systems marginalise and oppress other groups. The preceding concurs with Baines' observations that "oppression takes place when [a] person acts or [a] policy is enacted unjustly against an individual or group because of their affiliation to a specific group … includ[ing] depriving people of a way to make a fair living, to participate in all aspects of social life, or to experience basic freedoms and human rights" (Baines, 2011:2). Phrased alternatively, oppression is typified in the form of interpersonal discrimination and prejudicial policies wielded or enacted by powerful groups and institutions. Dominelli (2002) discussed the concept of 'othering' as a critical process in social oppression by which a dominant group constructs an individual or group as 'others' and, as a result, the 'other' is excluded from hierarchies of power and privilege, as those under such categorisation are viewed as inferior, powerless or even pathological.

AOP is a privilege, a viewpoint, an approach to life for those who stand for honesty, fairness, integrity and equality. It focuses on identifying, reviewing and critiquing various forms of disempowerment that certain groups exercise over others (Knauer, 2012). By investigating aspects such as group interactions, group dynamics, social constructs, and displays of oppression (e.g. classism, heterosexism, racism, homophobic standpoints, sexism, etc.) we can begin to work towards balancing and levelling the imbalance of power that is prevalent in communities. By doing so, the strength of the communities are brought to light because of the interdependency and connectedness their struggles; furthermore, the understanding of one another's privileges, power and role in society is strengthened.

Furthermore, someone suffers oppression as a result or outcome of a fundamental belief that s/he is in some way or another inferior. It is seldom the case that oppression is solely attributed to formal government exploitation or action. In psychology, racism, sexism and other prejudices are often studied as individual beliefs, which may lead to oppression if these prejudices are codified in law or become parts of a culture (Dispenza & O'Hara, 2016). By comparison, in sociology, these biases or preconceptions are often portrayed as longstanding oppressive systems prevalent in some societies. In sociology, mechanisms of oppression could be identified as progression of defamation, demonisation, belittling, and dehumanisation, which often lead to blaming and incrimination in order to justify the hostility against groups and individuals who are targeted. Although there exist many rules and regulations against this type of oppressive behaviour, much still needs to be done to free communities, especially the rural ones, from this behaviour.

Globally, the LGBT community has been (and continues to be) the victims of inadequate information and social norms and beliefs regarding their sexual orientation. Recent studies provide sound empirical confirmation of bias and prejudgment towards the LGBT community. These individuals have to live with enormous humiliation and disgrace, and at times they suffer because of homophobic infringements and assaults. The Universal Declaration of Human Rights and the notion of Human Rights in general were formulated to reduce and curb oppression through clear communication on the fundamental freedom that any system should allow to all of the people over whom it has power (Jacobs et al., 2012).

Throughout history, the oppression of virtually all minorities (women, people of colour, indigenous people, LGBTQ people, immigrants, disabled people, low-income people, children, and the elderly, to name a few) has been insidious, if not legally enforced and brutally prevalent. When certain groups are oppressed by government action, war, policies and laws, inequities are clear and visible; at other times, these inequities can be indirect and systemic. For example, when African people were stolen and forcibly brought to America as slaves; ripped from their families; not counted as human beings; victimised, mutilated and murdered; systematically disenfranchised and segregated; denied access to education, services, and legal protections, oppression was clear and visible. Today, because people of African descent have equal rights under the law (achieved less than 50 years ago with the Civil Rights Act and the Voting Rights Act', many people (and in particular white people) are reluctant to acknowledge the way that this terrible history of oppression continues to play out in society (Keepnews, 2011).

LGBT people are a branch of the AOP umbrella because heterosexism and transphobia place LGBT people into the category of the oppressed; moreover, many LGBT people carry the weight of overlapping oppressions, such as classism, racism, ableism or sexism. While establishing a hierarchy of oppressions is generally an unproductive approach, unless one has experienced forms of oppression, one cannot know what it feels like and it cannot be declared an entirely equal experience. Acknowledging intersecting oppressions and parallel struggles within any movement is important, and so it is for the LGBT movement. The systems of white supremacy, patriarchy, classism, heterosexism, transphobia, ableism, ageism, etc., create a terrible force that negatively affects all in its path – both the oppressed and the oppressors. The great diversity of the LGBT community is a cause for strength and an opportunity for unification through learning, recognition and respect – if we follow an anti-oppressive approach. In social services, it regulates any possible oppressive practices and helps in delivering welfare services in an inclusive manner. However, the LGBT community is still

suffering from oppressive practices mainly from their counterparts, families, service providers and the society at large.

The exclusion (homophobia) which results from stigma based on sexual orientation can greatly affect an individual or a system. This process is often evaluative, where the individual ends up measuring him/herself in a hierarchy against the other based on the personal values s/he holds. Disposing to this results in one's identity or trait being regarded as superior to the other, thus creating an "us-them" dynamic (othering process), resulting in division and creating risk for oppression. Social work solutions to the problems of oppressed groups must include policies that address all elements of oppression, but social workers also need to be aware that these efforts may not necessarily be supported by partners in the process of social justice (Dominelli, 2008).

2.11 Conclusion

In this chapter, the researcher examined legislation that has affected LGBT people living in South Africa. The challenges faced by LGBT communities and the government protection available to them have been investigated. While government legislation is supportive of the LGBT community, the South African society is still battling with homophobia that continues to go unpunished, and older black gay men are still harassed because of their sexuality. Furthermore, HIV/AIDS is still a prominent threat to black gay men, in particular the older black gay men from rural settings, and social stigma makes it even harder for this community to receive treatment (Itaborahy & Zhung, 2015). Notwithstanding, there have been many advances since the dark days of apartheid and immorality Acts; LGBT people are now protected, not persecuted, by the government. For most of its history, the LGBT community had to hide in the shadows, invisible to the public, but now they have the opportunity to be seen and heard, and to continue their fight for freedom and equality. However, the struggle for access to public services such healthcare services, is still far from over.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

Research methodology is more than identifying methods to collect data. It is a procedure by which researchers go about their work to describe, explain, explore and predict phenomena (Patton, 2002). In Chapter Two, existing literature was reviewed on LGBT, particularly black older gay men living with HIV/AIDS to gain a better understanding of the study topic. Following a brief overview provided in Chapter One of the thesis, Chapter Three aims to critically analyse the research process and to describe the best suited research methodology applied to this study. Detailed attention is given to the research question, the aim and objectives, the best suited approach, the study design, the target population and sample as well as the data collection procedures, reflexivity and instruments used to achieve the research aim.

3.2 Research question

According to Bryman (2004), the research question guides the investigation to focus on a narrow topic and to guide every aspect of the research project, which includes the literature review, research design, data collection, data analysis, interpretation of results, and the focus of the discussion. In this study on aging and healthcare concerns and experiences of older gay men living with HIV/AIDS, the researcher identified the following question to be answered by the end of the study:

What are the healthcare experiences and concerns of older gay men living with HIV/AIDS in a township in the Cape Metropole?

3.3 Aim of the study

The research aim, as defined by Bryman (2004), is a broad statement of desired outcomes or the general intentions of what the researcher would like to achieve. With specific reference to this current study, the aim of the researcher was to develop an in-depth understanding of aging and healthcare experiences and concerns of older black gay men living with HIV/AIDS in a selected township in the Cape Metropole. The aim was furthermore to contribute to the small body of research that currently exists regarding ageing with HIV/AIDS as a gay man in the black community.

3.4 Research objectives

People are living and aging with HIV, thanks to advancements in HIV antiretroviral medication (UNAIDS, 2014). Because of this, much more research is needed on how to care for people aging with HIV. The outcome of this research may contribute to public healthcare interventions and social care policies in South Africa. McCuen (1996) defines research objectives as the specific outcomes of a research project and should summarise what the researcher hopes to achieve. With reference to this study, the objectives of this study were identified as follows:

- To explore and describe the experiences and concerns of healthcare of older black gay men living with HIV/AIDS in a township in the Cape Metropole.
- To explore and describe cultural factors that affect the healthcare of older black gay men living with HIV/AIDS in township in the Cape Metropole.
- To explore and describe healthcare professionals' essential treatment services to the older black gay men living with HIV/AIDS in township in the Cape Metropole.
- To present recommendations for strategies that can enhance healthcare of older black gay men living with HIV/AIDS in a township in the Cape Metropole.

3.5 Research approach

The methodology used for this research was a qualitative research approach, as this approach is designed to answer questions and best reflect individuals' experiences in the context of their everyday lives. A qualitative approach was best suited to achieve the aims and objectives of this study, which, in short, were to explore and describe the healthcare concerns and experiences of HIV positive older gay men.

Quantitative research was considered not suitable for this research as it would not explore and describe the gathered information but rather provide generalisable findings that could be applied to other populations. It also provides statistical relations rather than pattern features and themes (Johnson & Christensen, 2008), which is not appropriate to this study. The rationale for this selection of research methodology was that qualitative research is inductive and it views the settings and people holistically, which is in line with the theoretical framework of this study. The qualitative research approach was considered suitable and enabled the HIV positive older gay men to explain their experiences and concerns regarding healthcare services. In qualitative research, the researcher seeks to find data that are rich and deep (D'Cruz & Jones, 2007).

The researcher furthermore applied a qualitative research approach as he sought to answer questions on healthcare concerns and experiences of older gay men living with HIV/AIDS. The quantitative method was not appropriate as this method is statistical, meaning the final report would have to contain correlations, comparisons of means, and statistically significant findings (Johnson & Christensen, 2008). This study sought to provide a narrative report on the research topic by illuminating direct quotations to provide contextual descriptions – a quantitative approach would not have provided this. A qualitative approach creates the opportunity to answer questions about complex phenomena, with the purpose of describing and understanding them from the participants' points of view. The qualitative researcher thus seeks a better understanding of a complex situation or issue (De Vos et al., 2013).

Furthermore, qualitative researchers embrace their involvement and role in the research process. Patton (2002) supports this notion, because researchers' involvement and immersion into the research is important as the real world is subject to change and therefore the researcher needs to be present to record the change, both before and after. The credibility of qualitative research is dependent on the researcher as they are the instrument (Patton, 2002). Qualitative research establishes less formal relationships with the participants than quantitative research, as participants engage in reciprocal communication styles with the researcher, explaining their responses in greater detail (Creswell, 2007). This allowed the researcher to explore certain aspects with HIV positive older gay men in more detail and created opportunity for elaboration on pertinent responses. Creswell (2007) states that by using a qualitative approach, researchers focus on determining the opinions of the participants on a specific issue. The researcher had limited knowledge on this research topic. However, the engagement with older gay men sharing their aging and healthcare experiences and concerns made a huge difference. Creswell (2007) further suggests that qualitative research holds the assumption that individuals play an active role in the construction of social reality.

The qualitative approach appeared best suited to achieve the aims and objectives of the study and to keep within the realms of the study's theoretical framework, which was AOP theory, as it is designed to answer questions and best reflect an individual's experience in the context of their everyday life. According to De Vos et al. (2008), during the interaction between the researcher and the participant, the participant's world is discovered and interpreted by means of qualitative methods. Qualitative research is applied through in-depth interviews, focus groups, observations and case studies that generate rich, detailed data which contribute to an in-depth understanding of the research problem (De Vos et al., 2008).

For the purpose of this study, the researcher used the qualitative research approach by conducting semi-structured in-depth interviews, interviewing older gay men in order to get a personal meaning and understanding of their experiences. By using this approach, the researcher was able to create a space where participants could feel free to express themselves and, in return, the researcher was able to gain an accurate understanding of this community's perceptions and experiences, which is pertinent to this study.

3.6 Research design

For this study, the researcher adopted explorative and descriptive research design, which speaks to the aim and objectives of this study. An explorative and descriptive design was deemed most applicable, as descriptive research focuses on the exploration and clarification of some phenomenon where accurate information is lacking (Babbie & Mouton, 2006). There exists little or no research on aging and healthcare concerns and experiences of HIV positive older gay men from black communities. An explorative design was followed in order to gain a better understanding of this situation, namely healthcare concerns and experiences of older gay men living with HIV/AIDS. This design was also adopted to gain new insights into the situation, phenomenon, community or individual. Explorative and descriptive research design can also be used where there is a lack of basic information on a new area of interest or to become informed with a situation to formulate a problem or develop a hypothesis.

Descriptive design examines the characteristics of a specific single population. This design was considered valid as it provides rich, meaningful descriptions of the research topic. The researcher felt it was necessary to use both exploratory and descriptive research design in order to explore and describe aging and healthcare concerns and experiences of HIV positive older gay men from the selected area. Babbie and Mouton (2006) describe research design as a blueprint of how the research will be conducted. Through explorative research design, the researcher aimed to generate new information, conduct a preliminary investigation or gain insight into the studied phenomenon and focus on the "what" questions (De Vos et al., 2008).

Babbie and Mouton (2006) explain that although explorative research design leads to insight, it may not be sufficiently descriptive; it is for this reason that descriptive research design was also integrated into this study. While explorative studies aim to generate new information, descriptive studies seek to accurately describe a phenomenon (De Vos et al., 2013). Descriptive research design is also more organised than explorative research design as it aims to attain a

deeper understanding of a phenomenon in order to gather rich data, which could inform an accurate description of the phenomenon (Babbie & Mouton, 2006).

3.7 Population and sample of the study

Patton (2002) proposes that researchers frequently draw a sample from a population, which is the group that researchers are ultimately interested in. A population refers to the entirety of elements such as people or organisations. For this study, the population were identified as older black gay men living with HIV/AIDS in the Cape Metropole area. The sampling method used was purposive sampling in order to gather information-rich cases for in-depth study (Patton, 1990). Information-rich cases enable researchers to obtain a large amount of knowledge on issues of central importance to the purpose of the research (Patton 1990), which was the intent of this study, namely to provide in-depth descriptions of experiences and concerns of older gay men living with HIV/AIDS.

3.7.1 Sample and sample size

Sample size, as indicated by Patton (1990), depends on what the researcher wants to know, the purpose of the inquiry, what is at stake, what will be useful and credible, and what can be done with the available time and resources. Patton (1990) further emphasises that there are no fixed rules for sampling size in a qualitative inquiry. Since the researcher sought to explore and describe healthcare concerns and experiences of older gay men living with HIV/AIDS, fifteen (15) older gay men were interviewed. The sample size was deemed sufficient as data were representative of the participants' experiences.

