. B. (2016). Structural racism and supporting Black lives—the role of health professionals. *New England Journal of Medicine, 375*(22), 2113-2115.

Harper, G. W., Crawford, J., Lewis, K., & Jadwin-Cakmak, L. (2021). Mental health challenges and needs among sexual and gender minority people in Western Kenya. *International Journal of Environmental Research and Public Health, 18*(4), 2163.

Harriman, N. W., Williams, D. R., Morgan, J. W., Sewpaul, R., Manyaapelo, T., Sifunda, S., ... & Reddy, S. P. (2021). Racial disparities in psychological distress in post-apartheid South Africa: results from the SANHANES-1 survey. *Social Psychiatry and Psychiatric Epidemiology,* 1-15.

Henriquez, N. R., & Ahmad, N. (2021). “The message is you don’t exist”: Exploring lived experiences of rural lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ) people utilizing health care services. *SAGE open nursing*, *7*, 23779608211051174.

Heredia Jr, D., Pankey, T. L., & Gonsales, C. A. (2021). LGBTQ-affirmative behavioral health services in primary care. *Primary Care: Clinics in Office Practice, 48*(2), 243-257.

Herman, A. A., Stein, D. J., Seedat, S., Heeringa, S. G., Moomal, H., & Williams, D. R. (2009). The South African Stress and Health (SASH) study: 12-month and lifetime prevalence of common mental disorders. South African Medical Journal, 99(5), 339–344.

Higgins, A., Downes, C., Murphy, R., Sharek, D., Begley, T., McCann, E., Sheerin, F., Smyth, S., De Vries, J., & Doyle, L. (2021). LGBT + young people's perceptions of barriers to accessing mental health services in Ireland. *Journal of Nursing Management, 29*(1), 58-67.

Hlongwa, E. N., & Sibiya, M. N. (2019). Challenges affecting the implementation of the Policy on Integration of Mental Health Care into primary healthcare in KwaZulu-Natal province. Curationis, 42(1), 1-9.

Ho, S. H., Shamsudin, A. H., Liow, J. W., Juhari, J. A., Ling, S. A., & Tan, K. (2024). Mental Healthcare Needs and Experiences of LGBT+ Individuals in Malaysia: Utility, Enablers, and Barriers. *Healthcare*, *12*(10), 998. https://doi.org/10.3390/healthcare12100998

Hussain, M. A., Elyas, T., & Nasseef, O. A. (2013). Research paradigms: A slippery slope for fresh researchers. *Life Science Journal, 10*(4), 2374-2381.

Jack, H., Wagner, R. G., Petersen, I., Thom, R., Newton, C. R., Stein, A., & Hofman, K.J. (2014). Closing the mental health treatment gap in South Africa: a review of costs and cost-effectiveness. *Global Health Action, 7*(1), 23431.

Jackson, C. L., Agénor, M., Johnson, D. A., Austin, S. B., & Kawachi, I. (2016). Sexual orientation identity disparities in health behaviors, outcomes, and services use among men and women in the United States: a cross-sectional study. *BMC Public Health, 16*, 1-11.

James, S. L., Abate, D., Abate, K. H., Abay, S. M., Abbafati, C., Abbasi, N., & Briggs, A. M. (2018). Global, regional, and national incidence, prevalence, and years lived with disability for 354 diseases and injuries for 195 countries and territories, 1990–2017: a systematic analysis for the Global Burden of Disease Study 2017. *The Lancet, 392*(10159), 1789-1858.

Janse van Rensburg, B., Kotsé, C., Moxley, K., Subramaney, U., Singela, S., & Seedat, S. (2022). Profile of the current psychiatrist workforce in South Africa: establishing a baseline for human resource planning and strategy. *Health Policy and Planning, 37*(4), 492-504.

Javed, A., Lee, C., Sakaria, H., Buenaventura, R. D., Cetkovich-Bakmas, M., Duailibi, K., ... & Aseem, M. W. (2021). Reducing the stigma of mental health disorders with a focus on low-and middle-income countries. *Asian Journal of Psychiatry, 58*, 102601.

Jessani, A., Berry-Moreau, T., Parmar, R., Athanasakos, A., Prodger, J. L., & Mujugira, A. (2024). Healthcare access and barriers to utilisation among transgender and gender diverse people in Africa: a systematic review. *BMC Global and Public Health, 2*(1), 44.

Jick, T. D. (1979). Mixing qualitative and quantitative methods: Triangulation in action. *Administrative Science Quarterly, 24*(4), 602-611.

Jörns-Presentati, A., Napp, A. K., Dessauvagie, A. S., Stein, D. J., Jonker, D., Breet, E., & Groen, G. (2021). The prevalence of mental health problems in sub-Saharan adolescents: A systematic review. *PloS One, 16*(5), e0251689.

Joseph, A., Cliffe, C., Hillyard, M., & Majeed, A. (2017). Gender identity and the management of the transgender patient: a guide for non-specialists. *Journal of the Royal Society of Medicine, 110*(4), 144-152.

Joseph, N. (2013). Pride and prejudices. *Index on Censorship, 42*(3), 37-39.

Jung, H., von Sternberg, K., & Davis, K. (2017). The impact of mental health literacy, stigma, and social support on attitudes toward mental health help-seeking. *International Journal of Mental Health Promotion, 19(*5), 252-267.

Kates, J., Ranji, U., Beamesderfer, A., Salganicoff, A., & Dawson, L. (2018). *Health and access to care and coverage for lesbian, gay, bisexual, and transgender (LGBT) individuals in the US*. Kaiser Family Foundation.

Katz-Wise, S. L., Rosario, M., & Tsappis, M. (2016). Lesbian, gay, bisexual, and transgender youth and family acceptance. *Pediatric Clinics, 63*(6), 1011-1025.

Kealy-Bateman, W., & Pryor, L. (2015). Marriage equality is a mental health issue. *Australasian Psychiatry, 23*(5), 540-543.

Ketefian, S. (2015). Ethical considerations in research. Focus on vulnerable groups. *Investigación y Educación en Enfermería, 33*(1), 164-172.

Keuroghlian, A. S., Ard, K. L., & Makadon, H. J. (2017). Advancing health equity for lesbian, gay, bisexual and transgender (LGBT) people through sexual health education and LGBT-affirming healthcare environments. *Sexual Health, 14*(1), 119-122.

Kidd, S. A., Howison, M., Pilling, M., Ross, L. E., & McKensie, K. (2016). Severe mental illness in LGBT populations: A scoping review. *Psychiatric Services, 67*(7), 779-783.

Kilanowski, J. F. (2017). Breadth of the Socio-Ecological Model. *Journal of Agromedicine, 22*(4), 295-297.

King, M. (2015). Attitudes of therapists and other health professionals towards their LGB patients. *International Review of Psychiatry, 27*(5), 396-404.

Kinitz, D. J., Salway, T., Kia, H., Ferlatte, O., Rich, A. J., & Ross, L. E. (2022). Health of two-spirit, lesbian, gay, bisexual and transgender people experiencing poverty in Canada: a review. *Health Promotion International, 37*(1).

Kivunja, C., & Kuyini, A. B. (2017). Understanding and applying research paradigms in educational contexts. *International Journal of Higher Education,* 6(5), 26-41.

Kum, S. (2017). Gay, gray, black, and blue: An examination of some of the challenges faced by older LGBTQ people of color. *Journal of Gay & Lesbian Mental Health, 21*(3), 228-239.

Langlois, A. J. (2018). International political theory and LGBTQ rights. The Oxford *Handbook of International Political Theory* (p.370). Oxford.

Larrieta, J., Wuerth, M., Aoun, M., Bemme, D., D'sousa, N., Gumbonsvanda, N., & Giacaman, R. (2023). Equitable and sustainable funding for community-based organisations in global mental health. *The Lancet Global Health, 11*(3), e327-e328.

Lee, C., & Ostergard Jr, R. L. (2017). Measuring discrimination against LGBTQ people: A cross-national analysis. *Human Rights Quarterly,* 37-72.

Lehohla, P. (2011). *Census 2011: Census in brief.* Statistics South Africa.

Levesque, J. F., Harris, M. F., & Russell, G. (2013). Patient-centred access to healthcare: conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health, 12*(1), 18.

Lewis, C. (2020). Rethinking access for minority segments in rural health: An LGBTQI+ perspective. *Australian Journal of Rural Health, 28*(5), 509-513.

Lewis, C., & Reynolds, N. (2021). Considerations for conducting sensitive research with the LGBTQIA+ communities. International Journal of Market Research, 63(5), 544-551.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Beverly Hills, Calif: SAGE.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. Annual review of Sociology, 27(1), 363-385.

Lund, C., Brooke-Sumner, C., Baingana, F., Baron, E. C., Breuer, E., Chandra, P., & Saxena, S. (2018). Social determinants of mental disorders and the Sustainable Development Goals: a systematic review of reviews. *The Lancet Psychiatry, 5*(4), 357-369.

Lund, C., Petersen, I., Kleintjes, S., & Bhana, A. (2012). Mental health services in South Africa: taking stock. *African Journal of Psychiatry, 15*(6), 402-405.

Luvuno, S. P., Mchunu, G., Ngidi, H., Ncama, B., & Mashamba-Thompson, T. (2019). add: A scoping review*. African Journal of Primary Healthcare and Family Medicine,11*(1), 1-10.

Lyonga, F. (2023). Researching Homosexuality in Difficult Contexts. *Sexes*, *4*(4), 569-586.

Maltempi, H., Yu, Y. J., & Bruna, S. (2024). LGBTQ+ Stigma and Health Effects: A Systematic Review of the Global Literature. *Global Journal of Health Science, 16(*5).

Malterud, K., Siersma, V. D., & Guassora, A. D. (2015). Sample Sise in Qualitative Interview Studies: Guided by Information Power. *Qualitative Health Research, 26*(13), 1753–1760.

Mangwegape, D. S., Manyedi, M. E., & Molato, B. J. (2024). Risk factors to mental health challenges among the LGBTI+ community in Gaborone, Botswana. *Curationis, 47*(1), 2543.

Maphumulo, W. T., & Bhengu, B. R. (2019). Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review. *Curationis, 42*(1), 1-9.

Marais, D. L., & Petersen, I. (2015). Health system governance to support integrated mental healthcare in South Africa: challenges and opportunities. *International Journal of Mental Health Systems, 9,* 1-21.

Maria, S., Irwin, P., Gillan, P., Anderson, J., & Sengstock, B. (2025). Navigating mental health Frontiers: A scoping review of accessibility for rural LGBTIQA+ communities. *Journal of Homosexuality, 72*(7), 1245-1267.

Marinda, E., Zungu, N., Chikovore, J., Mthembu, J., Magampa, M., Mathentamo, Q., & Simbayi, L. (2022). Association between ART adherence and mental health: results from a national HIV sero-behavioural survey in South Africa. AIDS and Behavior, 26(5), 1517-1529.

Matsea, T., Ryke, E., & Weyers, M. (2018). Assessing mental health services in a rural setting: Service providers' perspective. *International Journal of Mental Health, 47(*1), 26-49.

McCann, E., Donohue, G., & Timmins, F. (2020). An exploration of the relationship between spirituality, religion and mental health among youth who identify as LGBT+: A systematic literature review. *Journal of Religion and Health, 59*(2), 828-844.

McCloskey, D., Aguilar-Gaxiola, S., & Michener, J. (2011). *CTSA Community Engagement Key Function Committee Task Force on the Principles of Community Engagement*. Center for Disease Control (CDC). https://ictr.johnshopkins.edu/wpcontent/uploads/2015/10/CTSAPrinciplesofCommunityEngagement.pdf

McConnell, E. A., Birkett, M. A., & Mustanski, B. (2016). Families matter: Social support and mental health trajectories among lesbian, gay, bisexual, and transgender youth. *Journal of Adolescent Health, 59*(6), 674-680.

McDermott, E., Gabb, J., Eastham, R., & Hanbury, A. (2021). Family trouble: Heteronormativity, emotion work and queer youth mental health. *Health, 25*(2), 177-195.

McDonald, K. (2018). Social support and mental health in LGBTQ adolescents: A review of the literature. *Issues in Mental Health Nursing, 39*(1), 16-29.

McGrath, J. J., Al-Hamzawi, A., Alonso, J., Altwaijri, Y., Andrade, L. H., Bromet, E. J. & Zaslavsky, A. M. (2023). Age of onset and cumulative risk of mental disorders: a cross-national analysis of population surveys from 29 countries. The Lancet Psychiatry, 10(9), 668-681.

McLeroy, K. R., Bibeau, D., Steckler, A., & Glans, K. (1988). An ecological perspective on health promotion programs. *Health Education Quarterly, 15(*4), 351-377.

Merriam, S. B., & Tisdell, E. J. (2016). *Qualitative research: A guide to design and implementation* (4th ed.). Jossey Bass.

Mertens, D. (1998). *Research methods in education and psychology. Integrating diversity with quantitative and qualitative approaches.* Thousand Oaks, California: Sage Publications.

Mertens, D. M. (2007). Transformative paradigm: Mixed methods and social justice. *Journal of Mixed Methods Research, 1*(3), 212-225.

Mezzina, R., Gopikumar, V., Jenkins, J., Saraceno, B., & Sashidharan, S. P. (2022). Social Vulnerability and Mental Health Inequalities in the “Syndemic”: Call for action. *Frontiers in Psychiatry, 13,* 894370.

Mitchell, L. A., Jacobs, C., & McEwen, A. (2023). (In) visibility of LGBTQIA+ people and relationships in healthcare: A scoping review. *Patient Education and Counseling, 114*, 107828.

Mitra, S., & Globerman, J. (2014). *Facilitators and barriers to healthcare for lesbian, gay and bisexual (LGB) people. Rapid Review #79*. Toronto, ON: Ontario HIV Treatment Network.

Moagi, M. M., van der Wath, A. E., Jiyane, P. M., & Rikhotso, R. S. (2021). Mental Health Challenges of Lesbian, Gay, Bisexual and Transgender People: An Integrated Literature Review. *Health SA Gesondheid, 26*, 1–12.

Mogotsi, I., Otchere, Y. O., Botchway, I., Muthoni, Y., Gariseb, R., & Ramalepe, L. M. (2024). Psychosocial Correlates of LGBTIQ+ Experiences in Selected African Countries: Reimagining LGBTIQ+ Research. *Journal of Social Issues, 80*(3), 1079–1111.

Monnapula-Masabane, P., & Petersen, I. (2023). Mental Health Stigma Experiences Among Caregivers and Service Users in South Africa: A Qualitative Investigation. *Current Psychology, 42*(11), 9427-9439.

Moonsamy, A., & Gurayah, T. (2024). Cultural perspectives and experiences of mental healthcare in Kwa-Sulu Natal, South Africa. *South African Journal of Occupational Therapy, 54(*1), 34-44.

Moran-Ellis, J., Alexander, V. D., Cronin, A., Dickinson, M., Fielding, J., Sleney, J., & Thomas, H. (2006). Triangulation and integration: processes, claims and implications. *Qualitative Research, 6*(1), 45-59.

