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Exploring the uptake of sexual and reproductive health services for lesbians and bisexual women in Bulawayo, Zimbabwe. A quantitative enquiry

Methembe Yotamu Khozah[1] and Wilfred Njabulo Nunu[1,2,3]

Abstract

Background: Sexual and reproductive healthcare is essential for all individuals, including LGBTQ+ individuals. However, lesbians and bisexual women often lack tailored services, leading to underutilization. This study aimed to assess the availability and uptake of sexual and reproductive health services for lesbian and bisexual Bulawayo women.

Methods: A cross-sectional study surveyed 67 lesbian and bisexual women recruited through the Voice of the Voiceless Organization. The participants completed a structured questionnaire on available services, factors influencing their uptake, and access challenges. Cross-tabulation was used to examine the associations between variables. Data were analyzed using Microsoft Excel and STATA Version 15 S.E.

Results: Most respondents were bisexual women aged 35 years. Cross-tabulations revealed significant associations between delayed or avoided services and the absence of specific services for lesbians and bisexual women as well as the presence of gender identity nondiscrimination policies.

Conclusion: Sexual and reproductive health programs play a vital role in meeting lesbian and bisexual women's needs. Improving service uptake requires strengthening the linkages between clinics and sexual health education programs, providing lesbian and bisexual women-friendly clinical services, and ensuring access to comprehensive information.

Keywords

Sexual and reproductive health services, lesbians and bisexual women, uptake, Bulawayo

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Background

The highest attainable standard of sexual and reproductive health (SRH) is a fundamental human right recognized by numerous international and national laws and mandates, including the Universal Declaration of Human Rights.[1] Individuals can exercise sexual and reproductive health rights (SRHRs) without fear of coercion, discrimination, or violence. The SRHR remains prominent on the international agenda, including in the United Nations' Sustainable Development Goal Number 5, which aims to ensure universal access to SRH and rights.[1] Every person needs equal access to opportunities and services, such as sexual and reproductive health services and protection from harm, regardless of their sexual orientation or gender identity.[2] Lesbians and bisexual women face several overlapping structural barriers to their basic SRH rights including access to SRH care. SRH care includes various services, such as sexually transmitted infection (STI) treatment, human papillomavirus (HPV)-related cancer prevention, and other reproductive tract morbidities.

[1]Faculty of Environmental Science, Department of Environmental Health, National University of Science and Technology, Bulawayo, Zimbabwe
[2]Faculty of Health Sciences, Department of Environmental Health, School of Public Health, University of Botswana, Gaborone, Botswana
[3]Faculty of Health Sciences, Department of Public Health, University of the Free State, Bloemfontein, South Africa

Corresponding author:
Methembe Yotamu Khozah, Faculty of Environmental Science, Department of Environmental Health, National University of Science and Technology, Corner Cecil Avenue and Gwanda Road, P.O Box AC 939, Ascot, Bulawayo, Zimbabwe.
Email: methembekhozah08@gmail.com

Worldwide evidence shows that sexual and gender minority individuals, such as lesbians and bisexual women, face discrimination, stigma, and even denial of care in the health system because of their sexual orientation and gender identity.[3] Such discrimination and fear cause delays in seeking sexual health services such as HIV counseling and testing. Lesbians and bisexual women, who are identified as a key "at risk" group due to socioeconomic marginalization and exclusion, and who experience high levels of violence because of such marginalization and gender nonconformity, face multiple barriers in healthcare facilities, ranging from verbal abuse to care denial.[4] It is critical to recognize that individual healthcare providers perpetuate barriers such as discrimination and are deeply ingrained in the healthcare system.[5]