3.7.2 Sampling procedure

Sampling is the process of selecting some members (sample) from a bigger group (population) to be the basis for studying an unknown situation or information regarding the bigger group (De Vos et al., 2013). In other words, it is the process of selecting the actual research participants from the identified population to produce a sample (De Vos et al., 2013). Participants had to meet the following criteria: be gay, African, 50 years or older, HIV positive and from the area in the Cape Metropole. Telephonic contact was made with participants, who were identified through their respectively clubs. The participants also identified some of their friends whom they thought would meet the criterion. An interview meeting was scheduled with each of the participants, and the interviews were conducted. Healthcare professionals were recruited

through their operational managers and for their participation, consent was granted. Interviews were scheduled and conducted.

3.8 Data collection process

Logical arrangements were made to interview the selected participants. Face-to-face, semi-structured interviews were conducted to gain knowledge of healthcare experiences and concerns of older gay men living with HIV/AIDS, and with key informants from the healthcare sector while having an advantage to be flexible (Greeff, cited in De Vos et al., 2005). The semi-structured interviews provided the researcher with the opportunity to be flexible with the questions. An interview schedule containing open-ended questions was used as the research instrument to collect qualitative data. Demographic questions were asked at the outset to ascertain the backgrounds of the participants.

The questions for the semi-structured interview were developed in accordance with the literature study to guide the interview and to elicit individual responses from the participants – a measurement that is used to validate, support and enrich the quality of the data (Babbie & Mouton, 2002, cited in De Vos et al., 2005; Strydom & Delport, cited in De Vos et al., 2005). Interviews serve the purpose of obtaining first hand experiences, perceptions and thus views from participants, and providing an insider's perspective (emic view) of the topic. These interviews were recorded and transcribed with consent from the interviewees. A pilot study was conducted to test the measurement instrument (Strydom, cited in De Vos et al., 2005). The pilot study proved valuable because it enabled the researcher to establish the suitability of the interview schedule and make the necessary adjustments before commencing with interviewing the participants.

3.8.1 Preparation of participants

Following the guidelines of De Vos et al. (2008), the researcher, before commencement of each interview session, fully prepared the participant for the interview. As part of the preparation process, the researcher explained the purpose of the interview to the participants and placed emphasis on confidentiality and that they could withdraw at any stage during the interview. Interviews were conducted in the participants' choice of language—which was IsiXhosa for all participants—and venue to ensure that the participants felt relaxed and comfortable during the interviews. Some participants felt comfortable and preferred conducting the interviews in their own homes, while the other participants preferred an outside venue.

Permission to audio record the interview was requested from the participants before the onset of the interviews. Each participant was also informed of the nature of the research as well as other ethical considerations as stated in Chapter One (section 1.7) and the annexures. Some participants were emotional about the subject. In such a case, the interview was halted for a couple of minutes and resumed again, while some interviews had to be discontinued because of uncontrolled emotions. Nonetheless, the interview process went well, and participants contributed fully. Some participants' thoughts would drift from the purpose of the interview; the researcher would then remind them of the purpose of the interview.

3.8.2 Course of the interviews

Each interview lasted approximately 45-60 minutes, depending on how much information the participant wanted to share. The interviews were conducted in IsiXhosa, as participants only conversed in IsiXhosa. These interviews were recorded us in an audio recorder; the use of an audio recorder enabled the researcher to devote full attention to the participants and on the interview process (Babbie & Mouton, 2006). Field notes were taken during the interviews, which included the participants' non-verbal cues and pertinent points mentioned during the interview. The researcher incorporated excellent interviewing and communication skills to elicit in-depth information from the participants. This was beneficial to the process as points of interest were explored in detail.

The interview commenced with general non-threating questions (Babbie & Mouton, 2006) and questions to gather background information from participants. This was done so that rapport could be established between the researcher and the participant. The researcher then moved to more sensitive and in-depth questions. Consistent and regular clarification and reflection of responses were done in order to ensure credibility of the responses, as the researcher intended to categorise responses into themes. This also contributed to the credibility of the research.

3.8.3 Instruments used during data collection

De Vos et al. (2008) explain that an interview schedule provides the researcher with a set of predetermined questions that may be used as an appropriate instrument to engage the participant and designate the narrative terrain. Even though the interview was guided by an interview guide, questions were adapted throughout the research project. This was done to ensure all areas of interest were covered and that participants fully understood the questions asked, and that the

questions were formulated in accordance with the expected reading levels of the participants (De Vos et al., 2008).

3.9 Interview techniques

The process of interviewing is the predominant mode of data collection in qualitative research. Interviews can be conducted with individuals and/or groups, all of whom the researcher expects to have knowledge of a phenomenon and be able to contribute rich information (Kumar, 2005). After information was provided on the research by using an information sheet, semi-structured, one-on-one interviews were conducted with all the participants. Researchers use this method of interviewing to gain a detailed picture of a participant's beliefs about, or perceptions/accounts of a particular topic.

The researcher used an interview guide with predetermined questions during the semi-structured interviews. The interview was however flexible and not dictated by questions (Smith et al., 1995). The researcher asked the same questions to all participants, but the probing differed. During the interviews, the researcher made use of techniques such as probing to obtain more detail on the perceptions of the participants.

The method of data collection to elicit data from participants was individual in-depth interviews. Kumar (2005) defines an interview as any person-to-person interaction between two or more individuals with a specific purpose in mind. Interviews can be considered either flexible or inflexible. For the purpose of this study, flexible semi-structured in-depth interviews were conducted with the participants. The interviewing approach that the researcher used was the interview guide – a list of questions was compiled, still allowing the freedom to formulate questions as they came to mind.

By using the interview guide, questions can be developed and sequenced appropriately. The main reason for selecting this method was because participants were adult males, and it allowed the researcher the opportunity to probe, explore and ask questions that adults would be able to understand and build a conversation that was able to elucidate their experiences and how it affected them.

Kumar (2005) defines in-depth interviewing as repeated face-to-face encounters between the researcher and informants, directed towards understanding the informants' perspectives on their lives, experiences or situations as expressed in their own words. "By using this method, the older gay men were afforded the opportunity to express themselves, and this enhanced rapport

between the researcher and the older gay men, which in turn led to an accurate and thorough account of the older gay men's perspectives of their lives, experiences and situations. Each interview was unique and interesting" (Cable, 2017:53).

3.10 Data analysis method

According to Babbie (2009) and de Vos (2011), qualitative data analysis is a process that includes coding and analysing the data after it has been collected. Qualitative data analysis is also referred to as the categorisation, ordering and summarising of data to obtain answers to research questions. During the interview process, the researcher made notes of certain behaviours and non-verbal cues displayed by participants. This assisted the researcher during the transcribing and categorising of common themes. Once accuracy was confirmed, common themes were identified using thematic analysis (Braun & Clarke, 2006).

Thematic analysis is a flexible approach to analysing data; it enables patterns or themes to be identified (Braun & Clarke, 2006). It reflects reality by reporting and examining the experiences of the participants and their construction of the meaning of these experiences (Braun & Clarke, 2006). From the identified themes, sub-themes were established and correlated with the hard data, which were verbatim quotes from the participants. For the analysis of the data, the researcher applied Tesch's (2003) eight steps as described in Creswell's (2009) eight stages of data analysis. These steps were implemented as follows:

Step 1: Firstly, the researcher had to translate the interviews into English as they were conducted in IsiXhosa, and thoroughly perused each transcript a number of times, keeping in mind the notes and observations made during the interview process. This was done to gain a general sense of the information, thereby enabling the researcher to reflect on the overall meaning (Creswell, (2009).

Step 2: Secondly, the researcher immersed himself in the transcripts. Immersion is a process of becoming thoroughly familiar with the topic, which involves careful reflection and interpretation on an intuitive level as opposed to using analytical techniques. The researcher made notes of possible arising themes, thoughts and views (Creswell, 2009). This was helpful during the analysis process, as the researcher was able to identify which themes were present. The researcher applied Step 2 to all the transcripts.

Step 3: Once the researcher had studied all the data of the transcripts, notes made on the various transcripts were reviewed and clustered together. This aided the process of identifying and clustering themes of interest.

Steps 4: According to Creswell (2009), this stage is the beginning of a detailed analysis with a coding process. The notes made on the transcripts guided the process of categorising the themes. This made the process easier for the researcher when coding was done. Once themes were identified, the researcher used a colour coding method to identify themes through Atlas.ti software.

Step 5: Creswell (2009) describes this stage as the stage where researchers provide descriptive wording for the already noted topics identified in Step 3. In this study, the researcher used a colour coding method. The researcher used descriptive words to categorise topics, and each topic was colour coded accordingly. Once categories were established, data were grouped accordingly.

Step 6: During this stage, the researcher clustered and grouped the colours codes together so that categories were grouped in related codes. The list of categories was condensed to form themes and sub-themes.

Step 7: The categorisation of data into themes and sub-themes allowed the researcher to analyse and initiate discussions and arguments, using direct quotes from the older gay men, meanwhile comparing and contrasting findings to the respective existing literature.

Step 8: During the final stage, the researcher recoded the existing data (Crotty, 1998). Data verification and trustworthiness were imperative to ensure the validity of this study. After analysing the data, the researcher had to verify and authenticate the data collected. This is deliberated in the next section.

3.11 Data verification

Patton (2002) emphasises that validity and reliability are two factors which any qualitative researcher should be concerned about while designing a study – analysing results and judging the quality of the study. Validity and reliability are more for quantitative research, whereas trustworthiness is required for qualitative research. To ensure validity and reliability in the study, examining the trustworthiness of the data was crucial. Validity means the researcher checks the accuracy of the study by employing certain quantitative procedures (Creswell, 2009).

Four criteria were used to measure the trustworthiness of the data: credibility, dependability, transferability and confirmability (Creswell, 2009). Credibility seeks to answer how compatible the findings are with reality (Babbie & Mouton, 2006). To ensure credibility, a comprehensive review of literature relating to older gay men's health concerns and experiences deepened the understanding of the subject and also built a coherent justification for common themes. Secondly, participant checking was used. In-depth interviews with the participants were conducted in IsiXhosa, except for one participant who responded to the research questions in Zulu. The recorded interviews were transcribed, returned to participants to confirm accuracy, and translated to English. The use of tape recordings and transcriptions of the interviews increased the accuracy of the participants' description of experiences.

According to Krefting (1991), the authority of the researcher can also be used to ensure credibility. Dependability is met through securing the credibility of the findings (Streubert & Carpenter, 1999). This was done by providing a detailed description of the processes applied throughout study, which ensured that if the study should be repeated in the same context, using the same methods, with the same participants, similar results would be achieved (Creswell, 2009). To ensure dependability, the researcher applied the same interview schedule, research approach and methodology for all the participants.

The researcher was consistent in the type of questions asked, and where necessary, flexible in his interviewing style. This ensured that the research process maintained a level of consistency and was carried out in accordance with qualitative principles (Ulin et al., 2005). Transferability is relative and depends entirely on the degree to which salient conditions overlap or match (Crawford et al., 2000). If the findings of the research can apply to other contexts or respondents, transferability exits.

The specific context defines the findings in which they occur; therefore, the researcher does not claim that the knowledge gained in a particular context will necessarily have relevance in another context or for the same context in another timeframe. The researcher ensured transferability through providing detailed descriptions of the research methodology used during the study in Chapter Four of this document. The researcher used quotations from the transcribed interviews in the findings chapter (Chapter Four).

Literature strengthened the information provided in the quotations to ensure transferability. Purposive sampling also contributed to transferability. Through purposive sampling, the researcher purposefully selected the locations and the informants who differed from one

another, thereby maximising the range of specific information. Conformability is the need to show that data, interpretations and findings of the research are rooted in contexts, and that the participants are not figments of the researcher's imagination (D'Cruz & Jones, 2007).

Data obtained, analysed and transcribed (attached as an annexure) were available for scrutiny by the participants. Conformability is the researcher's ability to use reflexivity in identifying own personal and social positions and power issues in research (D'Cruz & Jones, 2004). To ensure conformability, Patton (2002) suggests that researchers ask themselves certain reflexive questions. In this instance, the researcher did introspection and considered several aspects that could affect conformability. This is discussed in the next section.

3.12 Self-reflexivity

Patton (2002) argues that it is of the utmost importance in qualitative research, and especially from a social constructionist paradigm point of view, that researchers recognise how their own personal experiences and background influence and affect their understanding of the topic under discussion. In this instance, the researcher is a heterosexual male conducting research with HIV positive older gay men.

The researcher kept in mind that this could affect the process and his understanding and interpretations in the process of discussions. Frankly speaking, there were times when participants felt distrust towards the researcher regardless of how best the researcher created the atmosphere of trust with the participants. This led to a lack of openness from the participants as they could not share their experiences freely. It was also challenging for the researcher to probe deeply.

After collecting and transcribing the data, the supervisor felt that more probing was required, and the researcher had to go back and probe a as much as he could. Throughout the process the researcher used reflexivity, and, in some instances, the researcher consulted with his supervisor when it was necessary. Initially, the researcher was concerned about his gender identity and his professional capacity as a social worker having an impact on the contentment of older gay men during the data collection process.

Due to the sensitivity of the topic, the researcher was concerned that the older gay men would feel interrogated, which at some stage occurred, as mentioned above, by his presence and therefore they did not openly respond during the interview process. Even for the sampling process, the researcher experienced some difficulties in recruiting participants, as one potential

participant withdrew from the process when the researcher identified himself as a heterosexual male.

The researcher decided that starting the interview without being completely open and honest with participants would affect the establishment of rapport with the participants. This is covered in the Social Work Code of Ethics. The participants were at ease and comfortable with this. With regard to the gender of the researcher, there were initial concerns that it could affect the trustworthiness of the study as it happened. In the beginning, the researcher was concerned that the older gay men would alter and adjust their responses in order to please the researcher and that the researcher would not be able to gain a true reflection of their experiences. It was evident in some instances during the interview process that there were sexuality concerns between the researcher and the participants. However, the researcher managed to apply his skills to resolve the challenge exceptionally during the second round of data collection. The researcher had to develop a questioning style that would not threaten the participants, and that would create an environment where the participants could openly express themselves. During this process, the researcher showed empathy and respect for their views, as information shared was sensitive.

This was a difficult experience for the researcher, but it was also a learning experience for the inexperienced researcher. The researcher made use of self-reflection throughout the research process to ensure emphatic responses and objectivity (Cho & Trent, 2006). Participants shared heartfelt experiences that everyone could sympathise with, and the researcher managed to empathise with the participants.

3.13 Ethics considerations

It is important to mention that the researcher had the privilege of being grounded and schooled in the code of ethics set out by the South African Council for Social Service Professions (SACSSP). The researcher is a social worker and has been working in the field for more than five years; he therefore has a thorough grounding in the importance of ethics when practicing social work.