Morar, T., Breedt, J. E., Mdaka, N., Maaroganye, K., & Robertson, L. (2024). Is mental health in South Africa moving forward? *BJPsych International, 21*(1), 1-3.

Moroz, N., Moroz, I., & D'Angelo, M. S. (2020). Mental health services in Canada: Barriers and cost- effective solutions to increase access. Healthcare Management Forum, 33(6), 282–287. https://doi.org/10.1177/0840470420933911

Muller, A., & Hughes, T. L. (2016). Making the invisible visible: A systematic review of sexual minority women's health in Southern Africa. *BMC Public Health*, *16*(1), 307.

Müller, A. (2017). Scrambling for access: availability, accessibility, acceptability and quality of healthcare for lesbian, gay, bisexual and transgender people in South Africa. *BMC International Health and Human Rights, 17*(1), 16.

Müller, A., & Daskilewicz, K. (2018). Mental health among lesbian, gay, bisexual, transgender and intersex people in East and Southern Africa. European Journal of Public Health, 28.

Müller, A., Meer, T., & Haji, M. (2020). *Quality through Inclusion? Community-led healthcare delivery, training and advocacy related to sexual and reproductive health of lesbian, gay, bisexual and transgender people in South Africa.* Amsterdam: COC Netherlands.

Myers, B., Petersen-Williams, P., Van Der Westhuisen, C., Lund, C., Lombard, C., Joska, J. A., ... & Sorsdahl, K. (2019). Community health worker-delivered counselling for common mental disorders among chronic disease patients in South Africa: a feasibility study. *BMJ Open, 9*(1).

Nama-Khoi Municipality. (2019). *Integrated Development Plan second revision 2019/2020.* Department of Cooperative Governance & Traditional Affairs. https://www.cogta.gov.sa/cgta_2016/wpcontent/uploads/2020/12/NAMAKHOIIDP1920.pdf

National Department of Health. (2023). Budget vote speech by Minister Joe Phaahla: National Department of Health, 2023/24. Government of South Africa. https://www.gov.za/news/speeches/minister-joe-phaahla-health-dept-budget-vote-202324-09-may-2023

Newcomb, M. E., & Mustanski, B. (2010). Internalised homophobia and internalising mental health problems: A meta-analytic review. *Clinical Psychology Review, 30*(8), 1019-1029.

Ngene, N. C., Khaliq, O. P., & Moodley, J. (2023). Inequality in health care services in urban and rural settings in South Africa. *African Journal of Reproductive Health*, *27*(5), 87-95.

Ngwenya, N., Nkosi, B., Mchunu, L. S., Ferguson, J., Seeley, J., & Doyle, A. M. (2020). Behavioural and socio-ecological factors that influence access and utilisation of health services by young people living in rural KwaSulu-Natal, South Africa: Implications for intervention. *PloS One, 15*(4), e0231080.

Nic Giolla Easpaig, B., Reynish, T.D., Hoang, H., Bridgman, H., Corvinus-Jones, S.L., & Auckland, S. (2022). A systematic review of the health and health care of rural sexual and gender minorities in the UK, USA, Canada, Australia and New Sealand. *Rural and Remote Health, 22*(3), 6999.

Nowaskie, D. S., & Sowinski, J. S. (2019). Primary care providers' attitudes, practices, and knowledge in treating LGBTQ communities. *Journal of Homosexuality*, *66*(13), 1927–1947.

Nyambe, A., Van Hal, G., & Kampen, J. K. (2016). Screening and vaccination as determined by the Social Ecological Model and the Theory of Triadic Influence: a systematic review. *BMC public health*, *16*(1), 1166.

Office of the High Commissioner for Human Rights. (n.d.). *About LGBTI people and human rights.* United Nations. https://www.ohchr.org/en/sexualorientation-and-gender-identity/about-lgbti-people-and-human-rights

Ojanen, T. T., Phukao, D., Boonmongkon, P., & Rungreangkulkij, S. (2021). Defining mental health practitioners' LGBTIQ cultural competence in Thailand. *Journal of Population and Social Studies, 29*, 158-176.

Orchard, K. (2023). "Small Victories of Survival in a Deeply Homophobic World": Current Realities and Paths Forward for Substance Use in the LGBTQIA+ Community. *Columbia Social Work Review, 21*(1), 45-62.

Owens, B., Mills, S., Lewis, N., & Guta, A. (2022). Work-related stressors and mental health among LGBTQ workers: Results from a cross-sectional survey. *PLoS One, 17*(10), e0275771.

Özdemir, R. C., & Erenoğlu, R. (2022). Attitudes of nursing students towards LGBT individuals and the affecting factors. *Perspectives in psychiatric care*, *58*(1).

Palaganas, E. C., Sanches, M. C., Molintas, M. V. P., & Caricativo, R. D. (2017). Reflexivity in qualitative research. *The Qualitative Report* *22*(2), 426-438.

Pallotta-Chiarolli, M., Sweid, R., & Sudarto, B. (2021). 'You Can't Be Gay and Do Religion': Understanding Muslim LGBTIQ+ Experiences of Accessing Support Services. *Journal of Intercultural Studies, 43*(1), 148-165.

Paschen-Wolff, M. M., DeSousa, A., Paine, E. A., Hughes, T. L., & Campbell, A. N. (2024). Experiences of and recommendations for LGBTQ+-affirming substance use services: an exploratory qualitative descriptive study with LGBTQ+ people who use opioids and other drugs. *Substance Abuse Treatment, Prevention, and Policy, 19*(1), 2.

Pate, K. D., Bankale, T., Daley, J., Smith, M., Swecker, K., & Soloski, K. (2024). Parts of Me: An Internal Family Systems Lens on the LGBTQIA+ Coming out Experience. *LGBTQ+ Family: An Interdisciplinary Journal, 20*(3), 157-170.

Patel, N. M., Savaliya, G. V., Mehta, P. J., & Kataria, L. R. (2025). Global Disparities in Mental Health Systems: A Comparative Cross-sectional Study of Ten Countries with Different Income Levels. Indian journal of psychological medicine, 02537176251379999. Advance online publication. https://doi.org/10.1177/0253717625137999

Patel, V. (2007). Mental health in low-and middle-income countries. *British Medical Bulletin, 81*(1), 81-96.

Patel, V. (2014). Why mental health matters to global health. *Transcultural Psychiatry, 51*(6), 777-789.

Patton, M. Q. (2014). *Qualitative research & evaluation methods: Integrating theory and practice.* Sage.

Pereira, H., Silva, P., & Beatris, C. (2022). The impact of psychological distress on the occupational well-being of sexual and gender minorities. *Health Care, 10*(4), 699

Perneger, T. V., Courvoisier, D. S., Hudelson, P. M., & Gayet-Ageron, A. (2015). Sample sise for pre-tests of questionnaires. *Quality of Life Research, 24*,147-151.

Petersen, I., Bhana, A., & Swarts, L. (2012). Mental health promotion and the prevention of mental disorders in South Africa. *African Journal of Psychiatry, 15*(6), 411-416.

Petersen, I., Fairall, L., Bhana, A., Kathree, T., Selohilwe, O., Brooke-Sumner, C., Faris, G., Breuer, E., Sibanyoni, N., Lund, C., & Patel, V. (2016). Integrating mental health into chronic care in South Africa: The development of a district mental healthcare plan. *British Journal of Psychiatry, 208(*s56), s29–s39.

Pretorius, L. (2024). Demystifying research paradigms: Navigating ontology, epistemology, and axiology in research. *The Qualitative Report, 29*(10), 2698-2715.

Priester, M. A., Browne, T., Iachini, A., Clone, S., DeHart, D., & Seay, K. D. (2016). Treatment access barriers and disparities among individuals with co-occurring mental health and substance use disorders: an integrative literature review. *Journal of Substance Abuse Treatment, 61*, 47-59.

Priya, A. (2020). Case Study Methodology of Qualitative Research: Key Attributes and Navigating the Conundrums in Its Application. *Sociological Bulletin, 70*, 94-110.

Quinn, G. P., Sutton, S. K., Winfield, B., Breen, S., Canales, J., Shetty, G., & Schabath, M. B. (2015). Lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ) perception and healthcare experiences. *Journal of Gay & Lesbian Social Services, 27*(2), 246-261.

Rahi S (2017) Research Design and Methods: A Systematic Review of Research Paradigms, Sampling Issues and Instruments Development. *International Journal of Economic Management Science, 6*, 403.

Rahimi, S., & Khatooni, M. (2024). Saturation in qualitative research: An evolutionary concept analysis. *International journal of nursing studies advances*, *6*, 100174.

Ramlagan, S., Naidoo, I., North, A., & Jooste, S. (2025). Psychological distress in South Africa: Analysis of 2017 national household survey data. Health SA Gesondheid, 30, 2920.

Ratanashevorn, R., Kim, S. R., Kashubeck-West, S., & Ojanen, T. T. (2024). Cultural humility, counseling alliance, and counseling outcome among LGBTQ+ clients. *Journal of Counseling & Development, 102*(3), 253-263.

Rathod, S., Pinninti, N., Irfan, M., Gorcsynski, P., Rathod, P., Gega, L., & Naeem, F. (2017). Mental health service provision in low-and middle-income countries. *Health Services Insights, 10*, 1178632917694350.

Rees, S. N., Crowe, M., & Harris, S. (2021). The lesbian, gay, bisexual and transgender communities' mental healthcare needs and experiences of mental health services: An integrative review of qualitative studies. *Journal of Psychiatric and Mental Health Nursing, 28*(4), 578-589.

Rehman, A. A., & Alharthi, K. (2016). An introduction to research paradigms. *International Journal of Educational Investigations, 3(*8), 51-59.

Reisner, S. L., Pardo, S. T., Gamarel, K. E., Hughto, J. M. W., Pardee, D. J., & Keo-Meier, C. L. (2015). Substance Use to Cope with Stigma in Healthcare Among U.S. Female-to-Male Trans Masculine Adults. *LGBT Health, 2*(4), 324-332.

Reiss-Brennan, B. (2014). Mental health integration: normalising team care. J*ournal of Primary Care & Community Health, 5*(1), 55-60.

Reiss-Brennan, B., Brunishols, K. D., Dredge, C., Briot, P., Grasier, K., Wilcox, A., & James, B. (2016). Association of integrated team-based care with healthcare quality, utilisation, and cost*. Jama, 316*(8), 826-834.

Remien, R. H., Stirratt, M. J., Nguyen, N., Robbins, R. N., Pala, A. N., & Mellins, C.A. (2019). Mental health and HIV/AIDS: the need for an integrated response. *AIDS (London, England), 33*(9), 1411.

Reynish, T., Hoang, H., Bridgman, H., & Nic Giolla Easpaig, B. (2022). Barriers and enablers to mental health help seeking of sexual, gender, and erotic minorities: A systematic literature review. *Journal of Gay & Lesbian Mental Health*, *27*(2), 129–150. https://doi.org/10.1080/19359705.2022.2036666

Robinson, J. P., & Espelage, D. L. (2012). Bullying explains only part of LGBTQ–heterosexual risk disparities: Implications for policy and practice. *Educational Researcher, 41*(8), 309-319.

Rosenkrantz, D. E., Black, W. W., Abreu, R. L., Aleshire, M. E., & Fallin-Bennett, K. (2017). Health and health care of rural sexual and gender minorities: A systematic review. *Stigma and Health, 2*(3), 229–243

Ruben, M. A., & Fullerton, M. (2018). Proportion of patients who disclose their sexual orientation to healthcare providers and its relationship to patient outcomes: A meta-analysis and review. *Patient Education and Counseling, 101*(9), 1549-1560.

Russell, S. T., & Fish, J. N. (2016). Mental health in lesbian, gay, bisexual, and transgender (LGBT) youth. *Annual Review of Clinical Psychology, 12*(1), 465-487

Ryan, C., Russell, S. T., Huebner, D., Dias, R. M., & Sanches, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing, 23*(4), 205-213.

Salerno, J. P., Devadas, J., Pease, M., Nketia, B., & Fish, J. N. (2020). Sexual and gender minority stress amid the COVID-19 pandemic: Implications for LGBTQ young persons' mental health and well-being. *Public Health Reports, 135*(6), 721-727.

Sallis, J. F., Cervero, R. B., Ascher, W., Henderson, K. A., Kraft, M. K., & Kerr, J. (2006). An ecological approach to creating active living communities. *Annual review of public health, 27*(1), 297-322.

Sallis, J. F., Owen, N., & Fisher, E. (2015). Ecological models of health behavior. *Health behavior: Theory, research, and practice, 5*(43-64).

Sankoh, O., Sevalie, S., & Weston, M. (2018). Mental health in Africa. *The Lancet Global Health, 6*(9), e954-e955.

Schwandt, T. A., Lincoln, Y. S., & Guba, E. G. (2007). Judging interpretations: But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *New directions for evaluation 2007*(114), 11-25.

Semrau, M., Evans-Lacko, S., Koschorke, M., Ashenafi, L., & Thornicroft, G. (2015). Stigma and discrimination related to mental illness in low-and middle-income countries. *Epidemiology and psychiatric sciences, 24*(5), 382-394.

Shaikh, A., Kamble, P., Daulatabad, V., Singhal, A., Madhusudhan, U., & John, N. A. (2024). Mental health challenges within the LGBTQ community: A societal imperative. *Journal of Family Medicine and Primary Care, 13(*9), 3529-3535.

Shan, Y., Liu, L., Wang, F., Yu, L., Liu, D., Zheng, C., & Yu, Z. (2025). Association between inequalities in mental health resources and burdens of mental health disorders in 146 countries and territories: An observational study. Journal of Affective Disorders, 379, 812-821.

Shenton, A.K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information, 22*, 63-75.

Shih, F. J. (1998). Triangulation in nursing research: issues of conceptual clarity and purpose. *Journal of Advanced Nursing, 28*(3), 631-641.

Shipherd, J. C., Green, K. E., & Abramovits, S. (2010). Transgender clients: Identifying and minimising barriers to mental health treatment. *Journal of Gay & Lesbian Mental Health, 14*(2), 94-108.

Shisana, O., Stein, D. J., Zungu, N. P., & Wolvaardt, G. (2024). The rationale for South Africa to prioritise mental health care as a critical aspect of overall health care. Comprehensive Psychiatry, 130, 152458.

Shivayogi, P. (2013). Vulnerable population and methods for their safeguard. *Perspectives in Clinical Research, 4*(1), 53-57.

Shoesmith, A., Hall, A., Wolfenden, L., Shelton, R. C., Powell, B. J., Brown, H., & Nathan, N. (2021). Barriers and facilitators influencing the sustainment of health behaviour interventions in schools and childcare services: a systematic review. *Implementation Science, 16*(1), 62.

Sibanyoni, E. K., Mkhise, S., & Amali, S. E. (2023). LGBTQIA+ victimisation: A theoretical discourse. *Sexuality, Gender & Policy, 6*(4), 253-262.

Silveri, G., Schimmenti, S., Prina, E., Gios, L., Mirandola, M., Converti, M., & Italian Working Group on LGBTQI Mental Health. (2022). Barriers in care pathways and unmet mental health needs in LGBTIQ+ communities. *International Review of Psychiatry, 34*(3-4), 215-229.