Lesbians and bisexual women in Bulawayo, Zimbabwe, encounter significant challenges in accessing healthcare services because of prevailing heteronormative attitudes among medical professionals. These attitudes often manifest as a lack of understanding or acknowledgement of female same-sex relationships.[3] Consequently, lesbians and bisexual women face marginalization and exclusion within society, leading to stigma, assault, and discrimination based on their perceived or actual sexual orientation and gender identity.[6] These experiences can have profound and enduring social and psychological effects on these individuals and have negative consequences for society. Lack of acceptance within the community further exacerbates these issues.[7]

One specific consequence of these barriers is the limited ability of lesbians and bisexual women to exercise their SRH rights, including access to necessary SRH care.[8] In Bulawayo, most lesbian and bisexual women are unable to access specific healthcare services because of heteronormative attitudes. This results in the avoidance of routine testing for STIs, cervical cancer, and human papilloma virus. As a result, they face a higher risk of contracting these diseases than their heterosexual counterparts. Consequently, if the barriers to SRH services for lesbians and bisexual women in Bulawayo are not addressed, it may hinder the country's progress in achieving the United Nations Programme on HIV/AIDS (UNAIDS) 90-90-90 targets for ending AIDS and other STIs by 2030. While previous studies have examined the health-seeking behaviors of lesbians and bisexual women, limited research has focused specifically on the uptake of SRH services by this population in Bulawayo. Therefore, this study aimed to explore the availability of sexual and reproductive health services for lesbian and bisexual women in Bulawayo as well as their level of uptake.

Methods

Study area

The study was conducted on lesbian and bisexual women, as captured in the Voice of the Voiceless clientele. Bulawayo is the second capital city in Zimbabwe and has an estimated population of 874,479 as of 2023.[9] The city is served by private and public health facilities, the majority of which are public and owned by the government. The city has many clinics run by the Ministry of Health and Child Care (sometimes in collaboration with nongovernmental organizations and donors) and three referral health facilities, namely, United Bulawayo Hospitals, Mpilo Central Hospital, and a mental institution, Ingutsheni Hospital.[10] The private sector also operates several healthcare facilities in the city. According to the National Aids Council, the city has a significant number of key populations, including the LGBQT+ community, which is not very open because of the country's constitution, criminalizes homosexuality, and only a few manage to express themselves freely.[10] A map of the study area is shown in Figure 1.

Study design

A cross-sectional survey design was employed to gather data on the accessibility and utilization of SRH services by lesbians and bisexual women. The study encompassed a sample size of 67 participants, all of whom self-identified as lesbian or bisexual females and were above 18 years old. This study was conducted between November 2022 and June 2023. The survey aimed to ascertain the range of SRH services presently accessible to this specific demographic along with their uptake rates. Additionally, this study sought to identify any challenges encountered by lesbian and bisexual women when accessing SRH services.

Target population and sampling

The target population was 210 lesbian and bisexual women who regularly visited the Sexual Rights Centre (SRC) and Voice of Voiceless (VoVo), according to the records of the VoVo organization that works with lesbians and bisexual women in Bulawayo. The individuals included in this study were willing and able to provide informed consent. Participants who were not identified as lesbian or bisexual were excluded. Convenience sampling was used to select participants from the target population of lesbians and bisexual women who frequently visited the SRC and VoVo in Bulawayo. The sample size was calculated using the Raosoft version 7.2.2.6 (which is a free online software found on http://www.raosoft.com/samplesize.html) sample size calculator. A sample size of 67 participants was deemed appropriate to achieve a 95% confidence level, 10% width of the confidence interval, and 50% expected attribute value from the target population of lesbian and bisexual women who regularly visit SRC and VoVo organizations.