Prior to the commencement of the research study, a proposal had to be submitted for approval to the Senate Higher Degrees Committee of the University of the Western Cape before the researcher was able to continue with the study. Once approval was obtained, the researcher sampled potential candidates to partake in the research. Informed consent was obtained from the participants and the researcher explained the research purpose, aims and objectives of the

study thoroughly, allowing time for questions and concerns to be addressed. Additionally, the participants were given an information sheet detailing the purpose, aims, objectives and research questions of the study.

Participants were required to read and sign an informed consent sheet before the commencement of the interview. Participants were assured of the principle of confidentiality and privacy. Each participant was informed that everything that was discussed during the interview would remain confidential. The older gay men were also informed that on completion of the research, recordings and transcripts would be destroyed. Participants were advised to give pseudonyms on the consent form.

Participants were informed that the interviews would be transcribed and that pseudonyms would be allocated to ensure anonymity. Anonymity was ensured by concealing the participants' identities in written and verbal reports of the results, as well as in informal discussions with the supervisor and fellow students. Beneficence was ensured by informing participants that they would not be harmed or deceived in any way and that the study would provide them with an opportunity to have their voices heard. If they did feel uncomfortable, there was the option of being referred to a counsellor and their participation was voluntary.

3.14 Conclusion

In this chapter, the researcher discussed the researcher methodology applied in this study. Chapter Three provides a comprehensive explanation of the research methodology and implementation. In discussing the research methodology, the researcher focused on the different processes followed, from planning right through to the end phases of the research. The researcher emphasised the relevancy and advantages of a qualitative approach rather than a quantitative approach. The challenges experienced during the sampling, data collection and analysis process was unpacked to provide a detailed account of the progression of the research.

CHAPTER FOUR: FINDINGS OF THE STUDY

4.1 Introduction

In this chapter, the researcher presents the findings of the data obtained from interviews conducted with older black older gay men living with HIV/AIDS in a township. The subjective experiences and concerns of this community are discussed and compared with reference to the main aim, research question and theoretical framework. The aim of this research was to explore and describe the healthcare experiences and concerns of older black gay men living with HIV/AIDS in a black township. The descriptions that emerge reflect the experiences of this community. These findings serve to illuminate the direct voices and experiences of older black gay men living with HIV/AIDS.

4.2 Demographic information

In order to provide a complete overview of the participants, a summary of their demographic information is illustrated in Table 4.1 and Table 4.2.

Table 4.1 provides an overview of the ten HIV positive older black gay male interviewees and includes the following information: pseudonym (as name), age, ethnic group, number of children, relationship status, and HIV status.

Table 4.1: Overview of the demographics of the participants

Name	Age	Ethnicity	Language	Relationship Status	Education	Employment
Nzipho	68	Black	IsiXhosa	Single	Standard 5	Old age grant
Zuko	65	Black	IsiXhosa	Single	Standard 7	Old age grant
Sithembele	59	Black	IsiXhosa	Single	Standard 7	Unemployed
Lufezo	71	Black	IsiXhosa	Single	Standard 6	Old age grant
Nxumalo	74	Black	IsiXhosa	Single	Standard 5	Unemployed
Sakhwe	69	Black	IsiXhosa	Single	Standard 4	Old age grant
Momoza	77	Black	IsiXhosa	Single	Standard 6	Old age grant
Zwempe	68	Black	IsiXhosa	Single	Standard 4	Old age grant
Zembe	70	Black	IsiXhosa	Single	Standard 8	Old age grant
James	43	Black	IsiZulu	Single	Standard 8	Employed

Table 4.2 provides an overview of the five key informants and includes the following information: pseudonym (as name), age, ethnic group, relationship status, and work experience.

Table 4.2: Overview of the demographics healthcare service providers (key informants)

Name	Age	Ethnic Group	Relationship Status	Work Experience (Years)
Mr Sakhwe	61	Black	Married	29
Ms Rumeyi	47	Black	Married	13
Mr Gwagwa	39	Black	Single	8
Ms Luphiwa	55	Black	Married	22
Ms Zondiwe	48	Black	Married	18

4.2.1 Summary of demographics

As outlined in the sampling process, participants were black older gay men living with HIV/AIDS and are from a township in the Cape Metropole. During the course of the interviews, significant common trends of similarities were discovered. The participants were mostly uneducated and without a stable income. Participants left their families in response to rejection on the basis of their sexual orientation while some left due to discrimination and anticipated homophobic attacks. Another key trend was the prevalence of poverty among participants, which is attributed to poverty-stricken backgrounds and the inability to secure employment and possibly make savings money for the fourth quarter of their lives.

In the next section, a brief overview of the background of each participant is discussed. Information relating to their circumstances and the family history are unpacked.

Zwempe

Zwempe is a 68-year-old gay man. He is single with one child from a previous heterosexual relationship. Zwempe is Zulu and IsiXhosa speaking from Kwa-Zulu Natal. He was a single child raised by his married parents. He never revealed his HIV positive status to his partner until his partner died. Zwempe is now living alone with no means of family support.

Nzipho

Nzipho is a 68-year-old gay man who speaks IsiXhosa. He is originally from the Eastern Cape. He is HIV positive. According to him he became infected at the age of 38 years. Nzipho does not have children and his parents passed on when he was still young in the rural areas of the Eastern Cape. His believes that being gay should not mean less. He believes that everyone should be equal before the law.

Zuko

Zuko is a 65-year-old HIV positive gay man. He was never married and does not have children. He was raised by his parents until he decided to move in with a friend at age 27. According to him, he experienced discrimination by his biological parents while he was still in the Eastern Cape. He says that he moved from the Eastern Cape hoping that discrimination would be better; however, it was not the case.

Lufezo

Lufezo is a 71-year-old gay man from the rural areas of the Eastern Cape. He was never married. However, he has three children from two different mothers. He is HIV positive since the age of 42. According to him, his mother, contrary to his father, was supportive towards his sexual orientation. He escaped from home due to the treatment he received from the family as a result of his sexual orientation.

Sithembele

Sithembele is a 59-year-old IsiXhosa speaking gay man. He was born in Nyanga in the Cape Metropole in the Western Cape. He was raised by his uncle who passed on when he was turning 28 years old. Sithembele was diagnosed with HIV in 2012. According to him, his uncle never had a problem with his sexuality but supported him instead. Sithembele believed that the South African system has failed the LGBT community, especially the policies regulating healthcare services. He was never married and does not have children.

Nxumalo

Nxumalo is a 74-year-old IsiXhosa speaking gay man from the rural areas of the Eastern Cape where he grew up. According to him, he left home because his family and community were not accepting of his sexual orientation and somewhat discriminatory towards him when he came out of the closet. When he moved to the Western Cape in the late 80s, he was hoping for better living and understanding of diversity in the province. However, he experienced hardships for being gay and HIV positive in a township. He lost his partner who succumbed to death because of HIV/AIDS. He neither has children nor family members to care for him during his older age.

Sakhwe

Sakhwe is a 69-year-old IsiXhosa speaking gay man. He was born in the rural areas of Umtata in the Eastern Cape and moved to the Western Cape with his parents at a tender age. His family could no longer accept him when they noticed that he was gay. He was kicked out of the family and told that he was diabolical. He is single and has one child whom he seldom sees. He is now HIV positive with the absolute minimal means of support. Neither his family nor his biological daughter provides any support.

James

James is 43 years old. He is proudly gay and has accepted his HIV positive status. He has one child, a son. According to him he never had a stable relationship in his life. He is now single, and his family washed their hands off him when he told them that he is gay. Like most older gay men, he is living alone with the only form of support from families of choice.

Zembe

Zembe is a 70-year-old IsiXhosa speaking gay man. Most of his family is in the Western Cape where he is originally from. Like most gay men, Zembe does not have children and does not have a partner. He is HIV positive. He does not have any source of income except for the older person's grant. He describes his life as a living hell as he believes that the South African Constitution has failed to address the issues affecting the LGBTI community.

Momoza

Momoza is a 77-year-old gay man. He was born in the North West province in 1941. He moved to the Eastern Cape Province in Umtata in 1947 when he was six years old. According to him, moving to the Eastern Cape was not by choice, but it was the only option left to him after both his parents passed away within a period of three months. He does not have children of his own because he was born gay and never had a relationship with the opposite sex. He considers it fortunate that his parents were no longer there to tell him to get married and have grandchildren, as is always the case in the black community. He is proudly gay and has fully accepted his HIV positive status. He never had a stable job in his life. He always worked only for a few months and then lost his job because employers opined that he did not possess the required qualifications.

For the purpose of this study, the researcher interviewed ten older gay men who are HIV positive and five healthcare service providers. The data collected from each participant during an in-depth interview were transcribed and then analysed according to Creswell's (2009)

framework for qualitative research. The researcher will now discuss the findings of the study according to themes and sub-themes, which are supported by direct quotations from the participants and also compared and contrasted with relevant literature. A summary of the themes and sub-themes that emerged in the study are depicted in table 4.2.

Table 4.3: Summary of themes and sub-themes

Themes	Sub-themes
Discrimination of HIV positive older black gay men by their families and communities	• IsiXhosa beliefs and cultural expectations that lead to discrimination
Negative healthcare experiences of HIV positive black older gay men in a township	• Ignorance and poor education of healthcare professionals • Poverty-stricken background that influences healthcare
Lack of support from families of older gay men	• Experiences of isolation – "My family rejected me a long time ago"

4.3 Theme 1: Discrimination of HIV positive older black gay men by their families and communities

The overview of this section is on the experiences and concerns of older black gay men who are HIV positive in the township, their descriptions about being older, gay, and with HIV positive status in the township, their feelings, and their individual stories. Questions were posed to unpack the abovementioned areas. The questioning did not focus entirely on negative experiences. However, what became evident from the data obtained was that most of the participants shared stories and focused on similar types of experiences, forming a trend of similar negative patterns. A common trend on discrimination of HIV positive older black gay men by their families and communities emerged from the responses as a key lesson, where five participants shared their concerns about discrimination.

4.3.1 Sub-theme: IsiXhosa beliefs and cultural expectations that lead to discrimination

Four participants lamented this discrimination in the form of a comparison – the older IsiXhosa beliefs and cultural expectations compared to the current way of living, and the urban areas to the rural areas and how it affects their lives. Participants believe that the way of life in which the community was born is extremely influential in terms of how 'being gay', 'older' and 'HIV positive' is perceived. In their explanations, the unjust and prejudicial treatment towards the older black gay men in the community is a common trend. Participants were convinced that

these acts were perpetuated by their sexuality and HIV positive status. Most participants expressed the opinion that beliefs and cultural expectations are root causes of discrimination by their community.

Zwempe, 64 year old, shared a story on how he was discriminated against and treated as less of a human being when he attended a community ceremony that was held in the neighbourhood. Zwempe was refused to share the same *isithebe* (meat serving bowel) with his heterosexual counterparts because of his sexual orientation. He believes that this act was as a result of his sexuality and HIV status for those who probably knew he was HIV positive. He was told that he could not share the serving bowel of meat with other men, but to eat alone. Zwempe is convinced that community beliefs and cultural expectations are active in the IsiXhosa speaking communities.

> *When I attended a traditional ceremony of one of my neighbours in December 2017, my neighbour's son was returning home from the bush. As per normal in our Xhosa tradition we would slaughter and make our umqombothi, meaning our traditional beer, men would eat and drink in groups according to the years they have acquired after coming back from the bush. To my surprise, the men I was supposed to sit and eat with refused to eat with me saying that they cannot allow me to share the same dish with them because I am not man enough, so I ended up sitting and eating alone. When I looked around, all the faces reflected approval that indeed I should be sitting and eating alone. I am not sure about other traditions, but the Xhosa tribe is still so primitive with toxic masculinity and patriarchal beliefs* (Zwempe).

Sakhwe, 69 years old, shared a rather negative experience that he had to go through at some stage of his life. He was forced to go through a humiliating experience where a traditional healer attempted to 'remove' his sexual orientation by 'cutting' into his skin. He was also unable to share his HIV positive status with his parents as he knew that they would discriminate against him.

> *Would you believe it when I tell you that I once was forcefully taken to the traditional healer or a fortune teller whichever way you call 'those people'. I can show you the scars all over my body. Their traditional healer had cut my skin saying that he was trying to remove the demons in my body which are associated with my sexuality. My parents passed on without knowing that I was HIV positive; I kept it to myself because I was afraid of what would have happened to me should I have disclosed my status to*

them as they always showed me how disappointed they were with me being gay (Sakhwe).

Lufezo also spoke about how he was discriminated against when he visited a public hall in Nyanga. He was humiliated by a worker distributing food parcels and made to come back the next day. Words such as "people like me will only receive parcels after everyone has received theirs" highlight how homophobia is rife in the townships.

It is very hard to be an old gay man living with HIV in the IsiXhosa culture. I remember when I went to the public service hall here in Nyanga after hearing from a friend of mine that there were food parcels given to the people with chronic illnesses prioritising those with minimal income and family support. I went there and stood in a long queue for like five hours and when it was my turn to receive the parcels the distributor who knew me from the township looked me in the face all the way down to my toes and said we cannot give you the food parcels. Before I could ask why, he told me that people like me will be called and received their parcels after everyone else has received theirs. I literally had nothing to eat at that time and I was so appalled by the fact that I had to go back home with an empty stomach and hands (Lufezo).

Two other participants highlighted how their families were disrespectful and othering of them because of their sexual orientation. Zwempe was even rejected by a young child in his community and Nzipho was made to feel 'abnormal' by his family for not having a wife and child. This is highlighted below:

Community tend to be ignorant. I remember asking my neighbour's child to accompany me to the Day Hospital, his parents could not really agree, and the boy was already refusing. I remember him mumbling something like, "I cannot be seen with you in public, people will start making conclusions about my sexuality" (Zwempe).

My family never seemed to accept me the way I am. They always made me feel like I am not normal, and I do not deserve to be treated in a normal manner just because I do not have [a]wife and kids (Nzipho).

Most participants participants had much to say about how beliefs and cultural expectations are influencing the way people ill-treat them in the rural areas of IsiXhosa speaking communities. Toxic masculinity and patriarchal beliefs contribute to the discrimination (Cho & Trent, 2006).

The participants felt that their community consists of people who are still clinging to the beliefs of the olden days and that their sexual orientation is sometimes associated with witchcraft. Below is an example of a professional nurse who made an absolutely discriminatory comment about the older gay men.

> *How can it be normal though? They are going against the will of God; this whole thing is wrong, it is not our culture. I even invite them to my church when I am helping them but just a few of them show up* (Nurse 5).