Simons, L., Schrager, S. M., Clark, L. F., Belser, M., & Olson, J. (2013). Parental support and mental health among transgender adolescents. *Journal of Adolescent Health, 53(*6), 791-793.

Snapp, S. D., Watson, R. J., Russell, S. T., Dias, R. M., & Ryan, C. (2015). Social support networks for LGBT young adults: Low cost strategies for positive adjustment. *Family relations, 64*(3), 420-430.

Sorsdahl, K., Petersen, I., Myers, B., Singela, S., Lund, C., & Van der Westhuisen, C. (2023). A reflection of the current status of the mental healthcare system in South Africa. *SSM-Mental Health, 4*, 100247.

South African Department of Health. (2013). *National Mental Health Policy Framework and Strategic Plan* 2013-2020. https: //www.health.gov.za/wp-content/uploads/2020/11/National-Mental-Health-Policy-Framework-and-Strategic-Plan-2013-2020.pdf

South African Department of Health. (2023). *National Mental Health Policy Framework and Strategic Plan 2023-2030*. Government of South Africa. https://www. https://www.health.gov.za/wp-content/uploads/2024/09/National-Mental-Health-Policy-Framework-and-Strategic-Plan-2023-2030.pdf

South African Depression and Anxiety Group. (2019). *Mental Health in South Africa.* https://www.sadag.org/index.php?option=com_content&view=article&id=2959:mental-health-in-south-africa

South African Government. (2002). *Mental Health Care Act 17 of 2002*. https://www.gov.za/documents/mental-health-care-act

South African National AIDS Council. (2017). South African National LGBTI HIV Plan 2017–2022. https://sanac.org.za/wp-content/uploads/2017/06/LGBTI-HIV-Plan-Final.pdf?utm

Spencer, S., Meer, T., & Müller, A. (2017). “The care is the best you can give at the time”: Healthcare professionals’ experiences in providing gender affirming care in South Africa. *PLoS One, 12*(7), e0181132.

Spengler, E. S., Miller, D. J., & Spengler, P. M. (2016). Microaggressions: Clinical errors with sexual minority clients. *Psychotherapy, 53*(3), 360.

Statistics South Africa. (2017). *Mortality and causes of death in South Africa, 2016: Findings from death notification.* http://www.statssa.gov.sa/publications/P03093/P030932016.pdf

Statistics South Africa. (2018). *Community Survey 2016 provincial profile: Northern Cape, 2016*. Pretoria, South Africa: Statistics South Africa.

Statistics South Africa. (2022). *Census Dissemination: Namakwa.* https://census.statssa.gov.za/#/province/3/2

Steel, S., Marnane, C., Iranpour, C., Chey, T., Jackson, J. W., Patel, V., & Silove, D. (2014). The global prevalence of common mental disorders: a systematic review and meta-analysis 1980–2013. *International Journal of Epidemiology, 43*(2), 476-493.

Stevens, M. (2012). *Transgender access to sexual health services in South Africa: findings from a key informant survey.* Gender Dynamix. | Academic Research and Publications

Stokols, D. (1992). Establishing and maintaining healthy environments: Toward a social ecology of health promotion. *American Psychologist, 47*(1), 6.

Stokols, D. (1996). Translating social ecological theory into guidelines for community health promotion. *American Journal of Health Promotion, 10*(4), 282-298.

Strumpher, J., Van Rooyen, R. M., Topper, K., Andersson, L. M. C., & Schierenback, I. (2014). Barriers to accessing mental healthcare in the Eastern Cape province of South Africa. *Africa Journal of Nursing and Midwifery, 16*(1), 45-59.

Sulla, V., Sikhali, P., & Cuevas, P. F. (2022). *Inequality in Southern Africa: An assessment of the Southern African customs union*. http://documents.worldbank.org/curated/en/099125303072236 903

Summers-Gabr, N. M. (2020). Rural–urban mental health disparities in the United States during COVID19. *Psychological Trauma: Theory, Research, Practice, and Policy, 12,* S222-S224.

Taskiran Eskici, G., Alan, H., Eskin Bacaksis, F., Gumus, E., Cakir, H., & Harmanci Seren, A. K. (2021). Under the same rainbow: A study on homophobia and discrimination among private sector healthcare professionals. *Journal of Nursing Management, 29*(1), 3-15.

Tavory, I., & Timmermans, S. (2014). *Abductive analysis: Theorising qualitative research*. University of Chicago Press.

Teo, C., Metheny, N., & Chum, A. (2022). Family support modifies the effect of changes to same-sex marriage legislation on LGB mental health: evidence from a UK cohort study. *European Journal of Public Health, 32*(1), 35-40.

Thaivalappil, A., Young, I., & Papadopoulos, A. (2024). More Than a Framework? Applying Socioecological Models Within Mental Health and Community Psychology Inquiries. *Canadian Journal of Community Mental Health, 43*(3), 37-45.

Them.us. (2025, July 18). *Trump administration's global rollback of LGBTQ rights harms HIV/AIDS fight in Africa.* Them.us.https://www.them.us/story/trump-administration-anti-lgbtq-africa-global-hiv-aids

Thornicroft, G., Bisoffi, G., De Salvia, D., & Tansella, M. (1993). Urban-rural differences in the associations between social deprivation and psychiatric service utilisation in schisophrenia and all diagnoses: a case-register study in Northern Italy. *Psychological Medicine, 23*(2), 487-496.

Torres Sanches, A., Park, A. L., Chu, W., Letamendi, A., Stanick, C., Regan, J., & Chorpita, B. F. (2022). Supporting the mental health needs of underserved communities: A qualitative study of barriers to accessing community resources. *Journal of Community Psychology.*

Ungar, M., & Theron, L. (2020). Resilience and mental health: How multisystemic processes contribute to positive outcomes. *The Lancet Psychiatry, 7*(5),441-448.

United Nations Children's Fund. (2021). *Defining social norms and related concepts*. https://www.unicef.org/media/111061/file/Social-norms-definitions-2021.pdf

United Nations. (2006). *Convention on the Rights of Persons with Disabilities.* https://www.un.org/disabilities/documents/convention/convoptprot-e.pdf

United Nations. (2015). *Transforming Our World: The 2030 Agenda for Sustainable Development.* New York: UN Publishing. https://sdgs.un.org/2030agenda

Vadivel, R., Shoib, S., el Halabi, S., el Hayek, S., Essam, L., Gashi Bytyçi, D., Karaliuniene, R., Schuh Teixeira, L., Nagendrappa, S., Ramalho, R., Ransing, R., Pereira-Sanches, V., Jatchavala, C., Adiukwu, F. N., & Kudva Kundadak, G. (2021). Mental health in the post-COVID-19 era: Challenges and the way forward. *General Psychiatry, 34*(1).

Valentine, S. E., & Shipherd, J. C. (2018). A systematic review of social stress and mental health among transgender and gender non-conforming people in the United States. *Clinical Psychology Review, 66*, 24-38.

van Rensburg, A. J., & Brooke-Sumner, C. (2025). How people-centred is South Africa's mental health system? An integrative review of research from 2011 to 2024. South African Health Review, 27, 2-29.

Van Spijker, B. A., Salinas-Peres, J. A., Mendosa, J., Bell, T., Bagheri, N., Furst, M. A., & Salvador-Carulla, L. (2019). Service availability and capacity in rural mental health in Australia: Analysing gaps using an Integrated Mental Health Atlas. *Australian & New Sealand Journal of Psychiatry, 53*(10), 1000-1012.

Ventriglio, A., Castaldelli-Maia, J. M., Torales, J., De Berardis, D., & Bhugra, D. (2021). Homophobia and mental health: A scourge of modern era. *Epidemiology and Psychiatric Sciences, 30*, e52.

Vergunst, R. (2018). From global-to-local: rural mental health in South Africa. *Global HealthAction, 11*(1).

Vergunst, R., Swarts, L., Hem, K. G., Eide, A. H., Mannan, H., MacLachlan, M., Mji, G., Braathen, S.H., & Schneider, M. (2017). Access to healthcare for persons with disabilities in rural South Africa. *BMC Health Services Research, 17*(1).

Victor, C. J., & Nel, J. A. (2016). Lesbian, gay, and bisexual clients' experience with counselling and psychotherapy in South Africa: Implications for affirmative practice. *South African Journal of Psychology*, *46*(3), 351-363.

Vidourek, R. A., & Burbage, M. (2019). Positive mental health and mental health stigma: A qualitative study assessing student attitudes. *Mental Health & Prevention, 13*, 1-6.

Visagie, S., & Schneider, M. (2014). Implementation of the principles of primary health care in a rural area of South Africa. *African Journal of Primary Health Care and Family Medicine*, *6*(1), 1-10.

Vostanis, P., Haffejee, S., Mwanda, A., & O'Reilly, M. (2025). Youth-led mental health promotion in South Africa. *Youth & Society, 57*(6), 958-981.

Watson, R. J., Grossman, A. H., & Russell, S. T. (2019). Sources of social support and mental health among LGB youth. *Youth & society, 51*(1), 30-48.

Webster, J. R., Adams, G. A., Maranto, C. L., Sawyer, K., & Thoroughgood, C. (2018). Workplace contextual supports for LGBT employees: A review, meta-analysis, and agenda for future research. *Human Resource Management, 57*(1), 193-210.

Westwood S. (2022). Religious-based negative attitudes towards LGBTQ people among healthcare, social care and social work students and professionals: A review of the international literature. *Health & Social Care in the Community, 30*(5), e1449-e1470.

Whitehorne-Smith, P., Lalwani, K., Martin, R., Mitchell, G., Milbourn, B., Abel, W., & Burns, S. (2024). A grounded theory exploration of the enablers and barriers of public healthcare access for people with comorbid serious mental and chronic physical illnesses in Jamaica. *Plos one, 19*(8), e0309678.

Whitton, S. W., Dyar, C., Newcomb, M. E., & Mustanski, B. (2018). Romantic involvement: A protective factor for psychological health in racially-diverse young sexual minorities. *Journal of Abnormal Psychology, 127*(3), 265-275.

Wickman, J., Mukherjee, S., Mints, A., & Northridge, J. L. (2025). A Social Ecological Approach to Identifying Barriers and Proposing Interventions at Multiple Levels to Improve Healthcare for LGBTQIA+ Youths in the United States. *Journal of Adolescent Health, 76*(6), 967-984.

Wilkinson, D. J., & Johnson, A. (2021). A systematic review of quantitative studies capturing measures of psychological and mental health for Gay and Lesbian individuals of faith. *Mental Health, Religion & Culture, 24*(9), 993-1016.

Williams, D. R., & Mohammed, S. A. (2013). Racism and health I: Pathways and scientific evidence. *American Behavioral Scientist, 57*(8), 1152-1173

Wold, B., & Mittelmark, M. B. (2018). Health-promotion research over three decades: The social-ecological model and challenges in implementation of interventions. *Scandinavian Journal of Public Health, 46*(20_suppl), 20-26.

Wolfe, H. L., Biello, K. B., Reisner, S. L., Mimiaga, M. J., Cahill, S. R., & Hughto, J. M. (2021). Transgender-related discrimination and substance use, substance use disorder diagnosis and treatment history among transgender adults. *Drug and Alcohol Dependence, 223*, 108711.

World Bank. (2020). *Rural population (% of total population) - South Africa*. World Bank.

World Economic Forum. (2011). *The Global Economic Burden of Non-communicable Diseases*. https://www.weforum.org/reports/global-economic-burden-non-communicable-diseases

World Health Organisation. (n.d. a). *Key terms and definitions in mental health*. World Health Organisation. Retrieved from: https://www.who.int/southeastasia/health-topics/mental-health/key-terms-and-definitions-in-mental-health

World Health Organisation. (n.d. b). *Mental health*. https://www.who.int/health-topics/mental-health#tab=tab_1

World Health Organisation. (2008). *mhGAP: Mental Health Gap Action Programme*. Geneva: WHO

World Health Organisation. (2013). *Mental health action plan 2013–2020.* . World Health Organisation. https://www.who.int/publications/i/item/9789241506021

World Health Organisation. (2017). De*pression and Other Common Mental Disorders: Global Health Estimates*. https://www.who.int/mental_health/management/depression/prevalence_global_health_estimates/en/

World Health Organisation. (2021). *Comprehensive mental health action plan 2013–2030*. https://www.who.int/publications/i/item/9789240031029

World Health Organisation. (2022a). *Occupational health: health workers.* https://www.who.int/news-room/fact-sheets/detail/occupational-health--health-workers

World Health Organisation. (2022b). *World mental health report: Transforming mental health for all.* https://iris.who.int/server/api/core/bitstreams/40e5a13a-fe50-4efa-b56d-6e8cf00d5bfa/content

World Health Organisation. (2022c). *World Mental Health Day 2022: Message of WHO Regional Director for Africa, Dr Matshidiso Moeti.* World Health Organisation Regional Office for Africa. https://www.afro.who.int/regional-director/speeches-messages/world-mental-health-day-2022

World Health Organization. (2025a). *Mental health atlas 2024*. World Health Organization. https://iris.who.int/server/api/core/bitstreams/5897b3c7-2848-47a7-ba22-0a7902342a81/content

World Health Organisation. (2025b). *Suicide.* https://www.who.int/news-room/fact-sheets/detail/suicide

World Health Organization & Calouste Gulbenkian Foundation. (2014). *Social determinants of mental health*. World Health Organization.

Wolvaardt, G. G., Stein, D. J., & Mumbauer, A. E. (2025). South Africa’s mental health human resources dilemma: from shortage to solution. South African Health Review, 27, 68-77.

Yearby, R. (2018). Racial disparities in health status and access to healthcare: The continuing significance of race. *American Journal of Law & Medicine, 44*(1), 31–42.

Yearby, R. (2024). The Return of Jim Crow: Government Discrimination Against Women, LGBTQIA+ Individuals, and Racial/Ethnic Minority Individuals. *American Journal of Public Health, 114*(12), 1331-1334.

Yin, R. K. (2013). Case Study Research: Design and Methods (Applied Social Research Methods) (5th ed.). SAGE, Inc.

Yin, R. K. (2018). Case Study Research and Applications: Design and Methods (6th ed.). SAGE, Inc.

Young, M. (2016). "Private vs. Public Healthcare in South Africa" Honors Theses. 2741. https://scholarworks.wmich.edu/honors_theses/2741

Zambezi, D., & Viljoen, F. (2024). Access to healthcare services for transgender people in South Africa: assessing healthcare experiences and human rights. *International Journal of Transgender Health, 25*(4), 791-803.

Zimmerman, L., Darnell, D. A., Rhew, I. C., Lee, C. M., & Kaysen, D. (2015). Resilience in community: A social ecological development model for young adult sexual minority women. *American journal of community psychology*, *55*, 179-190.