Data collection procedure and tools

The data collection procedure for this study involved the use of a semistructured questionnaire uploaded to Kobo Collect

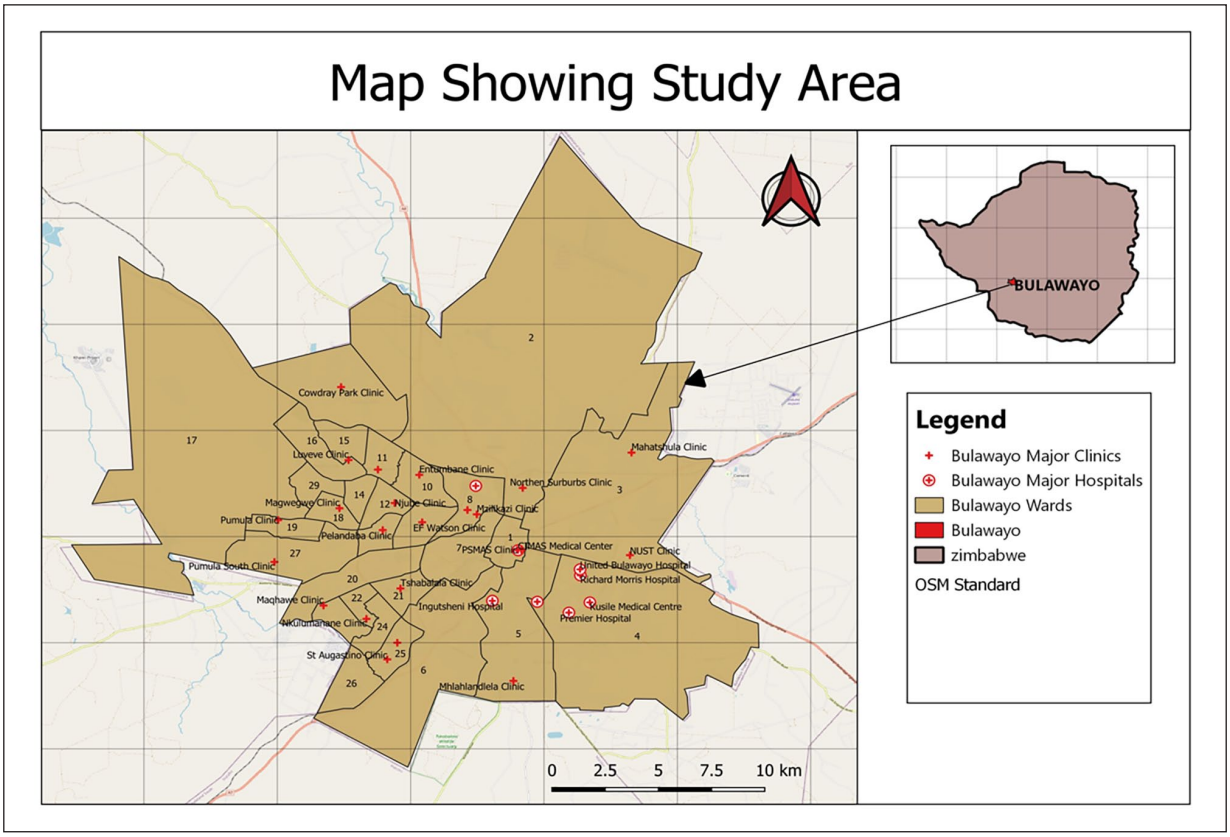

Figure 1. Study area map (Map developed by Methembe Yotamu Khozah).

software (which is an online free software available on https://www.kobotoolbox.org/). KoboToolBox is an open and free open-source suite tool used for field data collection and storage. The questionnaire was developed using Microsoft Word and then imported and deployed onto KoboToolBox. The questionnaire used in this study was specifically designed to collect quantitative data on the accessibility and utilization of SRH services by lesbian and bisexual women in Bulawayo in April 2023. The questionnaire development process was informed by the outcomes of a qualitative survey conducted prior to this research. This information was used to identify key variables that were relevant to the research objectives and questions. These variables included sociodemographic characteristics (age, sexual orientation, education, and religion), availability and utilization of SRH services, factors influencing service uptake, barriers to access, and the impact of policies on SRH service accessibility for lesbian and bisexual women. The outcome variable for this study was delay in accessing SRH services, which was measured by asking participants to report whether they had delayed accessing SRH services from the time they first attempted to do so. To ensure that the questionnaire was clear and comprehensive, a pilot test was conducted with a small group of lesbian and bisexual women (12) who were not part of the study sample. The pilot test helped identify and address any issues with the questionnaire, such as ambiguous questions or difficulties in understanding the response options.