Throughout these narratives, it became clear that the participants are discriminated against by their families and communities as some participants shared that they had no choice but to hide their sexual orientation due to anticipated rejection and discrimination.

4.4 Theme 2: Negative healthcare experiences of HIV positive black older gay men in a township

This section examines negative healthcare experiences of older gay men in a township. Discussions of issues surrounding healthcare took place with participants who shared the experiences they had with healthcare professionals. This theme emerged from the frequency of narratives where participants lamented experiencing and/or witnessing negativity by healthcare professionals. This negativity was based on sexual orientation, older age, social class and HIV positive status. In detailed descriptions, participants mostly reported negative experiences of healthcare services in their community. Participants shared their experiences and concerns around healthcare services in terms of two categories: (i) what they believed was poor education of healthcare professionals about older LGBT needs, and (ii) their experience of poverty which contributes to poor healthcare in their community. Key informants were also included in this research for the purpose of triangulating and synthesising the data. What became evident from the data obtained during in-depth interviewing with the five key informants (nurses and doctors), it emerged that education on older LGBT issues is a concern. Both doctors and nurses shared how uncomfortable they felt when dealing with gay clients. Below are examples to illustrate this notion.

4.4.1 Sub-theme: Poor education and ignorance of healthcare professionals

When sharing their experiences, participants spoke about what they believe is poor education of healthcare professionals. The lack of relevant educational skills and ignorance about LGBT healthcare needs influence the way older black gay men are treated. All the participants had negative experiences with healthcare professionals. Participants are calling for what they referred to as 'sensitisation' by healthcare professionals.

A significant proportion of the older gay men indicated they would not feel comfortable being 'out' by care workers (Holt et al., 1998). Participants said they believe their identity will not be respected and they anticipate (and already received) homophobic harassment. Three participants highlighted how fearful they feel about attending the clinic run by healthcare professionals. The sexual health seeking strategies described by the participants are built around avoiding healthcare workers who are likely to harass them. For example:

> *I'm afraid that they will be homophobic and will not be able to understand how I might feel if I need to access services* (Lufezo).

> *I would feel it necessary to be something other than my true self in order to secure the support I need* (Sakhwe).

> *People are aware of us but accepting us like human beings is another story, because they don't understand what we are going through inside, so that causes a problem in terms of when we need help from them; they see us as a different thing* (Sithembele).

James shared a story about how he was treated by a nurse at the clinic. After refusing to allow him to come back and not having to queue again after he left his card at home, she started belittling him about his sexual orientation and then got security guards to remove him. It is clear that homophobia contributed to her actions.

> *I got there on time; however, the queue was already long. I survived it and got to the nurse around 2 pm. The nurse requested my clinic card; I started searching for it but could not find it. She told me to go back home and get it. And that it was up to me if I decide to return the same day or the next, but maintained that, either way I will have to start from the [back of the] queue. Seeing the long queue behind me, I begged her to help me without queuing again when I come back, she was refusing, telling me that "these 'izitabane' [gay men], like special treatment and attention". She literally*

dragged me with my clothes, she could not succeed, and she decided to call two security guys to do the job, but those guys did not force me out but just accompanied me (James).

Zuko was also made to feel inadequate when he required services:

It is so painful to be made inadequate and less human when you seek the services you are entitled to (Zuko).

A healthcare professional who was a key informant in the study explained some of her overwhelming uncertainties regarding the services rendered to older gay men. The nurse explained that at times she gets confused regarding the terminology and the choice of words to use when helping the LGBT patient. She does seem to recognise that there is a need to treat LGBT persons differently from the heterosexual clientele but is challenged with the delivery. The lack of acknowledging diversity is a concern as is evident below:

It is not always easy for me to ensure that I give them the best treatment they deserve and are entitled to. Sometimes it gets difficult for me to do my best because the LGBT patients already have the mentality that they are always bound to get discriminated [against] in healthcare. Well, sometimes, if not every time, it is not intentional. One other thing that those of us who work in LGBT healthcare sectors struggle with is the constantly changing nature of LGBT identity categories and the increasing problematizing of gender and sexual categories. For example, how do you as a man in our IsiXhosa community ask questions about sexual behavior without reifying the gender binary, i.e. do you have sex with men, while the constantly involving language and concepts of gender sexual identity can be overwhelming at times, if we do not keep up we lose the ability to connect and therefore effectively do our work. …Being able to effortlessly flow between pronouns, names and identity in conversations – being able to weave these together in a way that fully honours and respects the person in front of you (Nurse 3).

In response to their lack of understanding and ignorance towards the healthcare needs of HIV positive older gay men, nurses resorted to uniformity to treatment. They believe that all the clients are the same and should get the same medical attention and treatment. This is perpetuated by the confusion attributed to the lack of knowledge and skills about the healthcare needs of the older gay men in this community.

Nurse 1 admitted to the confusion she always finds herself in because of the lack of sufficient understanding of distinct healthcare needs of older gay men. She believes that she is not anti-gay and will do anything possible to ensure appropriate and professional conduct towards older gay men. However, uncertainties are overwhelmingly creating confusion as she always finds it difficult to know and differentiate between what is a right practice and what is a wrong practice (Emlet, 2014). She admits confusion on how to address gay patients as there is not sufficient training done by the Health Department on how to deal with LGBT patients. There are probably not many openly gay nurses in the Health Department, but openness about being gay may lead to a better understanding of the health issues of HIV positive gay men, as demonstrated in the quotes below:

> *I do not have much understanding about the older gay men as I believe I am supposed to, which is why I treat all my patients the same and regardless of their sexual orientation. I have heard from the workshops that I have recently attended that this community have different medical needs for their distinct medical conditions; therefore professionals need to possess a certain level of understanding of their challenges. I will be honest with you, I am not in any way homophobic; everyone knows that I am gay friendly. However, sometimes it gets so overwhelming because you do not know if you are doing something right or not. I always try to be friendly towards them, but I do not think I always get it right, maybe I somehow get it all wrong. I have several encounters where by my gay patients were not happy with the way I have treated them, saying that I am one of the homophobic nurses in the hospital* (Nurse 1).

Nurse 2 is a male nurse who strongly believes that no man should have sex with another man. He admits that sexual identity can sometimes be confusing to him, while his culture also affects the way he addresses gay patients as he lacks sufficient knowledge on gay healthcare needs.

> *How do you as a man in 'our IsiXhosa' community ask questions about sexual behavior without reifying the gender binary, i.e. do you have sex with men, while the constantly evolving language and concepts of gender and sexual identity can be overwhelming at times* (Nurse 2).

Sithembele, 59 years old, expressed that education about specific LGBT healthcare challenges are not sufficient in the healthcare sector. He believes that the conduct and the behavior of the professionals are perpetuated by the lack of their profession related competence. He lamented

that there is no difference between the healthcare professionals and the ordinary community people in terms of conduct, as is stated below.

> *For a long time I have allowed myself to believe that professional people are equipped enough to embrace diversity in South Africa. However, I was wrong; if you do not believe me, just pay a surreptitious visit to one of the Day Hospitals here. The professionals are behaving like ordinary and illiterate people who do not even know what sexual diversity means* (Sithembele).

In response, the nurses seem to disagree; they blame the gay men for being defensive when being asked questions that relate to their sexuality. The nurse suggesting that gay men have inferiority complexes is arguably a competence issue. Batho Pele principles are all about the "patient's rights" and they are not being upheld in this exchange.

> *You can literally just ask a gay man whether they are men or women because at times we really cannot tell, and you will get all that I have mentioned and more. They are a very sensitive and vulnerable population, I believe. Their inferiority complex is really working on them because I believe they say all this because they want to feel better about themselves, and in compensation of feeling, they are attacking by merely asking a simple question. Maybe by asking, so who are the men in this relationship of yours, they would blow it out of proportion and ask you if you have asked any other couple who have come to you with a problem before* (Nurse 4).

Most participants' narratives portray public health clinics as places where healthcare workers constantly threaten older gay men's rights to privacy and confidentiality by engaging in gossip and homophobic verbal harassment. Participants had their experiences or witnessed such harassment from healthcare professionals; while on the other hand, nurses in the excerpts below were clearly homophobic towards gay men as a whole:

> *I personally asked one man if he doesn't think having sexual intercourse with other men is the reason he keeps on coming here with the same problems. They are so prone to having anal diseases, and without a doubt it is caused by their unnatural way of having sex. God created Adam and Eve, not Adam and Adam (laughing*) (Nurse 3).

> *They get the same HIV treatment; they must be grateful for that. Maybe if I can be more knowledgeable about the life they lead, I would be a bit more understanding of their situation. But for now, I am really offering healthcare services to them because I*

am employed to do so; otherwise it is not pleasant at all for me. If possible, organise for us LGBTI awareness workshops so that we could understand their community better (Nurse 5).

Sakhwe appears to have suffered a great deal from the maltreatment at the hands of healthcare workers. This often took the form of healthcare workers' use of local derogatory slang words such as *stabane* (hermaphrodite) and *Sgezo* as well as its English equivalent (faggot). This has led to him even stop treatment, as is illustrated below:

I have stopped to engage in any community initiatives since I became everyone's laughing stock. My heterosexual male counterparts would always tease me about my sexuality, calling me names such as 'Sisi-Bhuti' which translates to 'half a man and half a woman'. I had even become a laughing stock for children and they disrespect me. My days are basic, I just coop up myself in this house, I no longer visit any healthcare institution, especially the public ones. I defaulted from my chronic illness treatment for up to a year (Sakhwe).

Three more participants highlighted their experiences of discrimination by community members and residential care staff.

After 25 years of democracy, we are still stigmatised and discriminated [against]. Sometimes I just feel like it would not be this hard for me if I was not gay because the kind of treatment that I get is not the same as my male counterparts, meaning that all the hardships are based on my sexuality (Zembe).

I have got friends but not close friends who are at the old age home here in Nyanga and I visit them at times. It is sad how poor old men are treated there. I ask one of them about going back home he told me that it's a living hell, however, its way better than staying at his home. He told me that they have to face staff members who are ignorant and not well equipped about their needs (Sithembele).

I am sitting in a wheelchair and I cannot walk, I am older, I am gay and to crown it all I am HIV positive. I have nobody but myself. Would you still have hope in life if you were to put your feet in my shoes? I feel so hopeless and helpless at the same time (Nxumalo).

Participants called for understanding of their specific healthcare needs by the healthcare service providers. They shared that it is your 'lucky day' when you are being served by a gay healthcare professional. Participants explained how this ignorance affects their routine attendance of healthcare institutions. They shared that they sometimes avoid visiting the healthcare institutions which may in turn contribute to even more suffering from a mental and physical health perspective. There are two examples of this below:

> *These people are not willing to understand us, and on top of that they are so ignorant* (Nzipho).

> *I don't think the larger society has fully accepted gay people and services for older people still lack infrastructures and sensitivity, specific to older people* (Zwempe).

4.4.2 Sub-theme: Poverty-stricken background that influences healthcare

A poverty-stricken background was also identified as one of the contributing factors to their experiences as HIV positive older gay men. Participants had a strong argument with regard to how marginalisation and sexual orientation contribute to their infringement of basic healthcare rights in their community. They felt that their struggles of securing decent employment during their young adulthood perpetuated their current financial struggles. Apartheid and the present government have not addressed poverty in the communities. Black gay men are rejected as gay and stigmatised because of their HIV positive status and are then denied opportunities to work, as economic policies of the present government has led to major unemployment. Participants demonstrated that financial instability is a major concern among older gay men in rural townships. Lifetime disparities and employment opportunities to build savings as well as discriminatory access to legal and social programmes that are traditionally established to support aging adults place older gay men at greater financial risk than their heterosexual male counterparts.

James shared that his lack of finances together with concealing his sexual identity affected healthcare service delivery to him. He believes that the attitude of healthcare professionals change when he reveals his sexual orientation and that the type of treatment received is perpetuated by one's sexuality and social class. He resorted to what he refers to as 'forced default'. James believes that he would still be on his chronic treatment (AIRVs) if it were not for the struggles he experienced with the healthcare professionals.

I am living in poverty and I am less healthy than those who are financially better off. I face barriers to receive formal healthcare and support and that is why I ended up not going to the clinic because I must always conceal my sexuality and gender identity to health providers and social service professionals (James).

A poverty-stricken background left James with no alternative but to force himself to continue seeking medical attention from public healthcare institutions. The participant expressed that his financial instabilities compelled him to continue seeking help from public healthcare institutions despite all the unsatisfactory treatment he has received for the longest time.

Other participants seemed to agree that financial instability and hardship contributed to their healthcare challenges. This is commensurate with many older South Africans who are not on a medical aid.

My health is terribly bad with all the illnesses that are associated with aging and with being HIV positive. Despite all the hardships I have had with the public institutions, I always have (and still do) relied on them for my healthcare needs because they are the only kind of medical attention I can afford (Nxumalo).

It was like very traumatic and I have seen a lot of cruelty. Financial (in)security and poverty are also the main challenges for me right now and I cannot blame anybody else but myself because at some stage of my life I assumed that I would not live to be old (Sakhwe).

They used to bring my treatment to my house but just decided to stop bringing the treatment to my place, and when I asked them they said that it is not easy to get to my place (Sithembele).

4.5 Theme 3: Lack of support from family of older gay men

For all adults, later life is known as a period of both growth and decline (Vincent, 2008). Rural and areas are known for lower overall health status and lower quality of life. This is related to lower socio-economic status and higher unemployment, which, in turn, reduces affordability of good nutrition and access to healthcare. This section illustrates aging concerns of older gay men in relation to healthcare. Questions were asked to unpack these concerns. In response to the questions, participants based their concerns on the lack of support and rejection by their families. For most participants, support from friends is the only form of support they can rely

on. This was the most emotional section of the study as the participants had to look back and share how they lost their families of origin as they face daily life struggles.

4.5.1 Sub-theme: Experiences of isolation – "My family rejected me a long time ago"

More than 70% of the participants expressed that they have fewer options of receiving informal caregiving, as some of their families rejected them when they learned of the participants being gay. Almost 75% of participants lamented rejection by their families of origin, as highlighted by Nzipho:

> *My family rejected me a long time ago, hence no contact or support, no children, and my partner of 43 years died from cancer as soon as we retired* (Nzipho).

Zembe recalled his conversation with an older heterosexual man when he said: "Unlike me, [heterosexuals] have their wife and kids around all the time". He does not have any form of family support. He stays alone in an RDP house, he defaulted his HIV treatment. He explained that he sometimes goes to bed on an empty stomach and that he is always alone, even when his health deteriorates. James stated the following:

> *We are twice as likely to be single and to live alone, and three to four times as likely to be childless. And many of us are estranged from our families of origin; we have no close relatives to lean on for help. Sadly, even the younger generation of gay men seems unwelcoming towards us* (James).