Appendices

Appendix A1: Recruitment Script English

Recruitment Script

Dear Participant

If recruited by Richie Cloete: The researcher's name is Danilo Harkers, and He is a Master's student at the Centre for Health Systems. Research & Development at the University of the Free State. He is conducting a research study exploring the perceptions of members of the LGBTQI+ community regarding access to mental health care services within their community. You are invited to participate in the study because you are part of the LGBTQIA+ Community, you are *18 or older and currently residing in the Nama-Khoi district municipality*.

If recruited by Researcher: My name is Danilo Harkers, and I am a Master's student at the Centre for Health Systems. Research & Development at the University of the Free State. I am conducting a research study exploring the perceptions of members of the LGBTQI+ community regarding access to mental health care services within their community. You are invited to participate in the study because you are part of the LGBTQIA+ Community, you are *18 or older and currently residing in the Nama-Khoi district municipality.*

If you agree, you are invited to participate in an interview at a place and time of your choosing. The interview is anticipated to take no more than 1 hour is anticipated and the interview will be audio recorded. Participation in this study is voluntary. Your identity as a participant will remain confidential during and after the study. Your identity will be held confidential through the use of pseudonyms and all data collected will be stored and only the researcher will have access to it.

If you have questions or would like to participate, please contact the researcher at 0718143121(Danilo)

Thank you for your participation.

Appendix A2: Recruitment Script Afrikaans

Werwing Script

Liewe Deelnemer

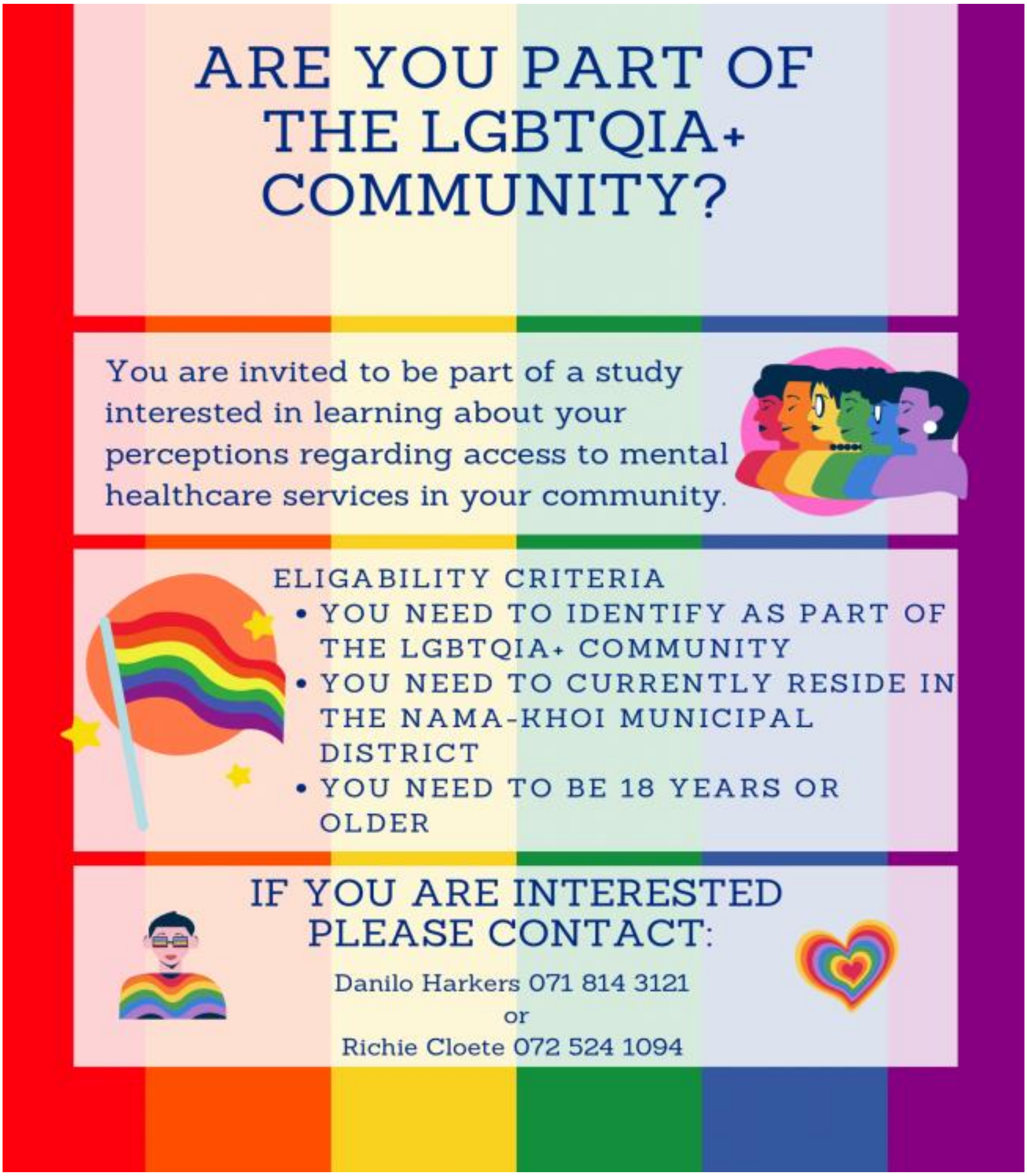
Indien deur Richie Cloete gewerf word: Die navorser se naam is Danilo Harkers, Hy is 'n Meestersgraadstudent aan "the Centre for Health Systems Research & Development" aan die Universiteit van die Vrystaat. Hy is besig met 'n navorsingstudie wat die persepsies van lede van die LGBTQI+-gemeenskap oor toegang tot geestesgesondheids dienste in hulle gemeenskap te ondersoek. Jy word dus genooi omdat jy deel is van die LGBTQIA+ gemeenskap omdat jy 18 of ouer is en omdat jy tans in die Nama-Khoi distrik municipalitiet woonagtig is.

Indien deur die navorser gewerf word My naam is Danilo Harkers, Ek is 'n Meestersgraadstudent aan "the Centre for Health Systems Research & Development" aan die Universiteit van die Vrystaat. Ek is besig met 'n navorsingstudie wat die persepsies van lede van die LGBTQI+-gemeenskap oor toegang tot geestesgesondheids dienste in hulle gemeenskap te ondersoek, en jy word uitgenooi om aan die studie deel te neem.

Indien jy belangstel, word jy genooi om deel te neem aan 'n onderhoud op 'n plek en tyd van jou keuse. Die onderhoud sal na verwagting nie meer as 1 uur neem nie en die onderhoud sal opgeneem word. Deelname aan hierdie studie is vrywillig. Jou identiteit as deelnemer sal tydens en na die studie vertroulik bly. Jou identiteit sal vertroulik gehou word deur die gebruik van skuilname en alle data wat ingesamel word, sal gestoor word en slegs die navorser sal toegang daartoe hê. Indien jy vrae het of wil deelneem, kontak asseblief die navorser by 0718143121(Danilo)

Dankie vir jou deelname.

Appendix B1: Recruitment Poster English



ARE YOU PART OF THE LGBTQIA+ COMMUNITY?

You are invited to be part of a study interested in learning about your perceptions regarding access to mental healthcare services in your community.

ELIGABILITY CRITERIA

- YOU NEED TO IDENTIFY AS PART OF THE LGBTQIA+ COMMUNITY
- YOU NEED TO CURRENTLY RESIDE IN THE NAMA-KHOI MUNICIPAL DISTRICT
- YOU NEED TO BE 18 YEARS OR OLDER

IF YOU ARE INTERESTED PLEASE CONTACT:

Danilo Harkers 071 814 3121
or
Richie Cloete 072 524 1094

Appendix B2: Recruitment Poster Afrikaans

IS JY DEEL VAN DIE LGBTQIA+ GEMEENSKAP?

Jy word genooi om deel te wees van n navorsingstudie, gemik op jou persepsie oor toegang tot geestesgesondheid dienste in jou gemeenskap

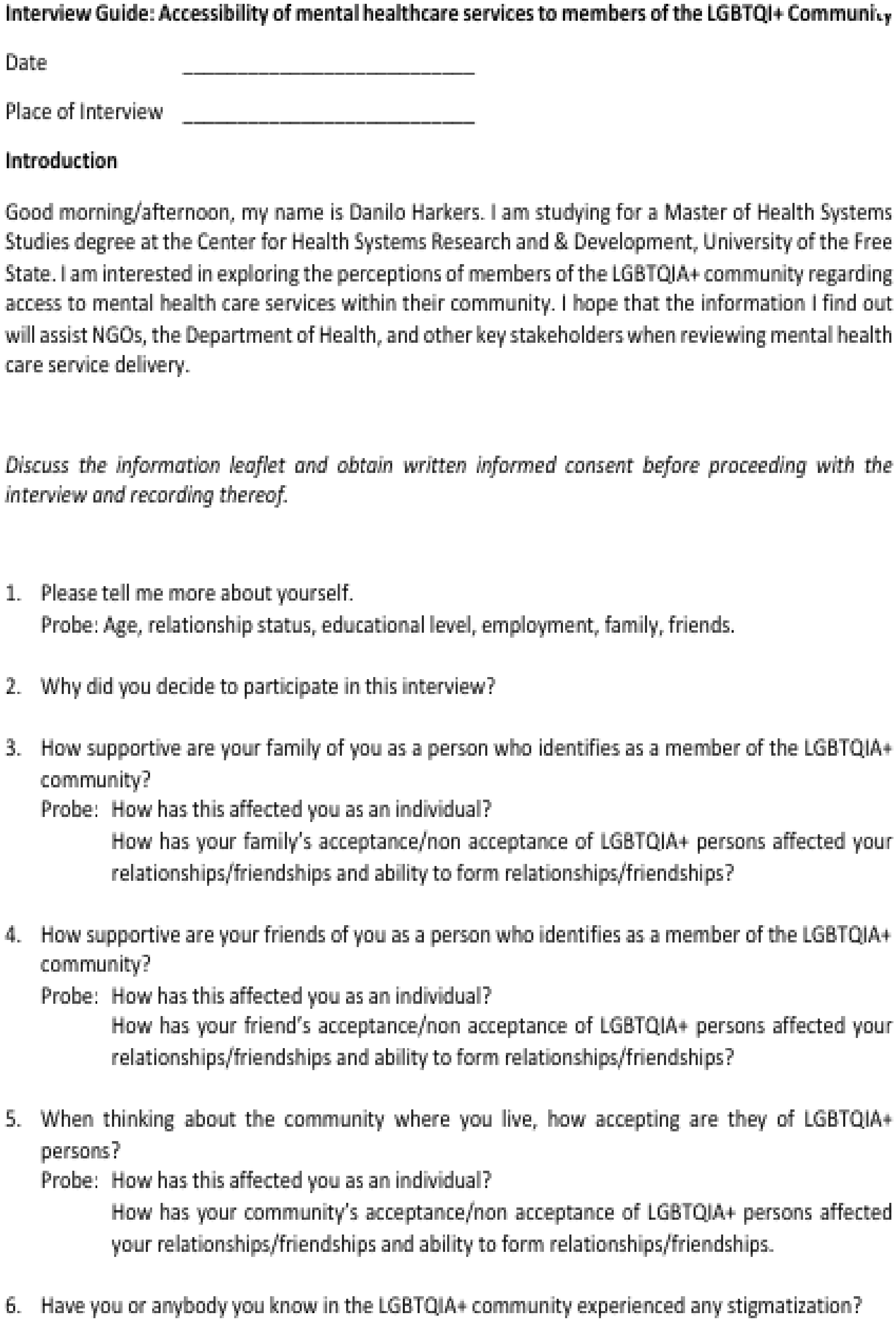
GESKIKTHEIDSKRITERIA

- JY MOET IDENTIFISEER AS DEEL VAN DIE LGBTQIA+ GEMEENSKAP
- JY MOET TANS IN DIE NAMA-KHOI MUNISIPALE DISTRIK WOONAGTIG WEES
- JY MOET 18 JAAR OF OUER WEES

AS JY BELANGSTEL KONTAK ASSEBLIEF:

Danilo Harkers 071 814 3121
or
Richie Cloete 072 524 1094

Appendix C1: Interview Guide English



Interview Guide: Accessibility of mental healthcare services to members of the LGBTQI+ Community

Date ____________________________

Place of Interview ____________________________

Introduction

Good morning/afternoon, my name is Danilo Harkers. I am studying for a Master of Health Systems Studies degree at the Center for Health Systems Research and & Development, University of the Free State. I am interested in exploring the perceptions of members of the LGBTQIA+ community regarding access to mental health care services within their community. I hope that the information I find out will assist NGOs, the Department of Health, and other key stakeholders when reviewing mental health care service delivery.

Discuss the information leaflet and obtain written informed consent before proceeding with the interview and recording thereof.

1. Please tell me more about yourself.
   Probe: Age, relationship status, educational level, employment, family, friends.

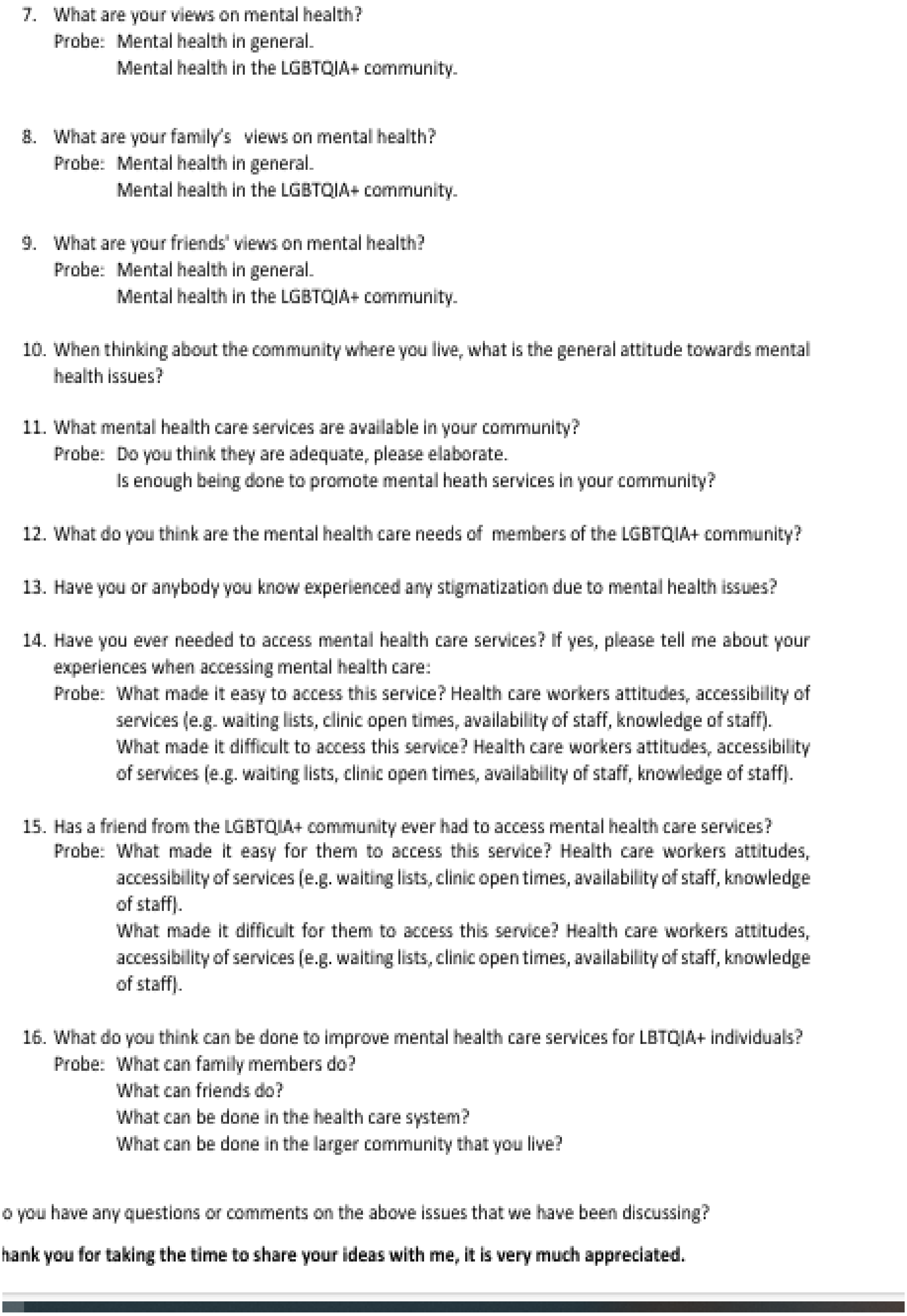
2. Why did you decide to participate in this interview?