The participants mentioned that heterosexual older adults typically turn first to their spouse or children, then to their parents or siblings, next to their in-laws or their spouse's family, and eventually to friends and other informal caregivers before finally seeking professional or institutional care. Zembe painfully shared how he had been rejected by family and other sources of support:

> *I grew up without my family. Can you imagine how hard it is when you are out there trying to make it in life without your family? I chose to be part of the family that I barely knew at that time, it is not even my fault that I left home; I was forced to do so because of the treatment I received from my parents. I never felt welcomed anywhere I go, be it at home, school, church, medical institutions and all other public service institutions from being a laughing stock to being a victim* (Zembe).

Zuko concurred that he lacks family support but appears to be having a close knit group of friends: I have gained a close and caring group of friends through being gay. I have no close family and no children for help and support".

Lack of support was identified by two other participants:

> *I was chatting with a heterosexual friend of mine about our health difficulties. Although his health is not so good, at least he has all the support he needs. I told him, Mzwabantu, you have kids to wheel you around! And a wonderful wife to make sure you get a private room in the Hospital and your meals come on time. Being gay, childless, and a widower of the AIDS crisis, I told him that I may be a survivor, but I am still quite mortal. So, the question of where I would spend the end of my own fourth quarter has been on my mind more and more lately* (Lufezo).

> *I neither have children nor any family member I can identify as form of support. I only chose and rely on my friend's family for a little support, which is sometimes not there when I desperately need it the most. As I have mentioned earlier on, I do not have children of my own, which has brought a lot of 'shame' to my family especially when my parents were still alive; they believed that in our culture it's a taboo not to have a child if you are a man. They believed that a man should marry a woman and have kids* (Zuko).

4.6 Discussion of findings

In this section, the main themes are discussed. These main themes are compared and contrasted to the literature and also integrated with the theoretical framework that was deemed relevant to the focus of this study.

4.6.1 Discrimination of HIV positive older black gay men by their families and communities

As mentioned in section 4.3, what became evident from the data obtained was that most of the participants shared stories and focused on similar types of experiences, forming a trend of similar negative patterns. A common trend on discrimination of HIV positive older black gay men by their families and communities emerged from the responses as a key lesson, where five participants shared their concerns about discrimination.

4.6.1.1 IsiXhosa beliefs and cultural expectations that lead to discrimination

The results from the investigation of this section show that older gay men also experience discrimination perpetuated by the beliefs and cultural expectations which internally affect their overall wellbeing. Aside from the challenges that all older adults face, such as physical limitations and changes in socioeconomic status or relationships, older gay men confront discrimination from entities that are traditionally relied upon for support (Movement Advancement Project (2010). It is evident that older gay man experience discrimination on a daily basis. This discrimination occurs in various ways, and in some instances this is extremely harmful to older gay men. A clear example was shared by a participant who had his skin cut because the family believed his sexual orientation was diabolical. This is a true reflection of harmful cultural practices towards the older gay men in the townships.

A 2011 Administration on Aging Study found that the LGBT older adults are 20% less likely to access government services than their heterosexual peers (Movement Advancement Project (2010; Czaja et al., 2010). These findings are evident and have been the point of argue in this study as well; it also supports the arguments in this study's findings. The participants called for greater awareness of stigma as an etiologic factor that contributes to the health of rural sexual minority populations, especially when it relates to provision of culturally appropriate care.

The older gay men have suffered a great deal of ignorance from heterosexual people, which greatly affects their overall wellbeing. Culturally perpetuated discrimination was one of the main concepts spoken about by the participants, and age-related, HIV-related, and sexuality-related stigmas were all talked about throughout the course of the study. Discrimination and stigmatisation with regard to healthcare services underscore all aspects of discussion in various forms. Participants often linked these two factors with their concerns and experiences for being gay in the IsiXhosa Township. It is surprising to see that the perpetrators of these types of violence still believe that it forms part of accepted cultural practice. However, this act is against the South African law. We can generalise and say that perpetrators of harmful traditional practices are not aware of law prescript on violence towards older gay men. The findings of this study made it clear that these acts result from ignorance and are perpetuated by the traditional beliefs carried and passed on from generation to generation.

While discussing their harmful cultural practices, participants reflected on when they were still young. They shared their reasons for taking part in traditional circumcision, which include personal validation of cultural manhood, the desire to conform to societal norms and

expectations, and unnecessary pressure from family members to 'convert' them to heterosexuality. In this context, older gay men can be considered as a vulnerable group who take up the subjugated position of masculinity. This backdrop was also supported by Vincent (2008).

Among other factors, experiences and concerns around healthcare services for IsiXhosa speaking older gay men are mainly perpetuated by marginalisation and cultural beliefs. Primitivism and masculinity are factors that also emerged when participants discussed cultural beliefs (Vincent, 2008). These cultural beliefs are rooted way back and are passed down from generation to generation. IsiXhosa, an indigenous South African language, is used in this community. This language has its own derogatory terms for the older gay men, which are used maliciously to label the older gay men (Taylor, 2001). If the researcher was to describe a gay man in this vernacular, it would be, "umntu oyindoda othandana namanye amadoda" which translates to someone who likes to fall in love with other men.

Words like *Italase* are also used to talk to and about people who are gender nonconforming, particularly men. Scott-Sheldon (2013), who is a member of the Guardian Africa network, argues that we need to find new words to articulate our sexual diversity. This also emerged when a participant recalled a situation where the healthcare provider felt uncomfortable and could not find the right word or pronoun when referring to him. This takes us back to Almack and Henderson's (2016) concept, referred to as "sensitisation", and how it may contribute to improving the healthcare services provided to older gay men.

4.6.2 Negative healthcare experiences of HIV positive black older gay men in a township

Discussions of issues surrounding healthcare took place with participants who shared the experiences they had with healthcare professionals. This theme emerged from the frequency of narratives where participants lamented experiencing and/or witnessing negativity by healthcare professionals. This negativity was attributed to sexual orientation, older age, social class and HIV positive status. In elaborate descriptions, participants reported mostly negative experiences regarding healthcare services in their community.

4.6.2.1 Poor education and ignorance of healthcare professionals

Healthcare concerns and experiences have been the main talking point throughout the course of this research study. The results of the study confirm that for HIV positive older gay men, access to and receipt of proper healthcare is still the primary concern in this area. The common trends

that formed through many similar answers by respondents show that finding good healthcare can be especially challenging for this community. It is for this reason that Mfongeh (FESSUD, 2010) in his study on challenges to service delivery, argues for the cultural competence of healthcare professionals as essential requirement in order to enhance specific needs of older gay men in rural areas.

Ignorance in healthcare services had (and still has) an immense impact on older gay men, much more than we would ever have imagined. In townships, ignorance is rooted way back. However, the older gay men have survived this marginalisation. Not only do older gay men who are HIV positive face difficulties accessing high quality end-of-life care, they also face issues in terms of their daily care. This study has clearly shown the difficulties and issues faced by older gay men who are HIV positive can be attributed to ignorance and prejudice by healthcare workers. It is furthermore because of poor communication between older gay men and healthcare service providers regarding treatment plans, and judgment by staff on their relationships. These difficulties have intensified to such an extent that many older gay men experience victimisation, discrimination and personal hardships at the hands of healthcare service providers because of their sexuality throughout their lives. This is contrary to Anti-Oppressive Practice (AOP), which is embedded in social work and rooted in ending socioeconomic oppression (Earnshaw & Chaudoir, 2009). These practices and difficulties are a violation of the human rights as prescribed in the South African Constitution of 1994, which includes humans' understanding of the world as experienced by themselves and by those with whom they work. However, this study found that professionals are mostly regulated by what the UNDP and USAID (2009) refer to as culturally accepted practice, which, in most cases is totally against what the law prescribes in terms of LGBT rights. As vulnerable as they are, older gay men are still treated unfairly and discriminated against by the healthcare providers who are supposed to be a source of support to them.

The AOP theory focuses on social differences. However, these differences arise because of disparities of power between the dominant and the dominated social groups. The UNDP and USAID (2009) argue that these major divisions are described in terms of race, gender, class, sexual preference, disability and age. Other differences such as mental health and single parenthood exist and interact with the major divisions, making the understanding and experience of oppression a complex matter. The UNDP and USAID (2009) continue to argue that the anti-oppressive principle of reflexivity demands that workers continually consider the ways in which their own social identity and values affect the information they gather.

Study results vary on whether older gay men, particularly those who are HIV positive, have less access to quality healthcare than their heterosexual counterparts. However, this study found that HIV positive older gay men from the Cape Metropole geographical area are still faced with a number of unresolved challenges regarding their healthcare needs. This was also postulated by Fredriksen-Goldsen et al. (2014), who indicated that older gay men from rural townships have lived through and survived the criminalisation and pathologisation of their sexual identity by their social and healthcare practitioners. The findings of this study show that the healthcare services' related challenges are mostly perpetuated by ignorance and poor educational skills displayed by healthcare professionals towards their older gay male patients.

As a result of such challenges, certain individuals of this community remained uncertain whether or not to reveal their sexual identities to their healthcare service providers. A majority of medical professionals report that they have encountered derogatory comments made about LGBT patients by other professionals or witnessed below average care (Keepnews, 2011). As a result, LGBT older adults are five times less likely to access health services (Keepnews, 2011). The lack of comfort with revealing sexual orientation in response to anticipated prejudices may result in missed opportunities for necessary health screenings and preventative care (Whitehead et al., 2016).

Considering this context, it is hardly surprising that a percentage of the participants (39%) in this study had not revealed their sexual identity to their healthcare practitioners and will continue to hide their sexual identity for fear of poor healthcare services, discrimination or HIV positive older gay bias. The decision to come out always has consequences for the type and quality of healthcare received and always leads to the mistaken assumption among nurses and other healthcare professionals that HIV positive older gay men do not make use of existing services.

Participants constantly expressed anxiety, fear and resentment regarding the lack of services and knowledge of healthcare staff on their needs. Consequently, there is an urgent need for what Lim and Levitt (2011:11) calls "scholarly discourse" around the nursing curriculum on the needs of older LGBT people in areas, with specific emphasis on HIV positive older gay men.

Professional bodies responsible for guiding and accrediting education curricula for nurses have an important role to play in promoting the needs of older gay men with chronic illnesses; the needs and issues of older gay men should be included in the criteria for accreditation. In

addition, nursing organisations and groups need to respond to Keepnews' (2011) call to support public policy proposals that promote older gay men's health and that reduce health disparities for this minority group of people. Participants often linked these factors to their concerns and experiences for being gay in the township. This means that concerns around healthcare services of HIV positive older gay men and stigmatisation by healthcare professionals have been a major point of discussion for the entirety of this study.

Choi and Meyer (2016) argue that the HIV positive older gay men face barriers to receiving formal healthcare and social support that their heterosexual male counterparts do not encounter. The authors further point to several studies reporting that older gay men avoid or delay healthcare or conceal their sexual and gender identity from healthcare providers and social service providers for fear of discrimination due to their sexual orientation, HIV positive status and gender identity.

Healthcare professionals should know the law that governs their everyday service delivery to patients. However, this research has discovered that the healthcare professionals start by ignoring what should be the moral and ethical practice enshrined in the Batho Pele principles and Patients' Rights Charter (Choi & Meyer, 2016). This implies a lack of supervision within healthcare institutions. The supervisor of doctors and nurses are not conducting their duties the way it should be done. The challenges of limited supervision are a bone of contention within health settings. Professionals are not called out for prejudices, harmful practices and misconducts (Choi &Meyer, 2016).

These findings are contrary to the basis and principles of gerontology, which is rooted in social sciences, policies and the public health of older people (Braun et al., 2016). The findings of this study call for competencies such as proposed by McKusick & Harper (2013) that are geared towards ensuring that trained professionals provide a framework for creating safe, supportive, and caring relationships with older gay individuals, groups, and communities that foster self-acceptance and personal, social, emotional, and relational development. The competencies are based on wellness, resilience, a strength-based approach and AOP (Goffman, 2009). It is for these similar patterns that Hughes (2014) conducted a study in an effort to understand the effective practices that healthcare service professionals reportedly exhibit when working with sexual minority persons living with chronic illness and/or disabilities; those studies clearly depicted deficiencies in information from healthcare providers on older gay men's healthcare needs.

4.6.2.2 Poverty-stricken background that influences healthcare

One other hand, similar patterns were also underscored which show that one's race, ethnicity, sexuality and geographic location are linked to poverty. Participants made comparisons that take into account other factors that influence poverty, such as age, parental status, and employment, which indeed showed that same-sex couples were much more vulnerable to being poor than different-sex couples.

Poor services for the HIV positive older gay men are attributed to poverty (Collins & Leibbrandt, 2007). Poverty among older gay men is dated way back. Thompson and Darbyshire (2013) argue that a government which implemented and quantified its mission of separateness with radical fervour did not target homosexual individuals until 1968, nearly twenty years after the inception of apartheid. This is clear confirmation that LGBT individuals were affected by anti-homosexual legislation during apartheid and by their continuing fight to win equal treatment. Older gay men are now prone to depression and numerous chronic illnesses including HIV/AIDS.

In 1996, South Africa's new Constitution declared discrimination based on sexual orientation illegal (Outright Action International, 1996); this makes South Africa's Constitution one of the most progressive in the world in terms of personal freedom. Everyone, especially the LGBT community, hoped that it heralded a new beginning for their lives. The Constitution states that: "No person shall be unfairly discriminated on one or more of the following grounds: colour, sexual orientation…" (Vijlbrief et al., 2020:105). Apartheid has contributed to the financial problems older gay men speak about. The lack of job opportunities because of the pass system contributed to their financial demise (Vijlbrief et al., 2020).

The laws and regulations meant to regulate the conduct of healthcare professionals and protect the rights of older gay men are ignored by the communities in which the older gay men live (Bashush et al., 2011). This is found particularly in townships. The older gay men survived the suffering and developed resilience throughout the years. However, their struggles continue and government still fails to address their challenges. The Older Person's Act 13 of 2006 (Republic of South Africa, 2010) is silent and not specific about LGBT persons being a vulnerable category; they therefore struggle to afford an old age home.

Participants had a strong argument with regard to how poverty contributes to their infringement of basic healthcare rights. They felt that their struggles to secure decent employment during

their young adulthood perpetuated their current financial struggles. Financial instability is a major concern among rural older gay men. Lifetime disparities and employment opportunities to build savings as well as discriminatory access to legal and social programmes that are traditionally established to support aging adults place older gay men at greater financial risk than their heterosexual male counterparts (Choi & Meyer, 2016). The data collected on poverty are consistent with the view that older gay men continue to face economic challenges that affect their income and life chances. This lifelong financial struggle has made the older gay men prone to depression, as reported during the course of the study.

Poverty remains a persistent problem in the areas and drastically affects older gay men, A Williams Institute study conducted in 2013 found that poverty rates have gone up for almost all populations, and that LGBT people are still more likely to be poor than their heterosexual counterparts. The sexual orientation poverty gap has decreased slightly, but this is because heterosexual poverty rates have increased, not because poverty rates have declined for LGBT people. Nonetheless, the older gay men have survived and appear to have developed resilience, even though more resources need to be allocated to them to improve their healthcare needs and overall wellbeing.

4.6.3 Lack of support from family of older gay men

areas are known for a lower overall health status and a lower quality of life. This is related to a lower socio-economic status and higher unemployment, which, in turn, reduces affordability of good nutrition and access to healthcare. This section discusses aging concerns of older gay men in relation to healthcare. Questions were asked to unpack these concerns. Families and social support systems have been found to be instrumental to the physical and psychological wellbeing of older gay men. However, participants in this research reported a lack of support from family members and their community. In response to the questions, participants based their concerns on the lack of support and rejection by their families. For most participants, support from friends is the only form of support they can rely on.

4.6.3.1 Experiences of isolation – "My family rejected me a long time ago"

In this section, common patterns point to care and support for the aging community. black older gay men are less likely to have health insurance and more likely to face financial barriers to healthcare than their heterosexual counterparts do (Fredriksen-Goldsen et al., 2014). This backdrop is supportive to the findings of the study. Throughout the course of this study, aging

has consistently been the concern for the older gay men. Their concerns were mainly perpetuated by ageism and their HIV positive status, and were based on the fear of being isolated with no visible means of support and caring structures as they face the fourth quarter of their life.

Fredriksen-Goldsen et al. (2014) posit that older gay men share many worries about aging with their heterosexual peers but are consistently more anxious across a range of issues, including future care needs, independence and mobility. For this community, these factors are also affected by their poverty-stricken backgrounds and non-accepting family members and community as a whole. Among other challenges that affect their overall wellbeing, older gay men have lost close people in their lives, which, in turn, make them prone to depression. Instead of receiving emotional support, family and community are rejecting and violating them.

Despite a new liberal constitutional environment, the gay 'space' generated post-apartheid are not inclusive of most gay South Africans. On the contrary, the legacy of apartheid in terms of race, gender and class inequality persists. This emerged as a key lesson from the study of Reygan and Henderson (2019).

The results of this study show that older gay men are less likely than heterosexual adults to have children who could assist them (Outright Action International, 1996). Furthermore, older gay men may be estranged or continue to conceal their sexual orientation from their biological families for fear of non-acceptance and no support (Movement Advancement Project, 2010). As a result, LGBT older adults tend to rely more heavily on friends or "families of choice"—families composed of close friends—and they do not have the many intergenerational levels of support that heterosexual aging adults typically have (Grossman et al., 2009).

Participants reported that they were forced out of out their families of origin, and that friends became sources of support. This is supported by the findings of a study conducted in South Africa that found gay men were not more isolated than heterosexual men, but they were more likely than heterosexual men to call on friends and partners instead of asking family for help (Cantor et al., 2007). Although caregiving received by friends and partners is critical, the same social expectations of long-term care and support that exists for biological kin do not exist with friends, possibly leading to less reliable care to the sexual minority, in particular older black gay men.

HIV positive older gay men have been rejected by family because of cultural beliefs that are still set in the past; families have not yet embraced the new laws of South Africa. As with many aspects of the Constitution (Outright Action International, 1996), ordinary black South Africans have not readily accepted the social justice precepts that underpin LGBT rights. As a result, LGBT older adults tend to rely more heavily on friends or "families of choice"—families composed of close friends—and do not have many intergenerational levels of support that heterosexual aging adults typically have (Grossman et al., 2009).

4.7 Conclusion

In this chapter, participant accounts revealed how socioeconomic status, ignorance and poor education of healthcare professionals is the cultural milieu affecting the overall healthcare of older gay men in the township. The researcher illustrated and discussed the findings of this study. Older gay men have survived numerous challenges associated with their sexuality, HIV status and marginalisation. The HIV positive older gay men are the most vulnerable community; they therefore need all possible forms of support.

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

In this chapter, the researcher presents the summary of the aims and objectives of the study, the overview of the main themes, limitations, recommendations and suggestions for future researchers, healthcare professionals and policy developers regarding the healthcare of older gay men.

5.2 Summary of the aim and objectives of the study

The aim of this study—exploring aging and healthcare concerns and experiences of HIV positive black older gay man to provide an in-depth understanding and account of their healthcare experiences and concerns—was explored and described. Within this broad aim, four objectives were identified, namely to:

i) Explore and describe the experiences and concerns of the care of older gay men living with HIV/AIDS in a township in the Cape Metropole.

ii) Explore and describe cultural factors that affect the care of older gay men living with HIV/AIDS in a township in the Cape Metropole.

iii) Explore and describe healthcare professionals' essential treatment services to older gay men living with HIV/AIDS in a township in the Cape Metropole.

iv) Present recommendations for strategies that may enhance the healthcare of older gay men living with HIV/AIDS in a township in the Cape Metropole.

A qualitative approach was adopted for this study, which successfully met the study's objectives and research question. Furthermore, a qualitative research methodology was deemed most appropriate as it kept within the realms of the study's theoretical framework (High et al., 2012). By applying this approach, an in-depth reflection of aging and healthcare experiences and concerns of HIV positive older gay men was obtained (CDC, 2016).

5.3 Summary of the literature review

The findings of this study were controlled and contrasted utilising AOP theory. This theory is a theoretically sound paradigm and was used as the theoretical framework to determine the

aging and healthcare concerns and experiences of older gay man. Literature detailing the perspectives of local and international researchers and authors was reviewed to provide both a global and a local perspective on aging and healthcare concerns and experiences of HIV positive older gay men.

5.4 Aims and objectives

The aim of this study was to gain an understanding of the healthcare experiences and concerns of black older gay men living with HIV/AIDS in a township in the Cape Metropole. As outlined in the first chapter, four objectives were identified to unpack the aim of the study. All objectives were substantially explored and described. The last objective of this study which aimed to present recommendations for strategies that may the enhance healthcare of older gay men living with HIV/AIDS in a township in the Cape Metropole was not fully explored, as the participants offered very few recommendations. This is probably because of the belief that change will not happen within the health sector.

5.5 Overview of the main themes

Three major themes of interest originated from this study. Following is a summary of each major theme:

5.5.1 Theme 1: Discrimination of HIV positive older black gay men by their families and communities

A common trend in terms of discrimination of HIV positive older black gay men by their families and communities emerged as a key lesson from the analysis of the responses of the participants, who shared their discrimination-related concerns. All the black HIV positive older gay men in this study shared that they have experienced discrimination from their families and from their community as a whole, both directly and indirectly. Participants reported that these acts were predominantly perpetuated by IsiXhosa beliefs and cultural expectations that are dated way back, and were based on their sexuality, HIV positive status and age.

5.5.2 Theme 2: Negative healthcare experiences of HIV positive black older gay men in a township

This theme emerged from the frequency of narratives shared by the participants on their experiences and/or witnessing of negativity by healthcare professionals. Upon discussing these

negative experiences, participants explained that this negativity occurs in different forms and for a number of reasons. Participants made it clear that ignorant and poor education of healthcare professionals is one of the challenges that make it difficult for them to seek medical attention. Participants shared stories that are a clear indication of either the lack of required education of healthcare professionals to deal with older gay men having chronic illnesses such as HIV/AIDS and embrace diversity in areas, or ignorance that is perpetuated by prejudice and stigma towards the HIV positive black older gay men. On the other hand, participants believe that their poverty-stricken background also has an impact on their poor healthcare services. Participants spoke about the difficulties and their inability to secure decent employment time.

5.5.3 Theme 3: Lack of support from the families of older gay men

Lack of support has always been part of the conversations on sexuality and aging-related healthcare challenges (Jacobs et al., 2012). Participants spoke about their none-accepting families towards their homosexuality and HIV positive status. Participants expressed deep sadness about being rejected by their families of origin, which compelled participants to pursue other forms of support, as they require additional support because of their health-related challenges. Families of choice through friends are the only common and convenient source of support for the older gay men.

5.6 Limitation of the study

All research studies are bound to have limitations irrespective of how well-organised and constructed a study is. The researcher therefore noted the following limitations:

i) Population sample

A limitation in this regard is that the study focused on aging and healthcare concerns and experiences of HIV positive older gay man, and therefore the findings may only be applicable to this area, namely the township in the Cape Metropolitan area. These findings were descriptive and successfully met the objectives and answered the research questions of the study. However, the findings of the study are limited to the HIV positive older gay men community. Another limitation of the study is that the focus was on healthcare institutions, both private and public, and that all other institutions were excluded.

ii) Lack of availability of data

Initially, the sample size comprised fifteen older gay men and ten key informants. However, due to the sensitivity of the topic and the older gay men and key informants' lack of interest, the study was limited to ten older gay men and five key informants. However, reliable data were obtained from the participants. Recommendations were made on how to overcome this limitation for future research.

iii) Lack of prior research studies on the topic

Aging and healthcare concerns and experiences of HIV positive black older gay men are understudied, resulting in limited available empirical research. Nonetheless, the researcher used existing literature as a base, which was deemed sufficient for the study.

5.7 Recommendations and suggestions

i) Recommendations for practice

More diverse healthcare providers with the ability to connect with black older gay men in different contexts of their lives are needed, including platforms to educate older gay men about their rights, especially those who are from backgrounds. This stems from the findings of the study that the participants feel disempowered and helpless, having lost faith in voicing the improvements that should be made to change their situation. The researcher synthesised the recommendations into a cohesive and clinically useful set of guidelines for the primary care of black older gay men in areas. Such guidelines may become a potential change agent in the healthcare system through enabling healthcare staff members and managers to translate current research evidence into their healthcare practices.

The issue of discrimination by healthcare professionals was a huge contention in the study and one of the primary reasons for participants not accessing healthcare services, therefore, this is one of the key findings and should not be reduced to 'minor' changes required. The recommendations could also provide primary care services with ways to improve policies, procedures and local LGBT population health initiatives that are mainly focusing on HIV positive black older gay men. At policy level, they could encourage the development of guidelines targeted to specific areas of the health system and ensure that providers who are expected to uphold these guidelines are called out in cases of non-compliance. It also needs to be mentioned that only a few participants made suggestions regarding strategies to improve their situation in terms of practice. This was due to participants feeling negative about any solutions to their situation. A feeling of overwhelming disempowerment and helplessness was

detected among certain participants. They felt that support for them has been and continues to be a major missing part of their lives, while discriminatory and unjust conduct by the healthcare service providers and their community affects every aspect of their lives. This includes no recognition in policies and not being taken seriously when voicing their concerns. Participants believe their suffering is dated way back and nothing much has been done to improve it. Older gay men are a vulnerable group that requires all possible forms of support, including emotional and psychological support, given the challenges associated with marginalisation they have faced throughout their entire life. This lifetime suffering makes them prone to contracting various health conditions, including chronic illnesses such as HIV/AIDS. According to the participants, nothing will ever be done to improve their situation until their community shows the willingness to accept and embrace diversity.

ii) Recommendations for policy inclusion

Conversely, guidelines that contradict the existing values of clinicians or highlight new knowledge and skills that are needed, may demand too much change to existing routine and therefore reduce the likelihood of the uptake of guidelines by healthcare professionals, i.e. HIV status, social class, geographic area and age. the researcher suggests that guideline development for black older gay men should be improved in the following ways to ensure reliability and uptake: Involvement of stakeholders of HIV positive black older gay men through consultation may assist in addressing diversity within LGBT groups as well as ensuring that issues of clinical environment, confidentiality, and communication are truly patient-centred while reducing incidents of homophobia as reported in this research findings. Rigour may be improved by applying a systematic review, which would ensure inclusion of local research and address multiple theoretical perspectives. Another essential element in presentation of the recommendations is to reference all recommendations with the evidence on which they are based. A further method to improve the rigour of guideline development is to detail the inclusion and exclusion criteria for the review, particularly as minority sexual orientation is such a multidimensional phenomenon. For example, guidelines should state whether HIV positive older gay men are included as a target group. Regular external review by an independent expert may also improve the perceived reliability of the guidelines for black areas. The researcher suggests that the most effective guideline reviewers for primary care for black older gay men and the LGBT community as a whole may be mainstream researchers or practitioners in the primary healthcare field. There is also a need to review the Older Person's

Act 13 of 2006 (Republic of South Africa, 2010) so that vulnerable groups are recognised and supported.

iii) Recommendations for future research

The gaps identified in the existing guidelines could be addressed with future research, in particular focusing on the primary care setting. For example, most of the guidelines reviewed made general statements pertaining to the LGBT group as a whole, rather than highlighting specific healthcare needs of older gay men according to sex, diverse expression of sexual orientation, socioeconomic status, age, and ethnicity. Further, research that examines the complexities of disclosure of sexual orientation would add much needed depth to future guidelines (Heaphy et al., 2004). Research on pandemics such as Corona virus (Covid-19) affecting the older gay men would also assist. Finally, an evaluation and review process should be built into the implementation plan to understand whether the desired improvement in access, cultural competence, and quality healthcare has been achieved.

5.8 Conclusion

Internationally, there is agreement that older LGBT people are a 'doubly invisible group'; hence, research specifically addressing their lives, needs and aspirations is sparse. Although older LGBT people are not a homogeneous group, by using qualitative methods, this study contributes empirical evidence on the fears and challenges facing HIV positive older gay men in relation to healthcare service delivery in areas, and in particular the anticipated fears they have regarding healthcare for their old age. These findings highlight the need for a comprehensive approach that incorporates the inclusion of LGBT issues in education for nurses and other practitioners, as well as a review of policy, practice and information materials. Without this, there is a real risk that this group of people, who have historically experienced discrimination, will face further discrimination as they enter older age.

REFERENCE LIST

Babbie, E.R. & Mouton, J. (2006). *The practice of Social research*. Cape Town: Oxford University Press.

Baines, D. (2011). *Doing Anti-Oppressive Practice: Social justice social work*. 2nd ed. Halifax and Winnipeg: Fernwood.