3. How supportive are your family of you as a person who identifies as a member of the LGBTQIA+ community?
   Probe: How has this affected you as an individual?
   How has your family's acceptance/non acceptance of LGBTQIA+ persons affected your relationships/friendships and ability to form relationships/friendships?

4. How supportive are your friends of you as a person who identifies as a member of the LGBTQIA+ community?
   Probe: How has this affected you as an individual?
   How has your friend's acceptance/non acceptance of LGBTQIA+ persons affected your relationships/friendships and ability to form relationships/friendships?

5. When thinking about the community where you live, how accepting are they of LGBTQIA+ persons?
   Probe: How has this affected you as an individual?
   How has your community's acceptance/non acceptance of LGBTQIA+ persons affected your relationships/friendships and ability to form relationships/friendships.

6. Have you or anybody you know in the LGBTQIA+ community experienced any stigmatization?



7. What are your views on mental health?
   Probe: Mental health in general.
   Mental health in the LGBTQIA+ community.

8. What are your family's views on mental health?
   Probe: Mental health in general.
   Mental health in the LGBTQIA+ community.

9. What are your friends' views on mental health?
   Probe: Mental health in general.
   Mental health in the LGBTQIA+ community.

10. When thinking about the community where you live, what is the general attitude towards mental health issues?

11. What mental health care services are available in your community?
    Probe: Do you think they are adequate, please elaborate.
    Is enough being done to promote mental heath services in your community?

12. What do you think are the mental health care needs of members of the LGBTQIA+ community?

13. Have you or anybody you know experienced any stigmatization due to mental health issues?

14. Have you ever needed to access mental health care services? If yes, please tell me about your experiences when accessing mental health care:
    Probe: What made it easy to access this service? Health care workers attitudes, accessibility of services (e.g. waiting lists, clinic open times, availability of staff, knowledge of staff).
    What made it difficult to access this service? Health care workers attitudes, accessibility of services (e.g. waiting lists, clinic open times, availability of staff, knowledge of staff).

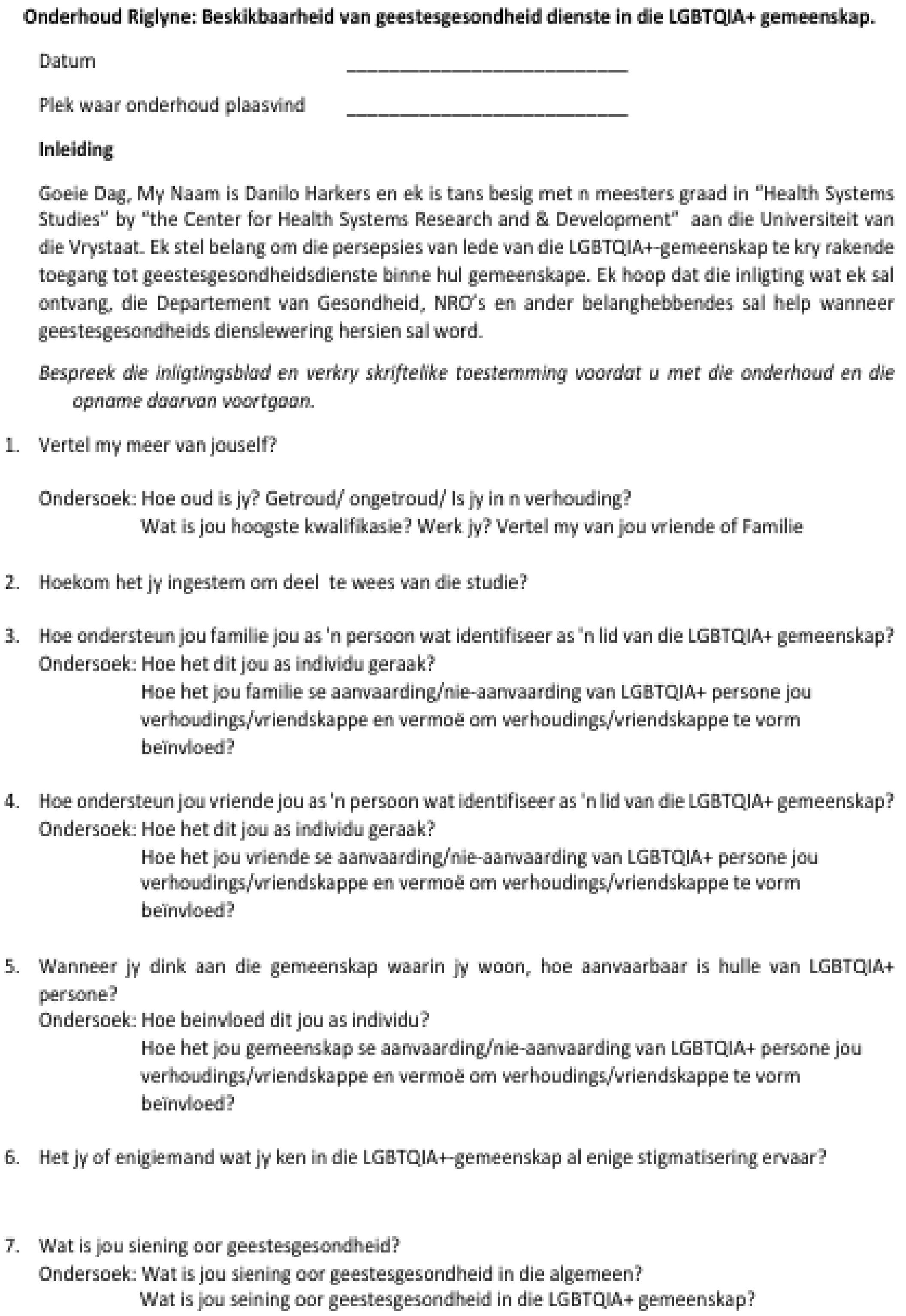
15. Has a friend from the LGBTQIA+ community ever had to access mental health care services?
    Probe: What made it easy for them to access this service? Health care workers attitudes, accessibility of services (e.g. waiting lists, clinic open times, availability of staff, knowledge of staff).
    What made it difficult for them to access this service? Health care workers attitudes, accessibility of services (e.g. waiting lists, clinic open times, availability of staff, knowledge of staff).

16. What do you think can be done to improve mental health care services for LBTQIA+ individuals?
    Probe: What can family members do?
    What can friends do?
    What can be done in the health care system?
    What can be done in the larger community that you live?

o you have any questions or comments on the above issues that we have been discussing?

hank you for taking the time to share your ideas with me, it is very much appreciated.

Appendix C2: Interview Guide Afrikaans



Onderhoud Riglyne: Beskikbaarheid van geestesgesondheid dienste in die LGBTQIA+ gemeenskap.

Datum ____________________________

Plek waar onderhoud plaasvind ____________________________

Inleiding

Goeie Dag, My Naam is Danilo Harkers en ek is tans besig met n meesters graad in "Health Systems Studies" by "the Center for Health Systems Research and & Development" aan die Universiteit van die Vrystaat. Ek stel belang om die persepsies van lede van die LGBTQIA+-gemeenskap te kry rakende toegang tot geestesgesondheidsdienste binne hul gemeenskape. Ek hoop dat die inligting wat ek sal ontvang, die Departement van Gesondheid, NRO's en ander belanghebbendes sal help wanneer geestesgesondheids dienslewering hersien sal word.

Bespreek die inligtingsblad en verkry skriftelike toestemming voordat u met die onderhoud en die opname daarvan voortgaan.

1. Vertel my meer van jouself?

   Ondersoek: Hoe oud is jy? Getroud/ ongetroud/ Is jy in n verhouding?
   Wat is jou hoogste kwalifikasie? Werk jy? Vertel my van jou vriende of Familie

2. Hoekom het jy ingestem om deel te wees van die studie?

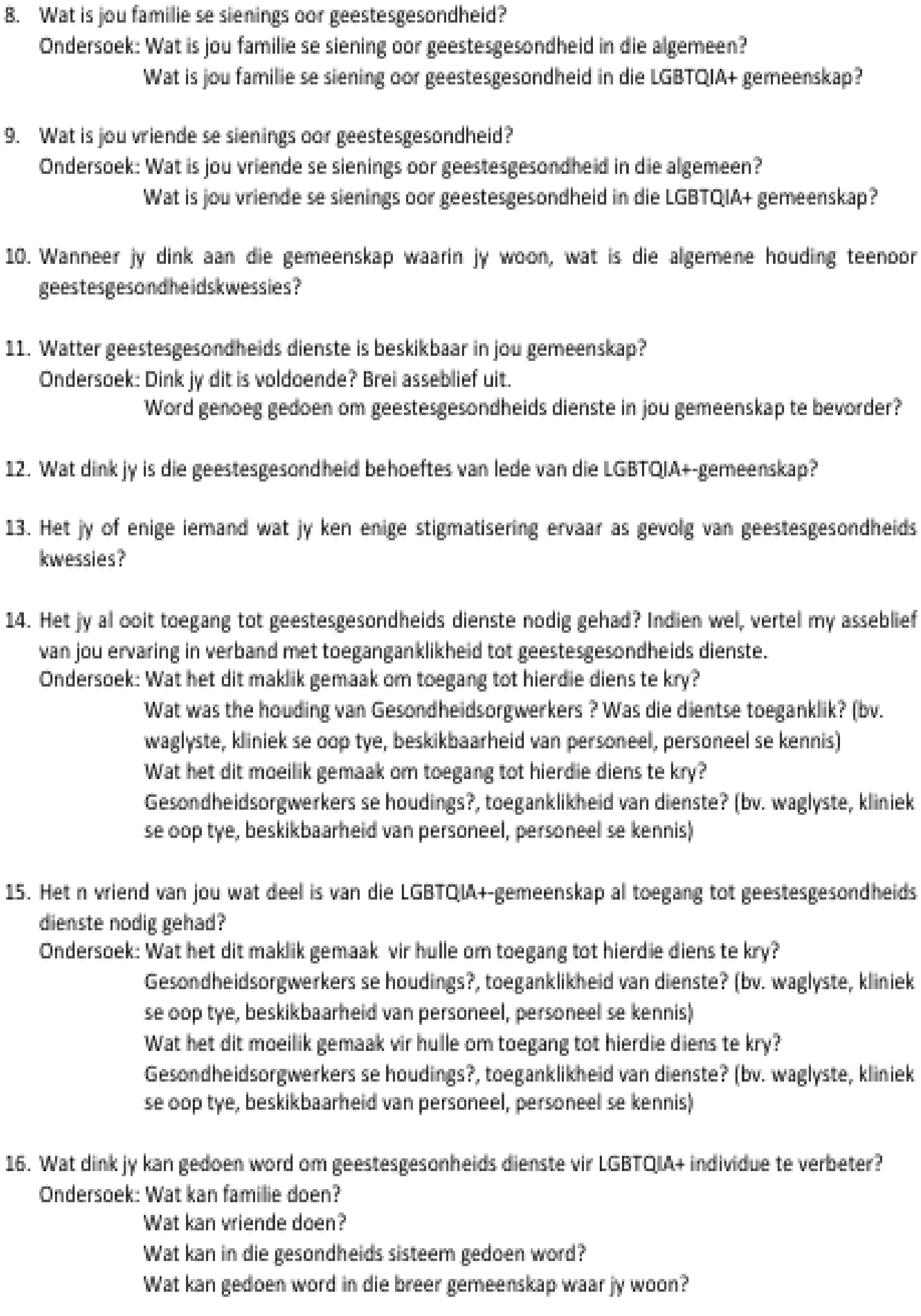
3. Hoe ondersteun jou familie jou as 'n persoon wat identifiseer as 'n lid van die LGBTQIA+ gemeenskap?
   Ondersoek: Hoe het dit jou as individu geraak?
   Hoe het jou familie se aanvaarding/nie-aanvaarding van LGBTQIA+ persone jou verhoudings/vriendskappe en vermoë om verhoudings/vriendskappe te vorm beïnvloed?

4. Hoe ondersteun jou vriende jou as 'n persoon wat identifiseer as 'n lid van die LGBTQIA+ gemeenskap?
   Ondersoek: Hoe het dit jou as individu geraak?
   Hoe het jou vriende se aanvaarding/nie-aanvaarding van LGBTQIA+ persone jou verhoudings/vriendskappe en vermoë om verhoudings/vriendskappe te vorm beïnvloed?

5. Wanneer jy dink aan die gemeenskap waarin jy woon, hoe aanvaarbaar is hulle van LGBTQIA+ persone?
   Ondersoek: Hoe beinvloed dit jou as individu?
   Hoe het jou gemeenskap se aanvaarding/nie-aanvaarding van LGBTQIA+ persone jou verhoudings/vriendskappe en vermoë om verhoudings/vriendskappe te vorm beïnvloed?

6. Het jy of enigiemand wat jy ken in die LGBTQIA+-gemeenskap al enige stigmatisering ervaar?

7. Wat is jou siening oor geestesgesondheid?
   Ondersoek: Wat is jou siening oor geestesgesondheid in die algemeen?
   Wat is jou seining oor geestesgesondheid in die LGBTQIA+ gemeenskap?



8. Wat is jou familie se sienings oor geestesgesondheid?
   Ondersoek: Wat is jou familie se siening oor geestesgesondheid in die algemeen?
   Wat is jou familie se siening oor geestesgesondheid in die LGBTQIA+ gemeenskap?

9. Wat is jou vriende se sienings oor geestesgesondheid?
   Ondersoek: Wat is jou vriende se sienings oor geestesgesondheid in die algemeen?
   Wat is jou vriende se sienings oor geestesgesondheid in die LGBTQIA+ gemeenskap?