Bashush, A., Gringeri, C. & Jeorge, M. (2011). Rigor in qualitative social work research: An empirical review on strategies used in published articles. *Social Work Research*, 35(3):11-19.

Boehmer, U., Miao, X., Linkletter, C. & Clark, M.A. (2012). Adult health behaviours over the life course by sexual orientation. *American Journal of Public Health*, 102:292-300. https://doi.org/10.2105/AJPH.2011.300334.

Botha, G., Kevan, G. & Richard, Y. (2009). *Sociologic control of homosexuality: A multi-nation comparison*. New York: Plenum, pp. 23-26.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2):77-101. ISSN 1478-088.

Braun, V., Gavey, N. & McPhillips, K. (2006). The "fair deal"? Unpacking accounts of reciprocity in heterosex. *Sexualities*, 6(2):237-261. https://doi.org/10.1177/1363460703006002005.

Brown, L.B. (1997). Women and men, not-men and not-women, lesbians and gays: American Indian gender style alternatives. *Journal of Gay & Lesbian Social Services*, 6(2):5-20.

Bryman, A. (2004). *Social research methods*. 2nd ed. New York: Oxford University Press.

Cable, B. (2017). Fathers experiences of single parenting. Master's thesis. University of the Western Cape.

Cahill, S. & Valadéz, R. (2013). Growing older with HIV/AIDS: New public health challenges. *American Journal of Public Health*, 103(3):e7-e15.

Cantor, M.H., Brennan-Ing, M. & Shippy, M. (2007). *Caregiving among older lesbian, bisexual, and transgender*. New York. doi:10.13140/RG.2.2.29507.30244.

CDC *see* Centres for Disease Control and Prevention.

Centres for Disease Control and Prevention. (2016). *HIV transmission*. Retrieved from: http://www.cdc.gov/hiv/basics/transmission.html. [Accessed: 7 December 2018].

Cherubini, A., Del Signore, S., Ouslander, J., Semla, T. & Michel, J-P. (2010). Fighting against age discrimination in clinical trials. *Journal of the American Geriatrics Society*, 58(9):1791-6. doi:10.1111/j.1532-5415.2010.03032.x.

Chetty, R. (2007). Moral hazard vs. liquidity and optional unemployment insurance United States. *Quarterly Journal of Economics*, 34(2):133-134.

Cho, J. & Trent, A. (2006). Validity in qualitative research revised. *Qualitative Research,* 6(3):319-340.

Choi, S.K. & Meyer, I.H. (2016). *LGBT aging: A review of research findings, needs, and policy implications*. Los Angeles: The Williams Institute.

Collins, D. & Leibbrandt, M. (2007). The financial impact of HIV/AIDS on poor households in South Africa. *AIDS (London, England),* 21(Suppl 7):S75-81. doi:10.1097/01.aids.0000300538.28096.1c.

Conron, K.J., Mimiaga, M.J. & Landers, S.J. (2010). A population based study of sexual orientation identity and gender differences in adult health. *American Journal of Public Health,* 100(10):1953-1960. https://doi.org/10.2105/AJPH.2009.174169.

Conway, D. (2009). Queering Apartheid: The National Party's 1987 gay rights' campaign in Hillbrow. *Journal of Southern African Studies*, 35(4):849-863. https://doi.org/10.1080/03057070903313210.

Corbin, J. & Strauss, A. (2014). *Basics of qualitative research: Techniques and procedures for developing grounded theory.* Sage.

Crawford, K.H., Leybourne, M.L. & Arnott, A. (2000). How we ensured rigor from a multi-site, multi-discipline, researcher study. *Forum: Qualitative Social Research,* 1(1): Art.12. doi:http://dx.doi.org/10.17169/fgs1.1.1122.

Creswell, J.W. (2007). *Qualitative inquiry & research design: Choosing among five approaches*. University of Michigan.

Creswell, J.W. (2009). *Research design: Qualitative, quantitative, and mixed methods*. University of Michigan.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process.* Sage.

Cudd, A. (2006). *Analysing oppression*. New York, NY: Oxford University Press.

Czaja, S.J., Sabbag, S. & Lee, C.C. (2010). Concerns about aging and caregiving among middle-aged and older lesbian and gay adults. *Aging and Mental Health,* 20(11):1-12. doi:10.1080/13607863. 2010.1072795.

D'Augelli, A.R., Grossman, A.H., Hershberger, S.L. & O'Connel, T.S. (2010). Aspects of mental health among older lesbian, gay, and bisexual adults. *Aging & Mental Health,* 5(2):149-158. https://doi.org/10.1080/13607860120038366.

Dalrymple, J. & Burke, B. (2000). Anti-oppressive practice. *In* Davies, M. (ed.), *The Blackwell Encyclopedia of Social Work*. Oxford: Blackwell.

Datti, P.A. (2012). Counseling with rural lesbian, gay, bisexual, and transgender persons. *In* Dworkin, S.H. & Pope, M. (eds.), *Casebook for counselling lesbian, gay, bisexual, and transgendered persons and their families.* Wiley, pp. 223-229.

De Barros, L. & Luiz, G. (2011). *SA finally ends gay blood donation ban*. Retrieved from: https://constitutionallyspeaking.co.za/christine-give-them-hell/. [Accessed: 20 May 2017].

D'Cruz, H. & Jones, M. (2007). *Social Work Research in Practice*. 2nd ed. Sage, pp. 127-130.

De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (2005). *Research at grassroots: For the social sciences and human service professions*. Pretoria: Van Schaik.

De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (2008). *Research at grass roots: For the social sciences and the human service professions.* 2nd ed. Van Schaik.

De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (2013). *Research at grassroots: For the social science and human profession*. 4th ed. Pretoria: Van Schaik.

De Vos, P. (2011). *Christine, give them hell!! Constitutionally speaking*. Retrieved from: https://constitutionallyspeaking.co.za/christine-give-them-hell/. [Accessed: 16 August 2020].

Deeks, S.G. (2011). HIV infection, inflammation, immunosenescence, and aging. *Annual Review of Medicine*, 62:141.

Dellinger, R.P., Levy, M.M., Carlet, J.M., Bion, J., Parker, M.M., Jaeschke, R., Reinhart, K. et al. (2008). Surviving Sepsis Campaign: International guidelines for management of severe sepsis and septic shock. *Intensive Care Medicine*, 34(1):17-60. doi:10.1007/s00134-007-0934-2.

Department of Health, South Africa. (1997). *White Paper for the Transformation of the Health System in South Africa*. Retrieved from: http://ws.dwa.gov.za/wspd/UserControls/DownloadImportFiles.aspx?FileID=30. [Accessed 21 July 2019].

Dispenza, F. & O'Hara, C. (2016). Correlates of transgender and gender nonconforming counselling competencies among psychologists and mental health practitioners. *Psychology of Sexual Orientation and Gender Diversity*, 3(2):156-164. https://doi.org/10.1037/sgd0000151.

Dominelli, L. (2002). *Anti-oppressive social work theory and practice*. Palgrave Macmillan: Basingstoke.

Dominelli, L. (2008). Global agenda for social work and social development: A path toward sustainable social work. *Social work (Stellenbosch. Online)*. ISSN 2312-7198.

Earnshaw, V.A. & Chaudoir, S.R. (2009). From conceptualising to measuring HIV stigma: A review of HIV stigma mechanism measures. *AIDS and Behavior*, 13(6):1160-1177.

Emlet, C.A. (2014). "You're awfully old to have this disease": Experiences of stigma and ageism in adults 50 years and older living with HIV/AIDS. *The Gerontologist*, 46(6):781-790.

Engelbrecht, L. (2012). The implications of neoliberalism for social work: Reflections from a six-country international research collaboration. *International Social Work*, 57(4):301-312.

Ethics Wiki. (2020). *Social beliefs.* Retrieved from: https://ethics.wikia.org/wiki/Social_beliefs#:~:text=Social%20beliefs%20are%20the%20beliefs,these%20campaigns%20are%20called%20activists. [Accessed: 20 August 2020].

FESSUD. (2010). *Studies in financial systems No. 15: The South African financial system*. European Union's Seventh Framework Programme for research, technological development and demonstration under grant agreement no 266800.

Fredriksen-Goldsen, K.I., Simoni, J.M., Kim, H.-J., Lehavot, K., Walters, K.L., Yang, J., Walters, K.L., Yang, J., Hoy-Ellis, C.P. & Muraco, A. (2014). The health equity promotion model: Reconceptualisation of lesbian, gay, bisexual, and transgender (LGBT) health disparities. *American Journal of Orthopsychiatry*, 84(6):653-663. http://dx.doi.org/10.1037/ort0000030.

Gevisser, M. & Cameron. E. (eds). (2007). *Defiant desire: Gay and lesbian lives in South Africa*. Routledge.

Given, L.M. (2008). Qualitative research methods. *In* Salkind, N.J. (ed.), *The Encyclopedia of Educational Psychology.* Thousand Oaks, CA: Sage, pp. 827-831.

Goffman, E. (2009). *Stigma: Notes on the management of spoiled identity.* Simon and Schuster.

Gott, M. & Hinchliff, S. (2003). Barriers to seeking treatment for sexual problems in primary care: A qualitative study with older people. *Family Practice*, 20(6):690-695.

Grant, J.M. (2010). Outing age: *Public policy issues affecting lesbian, gay, bisexual and transgender elders*. Washington: National Gay and Lesbian Task Force Policy Institute.

Gray, A.J. (2002). Stigma in psychiatry. *Journal of the Royal Society of Medicine*, 95(2):72-76.

Grinnell, R. (2008). *Research methods for BSW students*. 7th ed. Pearson.

Grossman. P., Hammerness, K. & McDonald, M. (2009). Redefining teaching, re-imagining teacher education. *Teachers and Teaching: Theory and Practice*, 15(2):273-289.

Hahm, H.C., Gonyea, J.G., Chiao, C. & Koritsanszky, L.A. (2012). Fractured identity: A framework for understanding young Asian American women's self-harm and suicidal behaviours. *Race and Social Problems*, 6(1):56-68. doi:10.1007/s12552-014-9115-4.

Harley, D.A., Nowak, T.M., Gassaway, L.J. & Savage, T.A. (2014). Lesbian, gay, bisexual and transgender college students with disabilities: A look at multiple cultural minorities. *Psychology in the Schools*, 39:525-538. https://doi.org/10.1002/pits.10052.

Harry, J. & DeVall, W. (1978). Age and sexual culture among homosexually oriented males. *Archives of Sexual Behavior*, 7:199-209. https://doi.org/10.1007/BF01542379.

Hatzenbuehler, M.L. (2009). How does sexual minority stigma "get under the skin"?: A psychological meditation framework. *Psychological Bulletin*, 135(5):707-730. https://doi.org/10.1037/a0016441.

Heaphy, B., Yip, A.K. & Thompson, D. (2004). Ageing in a non-heterosexual context. *Ageing and Society*, 24(6):881-902.

Henderson, N. & Almack, K. (2016). Lesbian, gay, bisexual, transgender ageing and care: A literature study. *Social Work*, 52(2):267-279.

Henderson, N. (2016). The persistence of homophobic discourses: Narratives of a group of gay men in Cape Town, South Africa. *Agenda: Empowering Women for Gender Equity*, 29(1):108-115. https://doi.org/10.1080/10130950.2015.1020644.

High, K.P., Brennan-Ing, M., Clifford, D.B., Cohen, M.H., Currier, J., Deeks, S.G., Deren, S. et al. (2012). HIV and aging: State of knowledge and areas of critical need for research. A report to the NIH Office of AIDS Research by the HIV and Aging Working Group. *Journal of Acquired Immune Deficiency Syndromes*, 60(Suppl 1):S1-18. doi:10.1097/QAI.0b013e31825a3668.

Holt, R., Court, P., Vedhara, K., Nott, K., Holmes, J. & Snow, M. (1998). The role of disclosure in coping with HIV infection. *AIDS Care*, 10(1):49-60.

Huebner, D., Rebchook, G.M. & Kegeles, S. (1999). Experiences of harassment, discrimination, and physical violence among young gay and bisexual men. *An American Journal of Public Health*, 94(7):1200-3. doi:10.2105/AJHP. 94.7.1200.

Hughes, A.K., Harold, R.D. & Boyer, J.M. (2011). Awareness of LGBT aging issues among aging services network providers. *Journal of Gerontological Social Work*, 54(7):659-677. https://doi.org/10.1080/01634372.2011.585392.

Hughes, M. (2014). LGBT people's knowledge of and preparedness to discuss end-of-life care planning. *Health & Social Care in the Community*, 22(5):545-52. doi:10.1111/hsc.12113.

Hughes, T.L. & Eliason, M.J. (2004). Substance and abuse in lesbian, gay, bisexual, and transgender populations. *Journal of Primary Prevention*, 22(3):261-295.

Hughes. M. (2009). Lesbian and gay people's concerns about aging and accessing services. *Australian Social Work*, 62(2):186-201. https://doi.org/10.1080/03124070902748878.

ILO *see* International Labour Organisation.

International Labour Organisation (ILO). (2014). *National Strategic Plan on HIV, STIs and TB 2012-2016*. South Africa. Retrieved from http://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=94058&p_country=ZAF&p_count=1060 [Accessed: 15 August 2020].

Itaborahy, L.P. & Zhung, J. (2015). *State-sponsored Homophobia. A world survey of laws: Criminalisation, protection and recognition of same-sex love*. refworld. Retrieved from: https://www.refworld.org/docid/519b6c2f4.html. [Accessed: 22 June 2019].

Jackson, N.C., Johnson, M.J. & Roberts, R. (2008). The potential impact of discrimination fears of older gays, lesbians, bisexuals and transgender individuals living in small-to moderate-sized cities on long-term health care. *Journal of Homosexuality*, 54(3):325-339.

Jacobs, J. & Archie, T. (2008). Investigating sense of community in first-year college students. *Journal of Experiential Education*, 30(3):282-285.

Jacobs, R.J., Rasmussen, L.A. & Hohman, M.M. (2012). The social support needs of older lesbians, gay men, and bisexuals. *Journal of Gay & Lesbian Social Services*, 9(1):1-30.

Johnson, R.B. & Christensen, L.B. (2008). *Educational research: Qualitative, quantitative, and mix approaches*. 4th ed. Sage.

Keepnews, D.M. (2011). Editorial: LGBT health issues and nursing . *Policy, Politics & Nursing Practice*, 12(2):71-72. https://doi.org/10.1177/1527154411425102.