10. Wanneer jy dink aan die gemeenskap waarin jy woon, wat is die algemene houding teenoor geestesgesondheidskwessies?

11. Watter geestesgesondheids dienste is beskikbaar in jou gemeenskap?
    Ondersoek: Dink jy dit is voldoende? Brei asseblief uit.
    Word genoeg gedoen om geestesgesondheids dienste in jou gemeenskap te bevorder?

12. Wat dink jy is die geestesgesondheid behoeftes van lede van die LGBTQIA+-gemeenskap?

13. Het jy of enige iemand wat jy ken enige stigmatisering ervaar as gevolg van geestesgesondheids kwessies?

14. Het jy al ooit toegang tot geestesgesondheids dienste nodig gehad? Indien wel, vertel my asseblief van jou ervaring in verband met toeganganklikheid tot geestesgesondheids dienste.
    Ondersoek: Wat het dit maklik gemaak om toegang tot hierdie diens te kry?
    Wat was the houding van Gesondheidsorgwerkers ? Was die dientse toeganklik? (bv. waglyste, kliniek se oop tye, beskikbaarheid van personeel, personeel se kennis)
    Wat het dit moeilik gemaak om toegang tot hierdie diens te kry?
    Gesondheidsorgwerkers se houdings?, toeganklikheid van dienste? (bv. waglyste, kliniek se oop tye, beskikbaarheid van personeel, personeel se kennis)

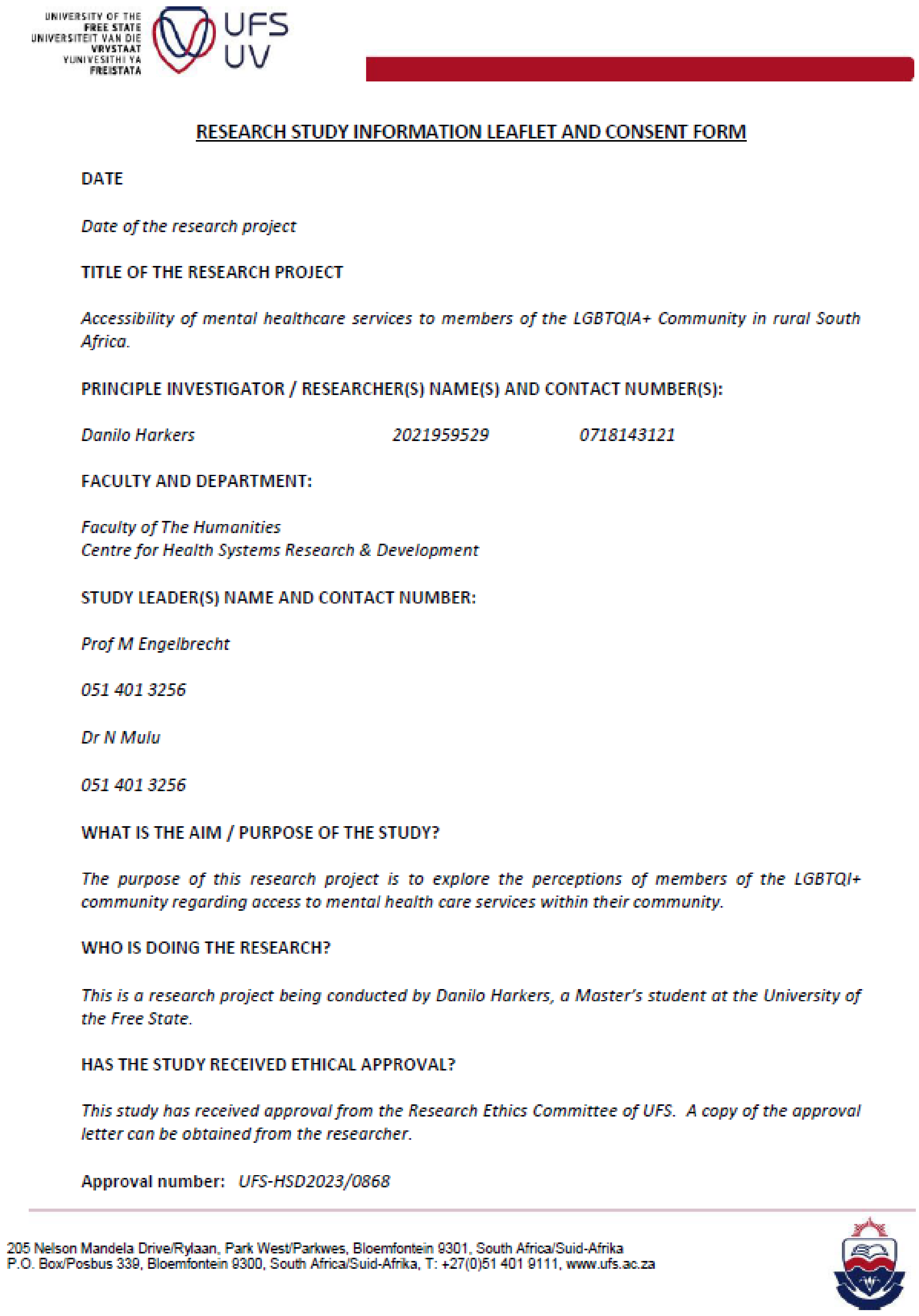
15. Het n vriend van jou wat deel is van die LGBTQIA+-gemeenskap al toegang tot geestesgesondheids dienste nodig gehad?
    Ondersoek: Wat het dit maklik gemaak vir hulle om toegang tot hierdie diens te kry?
    Gesondheidsorgwerkers se houdings?, toeganklikheid van dienste? (bv. waglyste, kliniek se oop tye, beskikbaarheid van personeel, personeel se kennis)
    Wat het dit moeilik gemaak vir hulle om toegang tot hierdie diens te kry?
    Gesondheidsorgwerkers se houdings?, toeganklikheid van dienste? (bv. waglyste, kliniek se oop tye, beskikbaarheid van personeel, personeel se kennis)

16. Wat dink jy kan gedoen word om geestesgesonheids dienste vir LGBTQIA+ individue te verbeter?
    Ondersoek: Wat kan familie doen?
    Wat kan vriende doen?
    Wat kan in die gesondheids sisteem gedoen word?
    Wat kan gedoen word in die breer gemeenskap waar jy woon?

Het jy enige vrae of opmerkings oor die bogenoemde kwessies wat ons bespreek het?

Dankie dat jy die tyd geneem het om jou idees met my te deel, dit word opreg gewaardeer.

Appendix D1: Consent Form English



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RESEARCH STUDY INFORMATION LEAFLET AND CONSENT FORM

DATE

Date of the research project

TITLE OF THE RESEARCH PROJECT

Accessibility of mental healthcare services to members of the LGBTQIA+ Community in rural South Africa.

PRINCIPLE INVESTIGATOR / RESEARCHER(S) NAME(S) AND CONTACT NUMBER(S):

Danilo Harkers	*2021959529*	*0718143121*

FACULTY AND DEPARTMENT:

Faculty of The Humanities
Centre for Health Systems Research & Development

STUDY LEADER(S) NAME AND CONTACT NUMBER:

Prof M Engelbrecht

051 401 3256

Dr N Mulu

051 401 3256

WHAT IS THE AIM / PURPOSE OF THE STUDY?

The purpose of this research project is to explore the perceptions of members of the LGBTQI+ community regarding access to mental health care services within their community.

WHO IS DOING THE RESEARCH?

This is a research project being conducted by Danilo Harkers, a Master's student at the University of the Free State.

HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This study has received approval from the Research Ethics Committee of UFS. A copy of the approval letter can be obtained from the researcher.

Approval number: *UFS-HSD2023/0868*

205 Nelson Mandela Drive/Rylaan, Park West/Parkwes, Bloemfontein 9301, South Africa/Suid-Afrika
P.O. Box/Posbus 339, Bloemfontein 9300, South Africa/Suid-Afrika, T: +27(0)51 401 9111, www.ufs.ac.za

WHY ARE YOU INVITED TO TAKE PART IN THIS RESEARCH PROJECT?

You are invited to participate in this research project because you are part of the LGBTQIA+ community, 18 or older, residing in the Nama-Khoi district municipality and your insights are valuable. You were referred to me by Richie Cloete Consultancy and approximately 10 people will be taking part in this study.

WHAT IS THE NATURE OF PARTICIPATION IN THIS STUDY?

You will be asked to engage in an interview which will take place at a venue and time of your choosing. The interview will be maximum of one hour long. The questions in the interview will focus on perceived barriers and facilitators to accessing mental health care services in your community.

CAN THE PARTICIPANT WITHDRAW FROM THE STUDY?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalised in any way.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

This research is not designed to help you personally, but the results may help the researcher learn more about how accessible mental health care is for people of the LGBTQI+ community.

WHAT IS THE ANTICIPATED INCONVENIENCE OF TAKING PART IN THIS STUDY?

All human interactions and talking about self or others carry some amount of risks. I will nevertheless minimize such risks and act promptly to assist you if you experience any discomfort, psychologically or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a Social Worker (Richie Cloete) for counselling or further assistance or intervention. If needed you can contact him on 072 524 1094

WILL WHAT I SAY BE KEPT CONFIDENTIAL?

Confidentiality will be maintained by ensuring that all information gathered from you, will be stored electronically and password coded. Your answers will be given a fictitious code number or a pseudonym, and you will be referred to in this way in the data, any publications, or other research reporting methods such as conference proceedings. Your answers may be reviewed by people responsible for making sure that research is done properly, including the transcriber, external coder, and members of the Research Ethics Committee. There will be no records that can identify you and your name will not appear in any reports, presentations or publications.

HOW WILL THE INFORMATION BE STORED AND ULTIMATELY DESTROYED?

Hard copies of your answers will be stored by the researcher for a period of five years in a locked cupboard/filing cabinet in the research supervisor's office for future research or academic purposes; electronic information will be stored on a password protected computer. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable. After a period of five years the data will be destroyed.

WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICPATING IN THIS STUDY?

You will not receive any incentive for participating in this study, however you will be reimbursed with an airtime voucher to the value of R20, for the airtime you used to contact the researcher.

HOW WILL THE PARTICIPANT BE INFORMED OF THE FINDINGS / RESULTS OF THE STUDY?

If you would like to be informed of the final research findings, please contact Danilo Harkers on 0718143121 or email: daniloharkers@gmail.com. Should you require any further information or want to contact the researcher about any aspect of this study, please contact 0718143121 or email: daniloharkers@gmail.com. Should you have concerns about the way in which the research has been conducted, you may contact Prof M Engelbrecht or Dr N Mulu at the Centre for Health Systems Research & Development, University of the Free State. Tel: 051 401 3256 or alternatively email: engelmc@ufs.ac.za or 2022049064@ufs4life.ac.za. If you have any questions regarding ethical issues, you may contact Ms Charné Vercueil at 051 -401 7083 or VercueilCC@ufs.ac.za

Thank you for taking the time to read this information sheet and for participating in this study.

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CONSENT TO PARTICIPATE IN THIS STUDY

I, the undersigned,

______________________________________ (*participant's full names to be included*), (the "**Participant**")

confirm that I voluntarily agree to participate in the research study referred to as the

____ (the **"Study"**) in relation to

____

____

and which Study is being conducted by

____

(*insert the name of the researcher*), (the "**Researcher**").

I, the undersigned Participant, further confirm that–

1. the Researcher has explained the nature, procedure, potential benefits and anticipated inconvenience of my participation in the Study;
2. I have read (or had explained to me) and understood the Study as explained in the attached information sheet;
3. I have had sufficient opportunity to ask questions and am prepared to participate in the Study;
4. I understand that my participation in the Study is entirely voluntary and that I am free to withdraw at any time without penalty (if applicable);
5. I voluntarily provide the UFS and the Researcher with my personal information and consent to the UFS and the Researcher collecting, disclosing and processing my personal information in order to conduct the Study and any related activities in relation thereto;
6. I hereby acknowledge and confirm that I understand the purpose for which the UFS and the Researcher may collect, store, use, delete, destroy, outsource, transfer or otherwise process, as the context and circumstances may require and as contemplated in terms of POPIA, my personal information as set out herein;
7. I am aware that the findings of the Study will be anonymously processed into a research report, journal publications and/or conference proceedings and that my personal information will be aggregated and deidentified at such stage;
8. I also give the UFS permission to share, without notification, the collected data with other researchers at the UFS or other Higher Education Institutions. This permission is dependent on the same principles of ethical research practices, anonymity/confidentiality, safekeeping of information, and other issues listed above applying.

I, the Participant, agree to the recording of the Semi-Structured Interview

Full Name of Participant: ____

Signature of Participant: ______________________________ Date: ________________

Full Name(s) of Researcher(s): ____

Signature of Researcher: _____________________________Date: ________________

Appendix D2: Consent Form Afrikaans

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NAVORSINGSSTUDIE-INLIGTINGSPAMFLET EN TOESTEMMINGSVORM

DATUM

Datum van navorsingsstudie

TITEL VAN DIE NAVORSINGSPROJEK

Accessibility of mental healthcare services to members of the LGBTQIA+ Community in rural South Africa.

HOOFNAVORSER/ NAVORSER(S) NAAM(E) EN KONTAKNOMMER(S):

Danilo Harkers 2021959529 0718143121

FAKULTEIT EN DEPARTEMENT:

Faculty of The Humanities
Centre for Health Systems Research & Development

STUDIELEIER(S) NAAM EN KONTAKNOMMER:

Prof M Engelbrecht

051 401 3256

Dr N Mulu

051 401 3256

WAT IS DIE DOEL VAN DIE STUDIE?

Die doel van hierdie navorsingsstudie is om die persepsies van lede van die LGBTQI+-gemeenskap rakende toegang tot geestesgesondheidsdienste in hulle gemeenskape te verken.

WIE DOEN DIE NAVORSING?

Dit is 'n navorsingsstudie wat deur Danilo Harkers, 'n Meestersgraadstudent aan die Universiteit van die Vrystaat, uitgevoer word.

HET DIE STUDIE ETIESE GOEDKEURING ONTVANG?

Hierdie studie het goedkeuring van die Navorsingsetiekkomitee van die UV ontvang. 'n Afskrif van die goedkeuringsbrief kan by die navorser gekry word.
GOEDKEURINGSNOMMER: *UFS-HSD2023/0868*

205 Nelson Mandela Drive/Rylaan, Park West/Parkwes, Bloemfontein 9301, South Africa/Suid-Afrika
P.O. Box/Posbus 339, Bloemfontein 9300, South Africa/Suid-Afrika, T: +27(0)51 401 9111, www.ufs.ac.za

WAAROM WORD JY GENOOI OM AAN HIERDIE NAVORSINGSPROJEK DEEL TE NEEM?

Jy word uitgenooi om aan hierdie navorsingsprojek deel te neem, omdat jy deel is van die LGBTQIA+ gemeenskap, omdat jy 18 of ouer is en omdat jy in die Nama-Khoi distrik munisipaliteit woonagtig is. Jou insigte is dus waardevol. Jy is deur Richie Cloete Consultancy na my verwys en ongeveer 10 mense sal aan hierdie studie deelneem.