Kessler, R.C., Birnbaum, H., Bromet, E., Hwang, I., Sampson, N. & Shahly, V. (2010). Age difference in age depression: Results from the National Comorbidity Surveys Replication (NCS-R). *Psychological Medicine*, 40(2):225.

Kirk, J.B. & Goetz, M.B. (2009). Human immunodeficiency virus in an aging population: A complication of success. *Journal of the American Geriatrics Society*, 57(11):2129-2138.

Knauer, N.J. (2012). The LGBT equality gap and federalism. *American University Review*, 70(1):221-228.

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *The American journal of Occupational Therapy Association*, 45(3):214-22. doi:10.5014/ajot.45.3.214.

Kumar, R. (2005). *Research methodology: Step-by-step guide for beginners*. 3rd ed. Sage.

Landers, S., Mimiaga, M.J. & Krinsky, L. (2010). The open door project task force: A qualitative study on LGBT aging. *Journal of Gay & Lesbian Social Services*, 22(3):316-336. doi:10.1080/10538720903426438.

Lim, F. & Levitt, N. (2011). Lesbian, gay, bisexual &transgender health. *American journal of Nursing*, 111(11):11. https://doi.org/10.1097/07/01.NAJ.0000407277.79136.91.

Luo, Y., Xu, J., Granberg, E. &Wentworth, W.M. (2012). A longitudinal study of social status, perceived discrimination, and physical and emotional health among older adults. *Research on Aging*, 34(3):275-301. https://doi.org/10.1177/0164027511426151.

Mader, S.L. (2008). Clinical aging. *Journal of the American Geriatrics Society*, 56(6):122-123-4

Masten, J. & Schmidtberger, J. (2011). Aging with HIV: A gay men's guide. *AIDS*, 25(13). 10.1097/QAD.0b013e32834982ea.

McCuen, R.H. (1996). *The elements of academic research*. 2nd ed. ASCE.

McKusick, V.A. & Harper, P.S. (2013). *History of medical genetics. In* Rimoin, D.L., Pyeritz, R.E. & Korf, B. (eds.), *Emery and Rimoin's Principles and Practice of Medical Genetics*. 6th ed. Elsevier, 1-39. 10.1016/B978-0-12-383834-6.00001-X.

Muller, A. (2013). Teaching lesbian, gay, bisexual and transgender in a South African health sciences faculty: Addressing the gap. *BMC Medical Education*, 13(1):174. doi:10.1186?1472-6920-13-174.

Moodie, E.M., Richardson, T.S. & Stephens, D.A. (2007). Demystifying dynamic treatment regimes. *Biometrics*, 63(2):447-55. doi:10.1111/j.1541-0420.2006.00686.x.

Movement Advancement Project. (2010). *2010 National LGBT Movement Report: A financial overview of leading advocacy organisations in the LGBT Movement*. Denver: MAP.

National Resource Centre on LGBT Aging. (2014). *Homepage*. Retrieved from: https://www.sageusa.org/. [Accessed: 11 April 2018].

Outright Action International. (1996). *South Africa: New Constitution Protects Gays and Lesbians.* National Coalition for Lesbian and Gay Equality. Retrieved from: https://outrightinternational.org/content/south-africa-new-constitution-protects-gays-and-lesbians [15 August 2020].

Patton, M.Q. (1990). *Qualitative research and evaluation methods*. 3rd ed. Thousand Oaks, CA: Sage.

Patton, M.Q. (2002). *Qualitative research and evaluation methods.* 7rd ed. Thousand Oaks, CA: Sage.

Republic of South Africa. (1967). Terrorism Act, 1967 (Act No. 83 of 1967). *Government Gazette*, 32205, R9079, Vol. 527. Cape Town.

Republic of South Africa. (2010). Older Person's Act, 2006 (Act No. 13 of 2006). *Government Gazette*, 29346, Vol. 497. Cape Town.

Retief, F. (2010). The evolution of environmental assessment debates: Critical perspectives from South Africa. *Journal of Environmental Assessment Policy and Management*, 12(4):375-397. https://doi.org/10.1142/S146433321000370X.

Reygan, F. & Henderson, N. (2019). All Bad?: Experiences of aging among LGBT elders in South Africa. *The International Journal of Aging and Human Development*, 88(4):405-421. https://doi.org/10.1177/0091415019836929.

Saghir, M.T., Robins, R., Walbran, B. & Gentry, A.K. (2010). Homosexuality: IV, Psychiatric disorders and disabilities in the female homosexual. *The American Journal of Psychiatry*, 127:147.

SANAC *see* The South African National AIDS Council.

Scott-Sheldon, L.A.J., Walstrom, P., Harrison, A., Kalichman, S.C. & Carey, M.P. (2013). Sexual risk reduction interventions for HIV prevention among South African Youth: A meta-analytic review. *Current HIV Research*, 11(7):549-558.

Shenton, A.K. (2004). Strategies for ensuring trustworthiness in qualitative research project. *Education for Information*, 22:63-75.

Smith, R.R., Winfree, R.A., Rumsey, G.W., Alfred, A. & Peterson, M. (1995). Apparent digestion coefficients and metabolisable energy of feed ingredients for rainbow trout Oncorhynchus Mykiss. *Journal of the World Aquatic Society*, 26(4):432-437. https://doi.org/10.1111/j.1749-7345.1995.tb00839.x.

Streubert, H. & Carpenter, D. (1999). *Qualitative research in nursing: Advancing the humanistic perspective*. 2nd ed. Philadelphia, PA.: Lippincott Williams & Wilkins.

Swarr, A.L. 2009. "Stabane", intersexuality, and same sex relationships in South Africa. *Feminist Studies*, 35(3):524-548. http://www.jstor.org/stable/40608390.

Taylor, B. (2001). HIV, stigma and health: Integration of theoretical concepts and the lived experiences of individuals. *Journal of Advanced Nursing*, 35(5):792-798.

The South African National AIDS Council. (2014). *The National Strategic Plan on HIV, STIs and TB 2012-2016*. Department of Health, South Africa.

The South African National AIDS Council. (2016). Draft of the South African National LGBTI HIV Framework 2017-2022. Department of Health, South Africa.

Thomas, T. (2016). Leading research impacting clinical care in Africa. *The South African Medical Journal (SAMJ)*, 110(8):144-147.

Thompson, D.R. & Darbyshire, P. (2013). Is academic nursing being sabotaged by its own killer elite?: A rejoinder. *Journal of Advanced Nursing*, 69(1):1-3. doi:10.1111/j.1365-2648.2012.06108.x.

Thompson, N. (2002). Social movements, social justice, and social work. *British Journal of Social Work*, 32(6):711-722.

Thompson, N. (2003). *Promoting equality: Challenging discrimination and oppression*. 2nd ed. Basingstoke: Palgrave Macmillan.

Ulin, P.R., Robinson, E.T. & Tolley, E.E. (2005). *Qualitative methods in public health: A field guide for applied research*. Jossey-Bass.

UNAIDS. (2014). *The Gap Report*. UNAIDS Geneva.

UNDP & USAID. (2009). *Being LGBT in Asia: Thailand country report: A participatory review and analysis of the legal and social environment for lesbian, gay, bisexual and transgender (LGBT) persons and civil society*. Bangkok.

Vijlbrief, A., Saharso, S. & Ghorashi, H. (2020) Transcending the gender binary: Gender non-binary young adults in Amsterdam. *Journal of LGBT Youth*, 17(1):89-106. doi:10.1080/19361653.2019.1660295.

Vincent, L. (2008). "Boys will be Boys": Traditional Xhosa male circumcision, HIV and sexual socialisation in contemporary South Africa. *Culture Health & Sexuality*, 10(5):431-46. doi:10.1080/13691050701861447.

Whitehead, J., Shaver, J. & Stephenson, R. (2016). Outness, stigma, and primary health care utilisation among Rural LGBT Population. *Plos One*. https://doi.org/10.1371/journal.pone.0146139.

Wilson, A. & Beresford, P. (2000). 'Anti-Oppressive Practice': Emancipation or appropriation? *British Journal of Social Work*, 30(5):553-573. doi:10.1093/bjsw/30.5.553.

Yep, R. (2011). *2010 ACA Year-in-Review Report*. American Counselling Association. Retrieved from: https://www.counseling.org/news/updates/2011/01/01/2010-aca-year-in-review-report. [Accessed: 19 August 2020].

Zaninotto, P., Falaschetti, E. & Sacker, A. (2009). Age trajectories of quality of life among the older adults: Results from the English longitudinal study of aging. *Quality of Life Research*, 18(10):1301-1309. doi:10.1007/s11136-009-9543-6.

APPENDIX A: INTERVIEW SCHEDULE

This interview schedule is to address the following research title: **"Aging and healthcare experiences and concerns of older gay men living with HIV/AIDS in a township in the Cape Metropole".** The objectives of the study will be:

- To explore and describe the experiences of care of older gay men living with HIV/AIDS in a township in the Cape Metropole.
- To explore and describe cultural factors that affect the care of older gay men living with HIV/AIDS in a township in the Cape Metropole.
- To explore and describe healthcare professionals' essential treatment services to the older gay men living with HIV/AIDS in a township in the Cape Metropole.
- To present recommendations for strategies that can enhance healthcare of older gay men living with HIV/AIDS in a township in the Cape Metropole.

Please make sure that you have given your written consent before taking part in this research study, also note that everything that will be shared during this interview will only be used for the research project and pseudonyms will be used to insure anonymity.

Date of interview: …… Pseudonym: ……. Age: ……..

Questions
Introductory question: 1. Can you tell me more about yourself? (age, area of origin, hobbies, relationship status)
Questions on Background: 2. Can you tell me more about your family background and upbringing? 3. Tell me about your education and previous work experience. 4. How would you define your gender and sexuality?
Questions on LGBT healthcare experiences and concerns: 6. Have you always felt comfortable with the perceptions other people have about the LGBT society? 7. What are your healthcare challenges as you are growing older? 8. How would you describe the community knowledge about older gay men? 9. How would you describe healthcare services in your community? 10. What are your experiences with healthcare providers? 11. Do you think it is difficult to access healthcare services due to your sexuality?

12. Do you think being older, gay and HIV positive brings stigma by healthcare providers?
13. Have you ever been discriminated by a health professional because of your sexuality and HIV status?
14. Is the government doing enough to address challenges faced by the HIV positive older gay men?
14. What do you think needs to be done to enhance older gay men living with HIV healthcare services?

Questions for key informants:

17. What do you understand about the LGBT community?
18. Are any ethics regulating your daily service delivery to older gay men living with HIV/AIDS?
19. How do you ensure none discriminatory service delivery?
20. How do you ensure that the HIV status and sexuality of your patients does not influence services?

Concluding questions:

21. Would you like to add anything else you think might be beneficial for the research project?

Thank you for your participation in this study.

APPENDIX B: CONSENT FORM

UNIVERSITY *of the*
WESTERN CAPE

University of the Western Cape

Private Bag X17, Bellville 7535, South Africa

Telephone: ++27-21- 959 2276

Fax: ++27-21- 959 2647

E-mail: nhenderson@uwc.ac.za

Title of Research Project: **Aging and healthcare experiences and concerns of older gay men living with HIV/AIDS in a township in the Cape Metropole**

The study has been described to me in a language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

Participant's name……..

Participant's signature……

Witness……..

Date……

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator: Dr. Neil Henderson
University of the Western Cape
Private Bag X17, Bellville 7535
Telephone: (021)959-2843
Fax: (021)959-2845

UNIVERSITY of the
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UKUZIBOPHELELA

Isihloko sophando: **Aging and healthcare experiences and concerns of older gay men living with HIV/AIDS in a township in the Cape Metropole**

Oluphando ndilucaciselwe ngolwimi endiluqondayo. Imibuzo endinayo ngophando iphendulekile. Ndiyakuqonda okuqulathwe kukuzibandakanya kwam nophando kwaye ukuzibandakanya kuyintando yam. Ndiyakuqonda ukuba inkcukacha zam azisayikupapashwa nakubani na. Ndiyakuqonda ukuba ndingakreqa nangaliphi na ixesha lophando ngaphandle koloyiko lweziphumo ezikrakra okanye ukulahlekelwa yinzuzo.

Igama ……..

Utyikityo……..

Ingqina…….

Umhla……...

Xa unemibuzo ngoluphando okanye unqwenela ukubika ingxaki othewahlangabezana nayo , Nceda uqhakamishelane nomqulunqi woluphando:

Igama: Dr. Neil Henderson
Idyunivesithi yaseNtshonakoloni
Private Bag X17, Bellville 7535
Inombolo yomnxeba: (021)959-2843
Ifekisi: (021)959-2845

APPENDIX C: INFORMATION SHEET

UNIVERSITY *of the*
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University of the Western Cape

Private Bag X17, Bellville 7535, South Africa

Telephone: ++27-21- 959 2276

Fax: ++27-21- 959 2647

E-mail: thembelanimange@gmail.com

Project Title: **Aging and healthcare experiences and concerns of older gay men living with HIV/AIDS in a township in the Cape Metropole**

What is this study about?

Fear of rejections and discrimination affects the LGBTI community in a number of ways. The first is that it creates psychological difficulties related to rejection. Rejection can manifest as depression. This is confirmed in a study by Hughes (2009), stating that due to fear of stigmatisation by the medical community, the most significant health risk for older gay men with HIV/AIDS may be that they end up avoiding routine healthcare due to discrimination such as homophobic attitude and communicating with non-gender-neutral terms, emanating from healthcare professionals. This study focuses on the healthcare experiences and concerns of older gay men.

What will I be asked to do if I agree to participate?

Questions relating to the participants family background, their healthcare experiences and concerns.

Would my participation in this study be kept confidential?

Yes, the participant's information will remain confidential and in the process sign a letter of consent outlining the stipulations and processes of the research, including protecting the identity of the participant with the use of pseudonyms.

What are the risks of this research?

The engagement might illicit some traumatic and upsetting issues for which the participants may require counselling services. The researcher will in this case refer the participant for counselling to the department of Social Development. The risks to the research should also be mentioned.

What are the benefits of this research?

Their experiences and concerns will add new knowledge to the field of HIV and AIDS as well as identify strategies to deal with the respondents' concerns. Furthermore, training with service providers and care givers on how to care for HIV positive older gay men without discrimination may emerge from this study.

Do I have to be in this research and may I stop participating at any time?

The participants are by no means obligated to participate in the research project and can withdraw from the research project with no consequences. This point is made clear in the consent form.

What if I have questions?

If you have any questions about the research study itself, please contact: Thembelani Mange on email: thembelanimange@gmail.com, Tel: (021) 859 2295 / Cell no: 0731263774. Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Department of Social work:

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This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.