WAT IS DIE AARD VAN DEELNAME AAN HIERDIE STUDIE?

U sal gevra word om deel te neem aan 'n onderhoud, wat op 'n plek en tyd van u keuse sal plaasvind. Die onderhoud sal maksimum een uur lank wees. Die vrae in die onderhoud sal fokus op u waargenome hindernisse en fasiliteerders tot toegang tot geestesgesondheidsdienste in u gemeenskap.

KAN EK VAN DIE STUDIE ONTTREK?

U deelname aan hierdie navorsing is heeltemal vrywillig. U kan kies om glad nie deel te neem nie. As u besluit om aan hierdie navorsing deel te neem, kan u enige tyd ophou deelneem. As u besluit om nie aan hierdie studie deel te neem nie of as u op enige tydstip ophou deelneem, sal u op geen manier gepenaliseer word nie.

WAT IS DIE POTENSIËLE VOORDELE OM AAN HIERDIE STUDIE TE NEEM?

Hierdie navorsing is nie ontwerp om u persoonlik te help nie, maar die resultate kan die navorser help om meer te wete te kom oor hoe toeganklik geestesgesondheidsorg vir mense van die LGBTQI+-gemeenskap is.

WAT IS DIE VERWAAGDE ONGERIEF OM AAN HIERDIE STUDIE DEEL TE NEEM?

Alle menslike interaksies en praat oor jouself of ander hou 'n mate van risiko's in. Ek sal nietemin sulke risikos minimaliseer en dadelik optree om u by te staan indien u enige ongemak ervaar, sielkundig of andersins tydens die proses van u deelname aan hierdie studie. Waar nodig sal 'n toepaslike verwysing na 'n maatskaplike werker (Richie Cloete) gemaak word vir berading of verdere bystand of intervensie. Kontak hom gerus op 072 524 1094

SAL WAT EK SÊ VERTROULIK GEHOU WORD?

Vertroulikheid sal gehandhaaf word deur te verseker dat alle inligting wat van u ingesamel word, elektronies gestoor en wagwoordgekodeer sal word. U antwoorde sal 'n fiktiewe kodenommer of 'n skuilnaam kry, en daar sal op hierdie manier na u verwys word in die data, enige publikasies of ander navorsingsverslagdoeningsmetodes soos konferensieverrigtinge. U antwoorde kan hersien word deur mense wat verantwoordelik is om seker te maak dat navorsing behoorlik gedoen word, insluitend die transkribeerder, eksterne kodeerder en lede van die Navorsingsetiekkomitee. Daar sal geen rekords wees wat u kan identifiseer nie en u naam sal nie in enige verslae, aanbiedings of publikasies verskyn nie.

HOE SAL DIE INLIGTING GESTOOR EN UITEINDELIK VERNIETIG WORD?

Harde kopieë van u antwoorde sal deur die navorser vir 'n tydperk van vyf jaar in 'n geslote kas/liasseerkabinet in die studieleier se kantoor gestoor word vir toekomstige navorsing of akademiese doeleindes; elektroniese inligting sal op 'n wagwoordbeskermde rekenaar gestoor word. Toekomstige gebruik van die gestoor data sal onderhewig wees aan verdere Navorsingsetiekoorsig en goedkeuring indien van toepassing. Na 'n tydperk van vyf jaar sal die data vernietig word.

SAL EK BETALING OF ENIGE AANSPORINGS ONTVANG OM AAN HIERDIE STUDIE DEEL TE NEEM?

U sal geen aansporing ontvang om aan hierdie studie deel te neem nie, maar u sal met 'n lugtydbewys ter waarde van R20 vergoed word vir die lugtyd wat u gebruik het om die navorser te kontak.

HOE SAL DIE DEELNEMER VAN DIE BEVINDINGE/RESULTATE VAN DIE STUDIE IN KENNIS GESTEL WORD?

Indien u van die finale navorsingsbevindinge ingelig wil word, kontak asseblief vir Danilo Harkers op 0718143121 of e-pos: daniloharkers@gmail.com. Indien u enige verdere inligting verlang of die navorser wil kontak oor enige aspek van hierdie studie, kontak 0718143121 of e-pos: daniloharkers@gmail.com. Indien u kommer het oor die wyse waarop die navorsing uitgevoer is, kn u vir Prof M Engelbrecht of Dr N Mulu by the Centre for Health Systems Research & Development, Universiteit van die Vrystaat, kontak Tel: 051 401 3256 of e-pos: engelmc@ufs.ac.za of 2022049064@ufs4life.ac.za. As u enige vrae het oor etiese kwessies, kan u, Mej Charné Vercueil kontak op 051 -401 7083 of e-pos VercueilCC@ufs.ac.za

Dankie dat u die tyd geneem het om hierdie inligtingstuk te lees en dat u aan hierdie studie deelgeneem het.

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TOESTEMMING OM AAN HIERDIE STUDIE DEEL TE NEEM

Ek, die ondergetekende,

____ (*deelnemer se volle name moet ingesluit word*), (die "**Deelnemer**")

bevestig dat ek vrywillig instem om deel te neem aan die navorsingstudie waarna verwys word as die (die "**STUDIE**") in verband met

____

____

en wat uitgevoer word deur
____

(*voeg die naam van die navorser in*), (die "**Navorser**").

Ek, die ondergetekende Deelnemer, bevestig dit verder dat –

1. Die Navorser het die aard, prosedure, potensiële voordele en verwagte ongerief van my deelname aan die Studie aan my verduidelik;
2. Ek het gelees (of aan my laat verduidelik) en verstaan dit soos in die aangehegte inligtingsblad verduidelik is;
3. Ek het genoeg geleentheid gehad om vrae te vra en Ek is bereid om aan die Studie deel te neem;
4. Ek verstaan dat my deelname aan die Studie heeltemal vrywillig is en dat ek vry is om enige tyd sonder boete te onttrek (indien van toepassing);
5. Ek verskaf vrywillig my persoonlike inligting aan die UV en die Navorser, en gee toestemming dat die UV en die Navorser my persoonlike inligting versamel, bekend maak en verwerk ten einde die Studie en enige verwante aktiwiteite met betrekking tot die Studie;
6. Ek erken en bevestig hiermee dat ek die doel verstaan waarvoor die UV en die Navorser my persoonlike inligting mag versamel, gebruik, skrap, vernietig, uitkontrakteer, oordra of andersins verwerk, soos die konteks en omstandighede mag vereis, en soos in terme van POPIA gebruik soos hier in uiteengesit is;
7. Ek is bewus daarvan dat die bevindinge van die Studie anoniem verwerk sal word in 'n navorsingsverslag, joernaalpublikasies en/of konferensieverrigtinge en dat my persoonlike inligting saamgevoeg en gedeidentifiseer sal word by sodanige geleentheid,
8. Ek gee ook die UV toestemming om, sonder kennisgewing, die versamelde data met ander navorsers by die UV of ander Hoër Onderwysinstellings te deel. Hierdie toestemming is afhanklik van dieselfde beginsels van etiese navorsingspraktyke, anonimiteit/vertroulikheid, veilige bewaring van inligting en ander kwessies wat hierbo gelys is, wat van toepassing is.

Ek, die Deelnemer, stem in tot die opname van die semi-gestruktureerde onderhoud

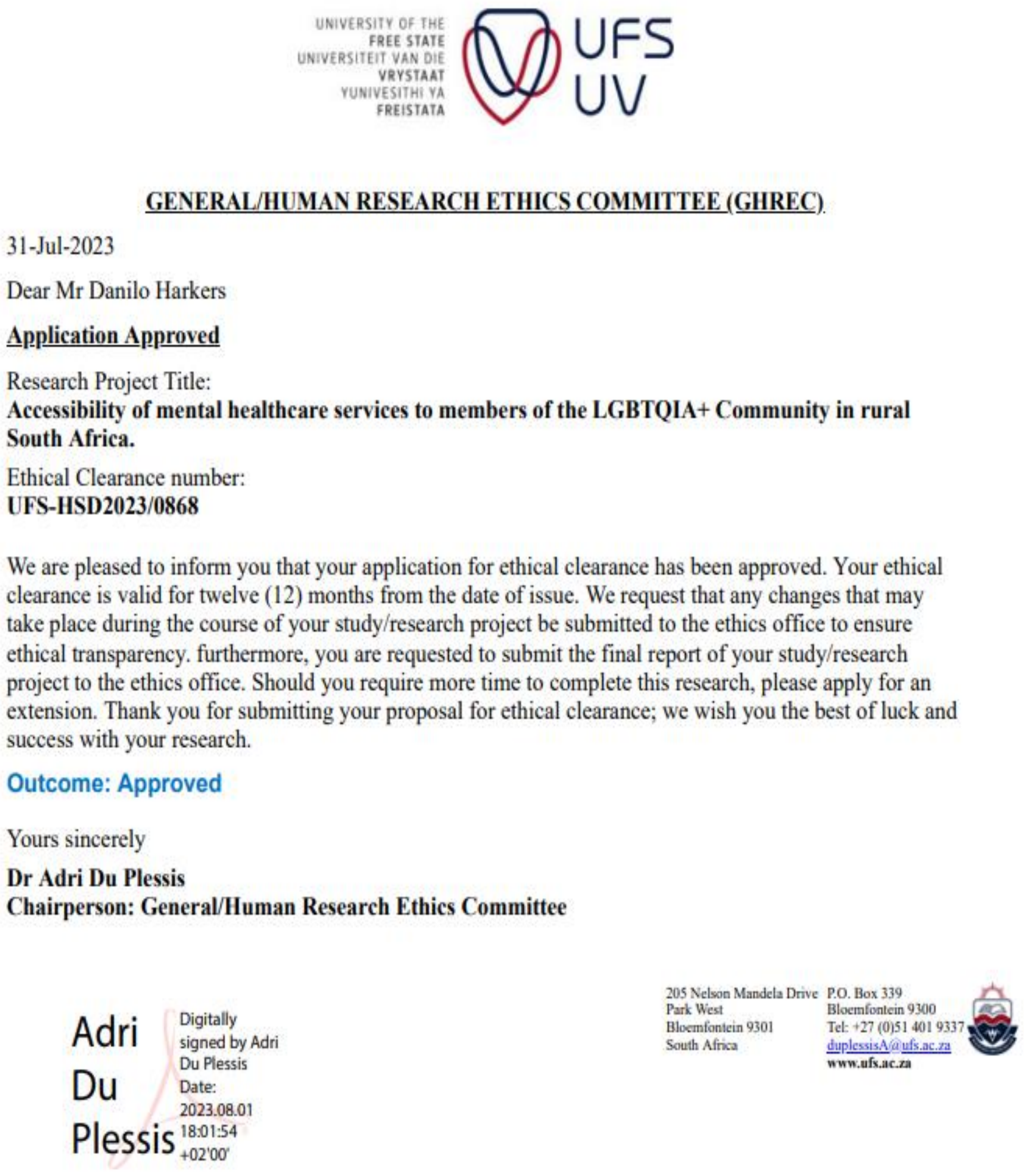
Volle Naam(e) van Deelnemer: ____

Handtekening van deelnemer: _________________________Datum: _______________

Volle Naam(e) van Navorser: ____

Handtekening van Navorser: __________________________Datum: _______________

Appendix E: Ethical Clearance



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GENERAL/HUMAN RESEARCH ETHICS COMMITTEE (GHREC)

31-Jul-2023

Dear Mr Danilo Harkers

Application Approved

Research Project Title:
Accessibility of mental healthcare services to members of the LGBTQIA+ Community in rural South Africa.

Ethical Clearance number:
UFS-HSD2023/0868

We are pleased to inform you that your application for ethical clearance has been approved. Your ethical clearance is valid for twelve (12) months from the date of issue. We request that any changes that may take place during the course of your study/research project be submitted to the ethics office to ensure ethical transparency. furthermore, you are requested to submit the final report of your study/research project to the ethics office. Should you require more time to complete this research, please apply for an extension. Thank you for submitting your proposal for ethical clearance; we wish you the best of luck and success with your research.

Outcome: Approved

Yours sincerely

Dr Adri Du Plessis
Chairperson: General/Human Research Ethics Committee

Adri Du Plessis
Digitally signed by Adri Du Plessis
Date: 2023.08.01 18:01:54 +02'00'

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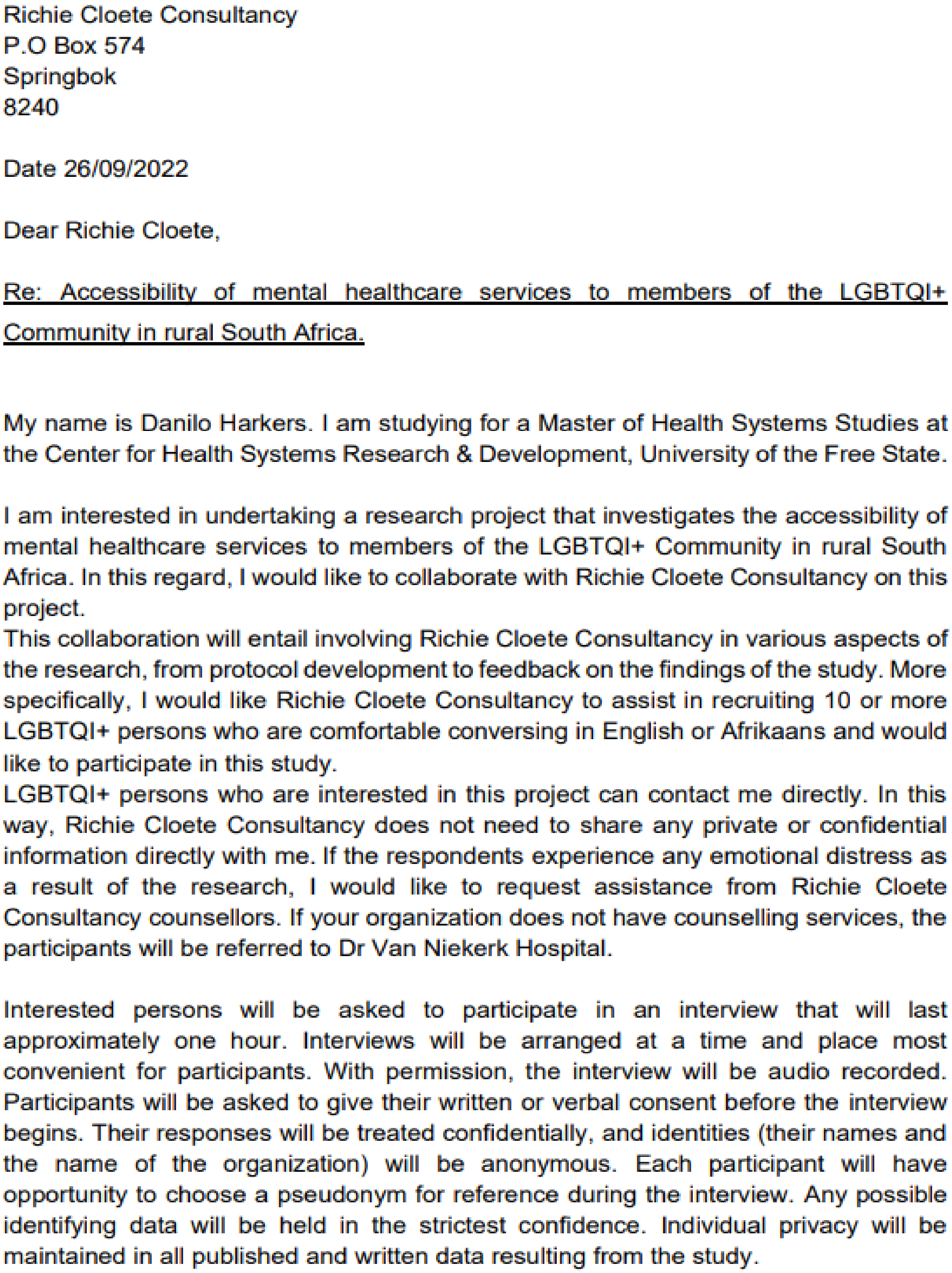
Bloemfontein 9300
Tel: +27 (0)51 401 9337
duplessisA@ufs.ac.za
www.ufs.ac.za

Appendix F: Permission Request to Richie Cloete Consultancy



Richie Cloete Consultancy
P.O Box 574
Springbok
8240

Date 26/09/2022

Dear Richie Cloete,

<u>Re: Accessibility of mental healthcare services to members of the LGBTQI+ Community in rural South Africa.</u>

My name is Danilo Harkers. I am studying for a Master of Health Systems Studies at the Center for Health Systems Research & Development, University of the Free State.

I am interested in undertaking a research project that investigates the accessibility of mental healthcare services to members of the LGBTQI+ Community in rural South Africa. In this regard, I would like to collaborate with Richie Cloete Consultancy on this project.

This collaboration will entail involving Richie Cloete Consultancy in various aspects of the research, from protocol development to feedback on the findings of the study. More specifically, I would like Richie Cloete Consultancy to assist in recruiting 10 or more LGBTQI+ persons who are comfortable conversing in English or Afrikaans and would like to participate in this study.

LGBTQI+ persons who are interested in this project can contact me directly. In this way, Richie Cloete Consultancy does not need to share any private or confidential information directly with me. If the respondents experience any emotional distress as a result of the research, I would like to request assistance from Richie Cloete Consultancy counsellors. If your organization does not have counselling services, the participants will be referred to Dr Van Niekerk Hospital.

Interested persons will be asked to participate in an interview that will last approximately one hour. Interviews will be arranged at a time and place most convenient for participants. With permission, the interview will be audio recorded. Participants will be asked to give their written or verbal consent before the interview begins. Their responses will be treated confidentially, and identities (their names and the name of the organization) will be anonymous. Each participant will have opportunity to choose a pseudonym for reference during the interview. Any possible identifying data will be held in the strictest confidence. Individual privacy will be maintained in all published and written data resulting from the study.

There are no direct benefits connected to participation. Participants are at any time free to withdraw/discontinue participation without prejudice or negative consequences.

I will apply for ethical clearance for this study from the General Human Research Ethics Committee (GHREC) at the University of the Free State. Data collection will only commence once I have obtained ethical clearance.

Please let me know if you require any further information. I look forward to your response as soon as is convenient.

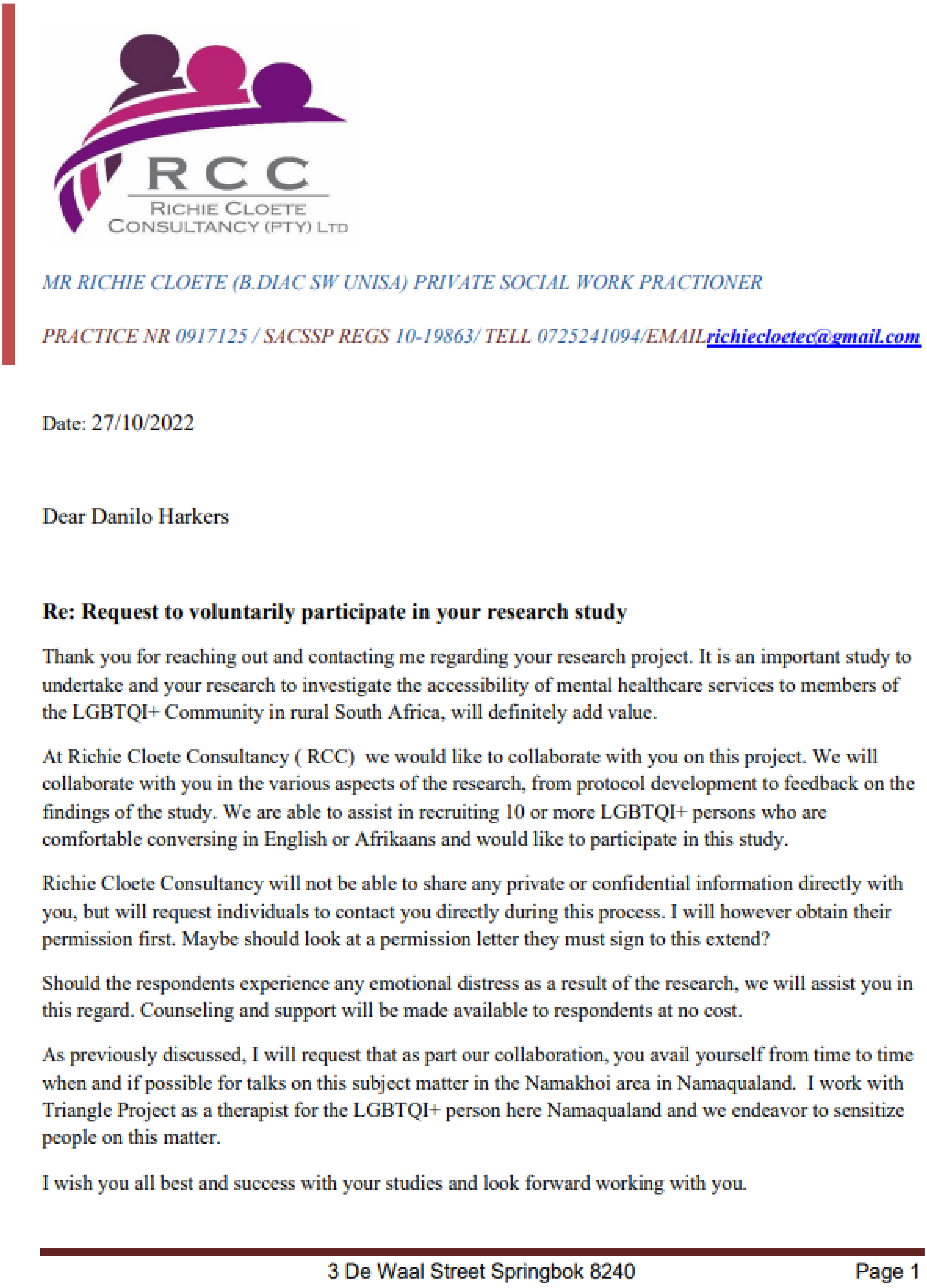
Yours sincerely,

Danilo Harkers

Danilo Harkers
071 814 3121
2021959529@ufs4life.ac.za

Prof. M Engelbrecht
054 401 3256
Engelmc@ufs.ac.za

Appendix G: Permission letter from Richie Cloete Consultancy



RCC
RICHIE CLOETE
CONSULTANCY (PTY) LTD

MR RICHIE CLOETE (B.DIAC SW UNISA) PRIVATE SOCIAL WORK PRACTIONER

*PRACTICE NR 0917125 / SACSSP REGS 10-19863/ TELL 0725241094/EMAIL**richiecloetec@gmail.com***

Date: 27/10/2022

Dear Danilo Harkers

Re: Request to voluntarily participate in your research study

Thank you for reaching out and contacting me regarding your research project. It is an important study to undertake and your research to investigate the accessibility of mental healthcare services to members of the LGBTQI+ Community in rural South Africa, will definitely add value.

At Richie Cloete Consultancy (RCC) we would like to collaborate with you on this project. We will collaborate with you in the various aspects of the research, from protocol development to feedback on the findings of the study. We are able to assist in recruiting 10 or more LGBTQI+ persons who are comfortable conversing in English or Afrikaans and would like to participate in this study.

Richie Cloete Consultancy will not be able to share any private or confidential information directly with you, but will request individuals to contact you directly during this process. I will however obtain their permission first. Maybe should look at a permission letter they must sign to this extend?

Should the respondents experience any emotional distress as a result of the research, we will assist you in this regard. Counseling and support will be made available to respondents at no cost.

As previously discussed, I will request that as part our collaboration, you avail yourself from time to time when and if possible for talks on this subject matter in the Namakhoi area in Namaqualand. I work with Triangle Project as a therapist for the LGBTQI+ person here Namaqualand and we endeavor to sensitize people on this matter.

I wish you all best and success with your studies and look forward working with you.

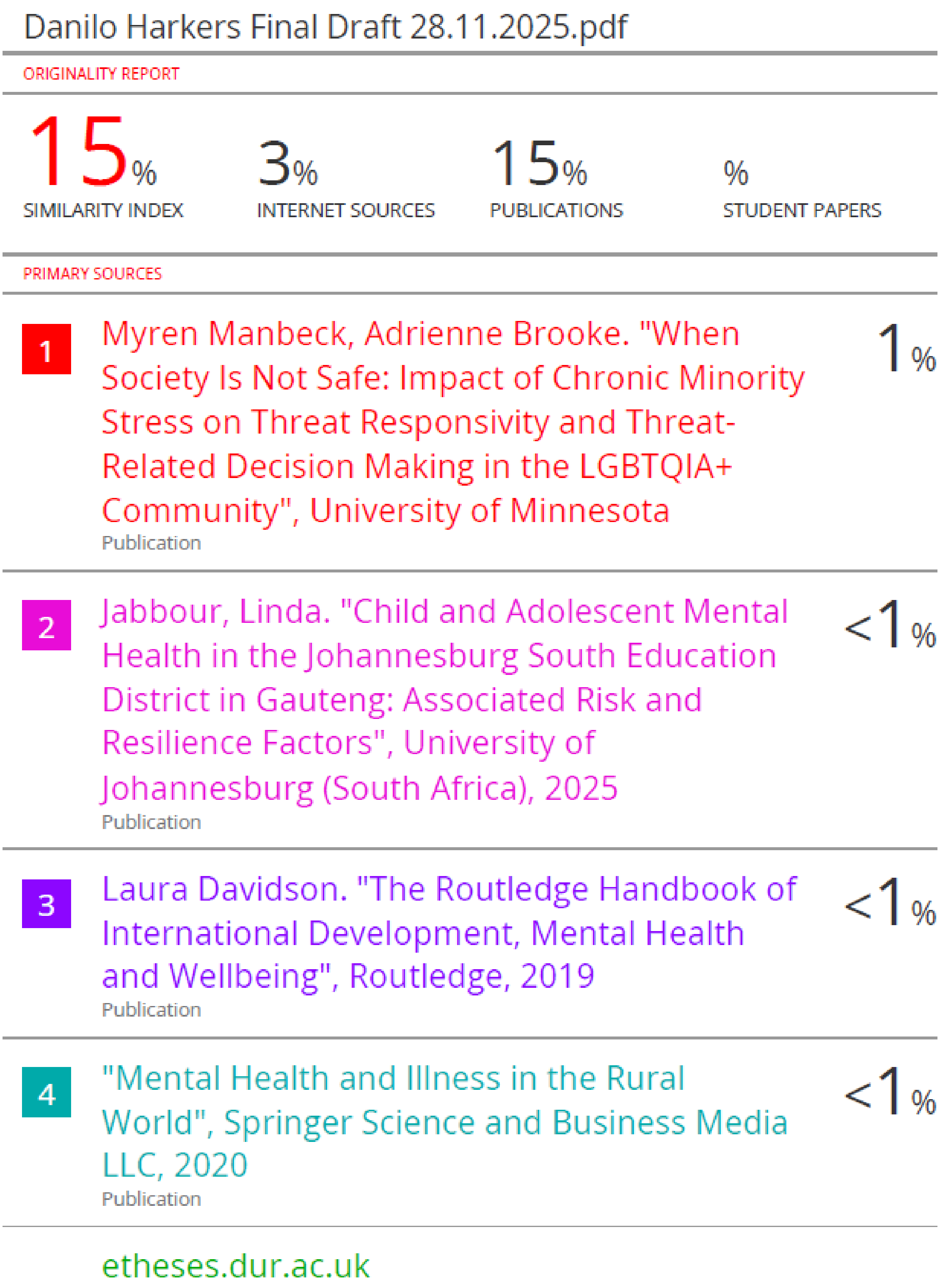
3 De Waal Street Springbok 8240 Page 1

Please do not hesitate to contact me should you have any further inquiry.

Kind regards

Richie Cloete

Appendix H: Turnitin Report



Danilo Harkers Final Draft 28.11.2025.pdf

ORIGINALITY REPORT

15%	3%	15%	%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	Myren Manbeck, Adrienne Brooke. "When Society Is Not Safe: Impact of Chronic Minority Stress on Threat Responsivity and Threat-Related Decision Making in the LGBTQIA+ Community", University of Minnesota Publication	1%
2	Jabbour, Linda. "Child and Adolescent Mental Health in the Johannesburg South Education District in Gauteng: Associated Risk and Resilience Factors", University of Johannesburg (South Africa), 2025 Publication	<1%
3	Laura Davidson. "The Routledge Handbook of International Development, Mental Health and Wellbeing", Routledge, 2019 Publication	<1%
4	"Mental Health and Illness in the Rural World", Springer Science and Business Media LLC, 2020 Publication	<1%

etheses.dur.ac.uk

Appendix I: Language Editor's Certificate

Bayswater
Bloemfontein
9301
Cell: 0631899752
elginettek@gmail.co

PROFESSIONAL LANGUAGE EDITING SERVICES

STRIVING FOR EXCELLENCE

BA- English major; BA Hons. Integrated Organisational Communication; PGCE Certificate; UCT Cert. in Copy-Editing; UFS Advanced Cert. in Labour Law

SPECIALISING IN THE LANGUAGE EDITING OF THESES, DISSERTATIONS, JOURNAL ARTICLES, PROPOSALS, POLICIES AND PUBLICATIONS.

LANGUAGE EDITING CERTIFICATE FOR MASTER'S DISSERTATION:

Danilo Harkers

Student number: 2021959529

at

University of the Free State

This is to certify that Danilo Harkers's Master's Dissertation:

Accessibility of Mental Healthcare Services to Members of the LGBTQIA+ Community in Rural South Africa

was edited for language, general layout and formatting.

The editor will not be held accountable for any changes made by the client after the document was edited. The client is free to accept or discard any changes. The editor will also not be held liable for whether or not the client passes or fails. It is the client's responsibility to review all documents before submission.

Date: 24 November 2025

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Elginette Kassim
Associate Member

Membership number: KAS002

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