Validity and reliability

The questionnaire was validated to ensure comprehensibility and clarity. The Kobo Collection tool was used for this purpose. A crosscheck was conducted to ensure that all questions were mandatory with the aim of achieving a response rate of 100%. The questionnaire was developed specifically for this study, drawing inspiration from previous studies and questionnaires related to SRH services and the experiences of lesbian and bisexual women.

Data analysis

An Excel file containing the data collected through the Kobo Collect software was retrieved and imported into STATA Version 15 (StataCorp LLC, TX, USA) S.E. for statistical analysis. Differences were considered statistically significant at a p-value < 0.05. The results are presented in tables using both SPSS and Excel Spreadsheets. Following data entry, all questionnaires, whether complete or incomplete, will be securely stored for 5 years, as mandated by the research regulations of the institute.

Table 1. Cross-tabulation of demographics by outcome delay of accessing services.

Sociodemographic characteristic		Sexual orientation						Total	
		Bisexual		Lesbian		Queer			
		Frequency (*N*)	Percentage (%)	Frequency (*N*)	Percentage (%)	Frequency (*N*)	Percentage (%)	Frequency (*N*)	Percentage (%)
Age	Under 20	1	3.1	0	0.0	0	0.0	1	1.5
	20–24	2	6.3	4	13.8	2	33.3	8	11.9
	25–29	10	31.3	11	37.9	2	33.3	23	34.3
	30–34	5	15.6	4	13.8	0	0.0	9	13.4
	35 and above	14	43.8	10	34.5	2	33.3	26	38.8
	Total	32	100.0	29	100.0	6	100.0	67	100.0
Level of education	Primary	4	12.5	3	10.3	0	0.0	7	10.4
	High school	13	40.6	11	37.9	3	50.0	27	40.3
	Tertiary	15	46.9	15	51.7	3	50.0	33	49.3
	Total	32	100.0	29	100.0	6	100.0	67	100.0
Religion	Nonbeliever	1	3.1	1	3.4	0	0.0	2	3.0
	Christianity	31	96.9	27	93.1	6	100.0%	64	95.5
	ATR	0	0.0	1	3.4	0	0.0	1	1.5
	Total	32	100.0	29	100.0	6	100.0	67	100.0
Employment status	Unemployed	6	18.8	5	17.2	0	0.0	11	16.4
	Employed	10	31.3	11	37.9	2	33.3	23	34.3
	Self employed	8	25.0	6	20.7	2	33.3	16	23.9
	Student	8	25.0	7	24.1	2	33.3	17	25.4
	Total	32	100.0	29	100.0	6	100.0	67	100.0

Results

Sociodemographic characteristics of study participants

The sample included 67 respondents, the majority of whom were bisexual women. The age group 35 years and above contributed significantly to the respondents. Over 49.3% of the respondents had completed at least one tertiary level of education. The findings also showed that over 95.5% of the respondents were Christians, with 3.0% indicating that they were nonbelievers. A significantly larger percentage of respondents were formally employed, while others cited that they were not working or were students. The findings are summarized in Table 1.

Furthermore, six sociodemographic characteristics were cross-tabulated with the outcome variable of delay in accessing services, and the results showed that four variables (age, employment status, highest level of education, and SRH services access place) were associated with delayed access to services. This was indicated by a Chi-squared *p*-value less than 0.05. Furthermore, multiple logistic regression analysis revealed that four variables (employment status, highest level of education, religion, and SRH services access location) were significantly associated with delay in accessing services. The findings are summarized in Table 2.

Factors influencing choice of SRH service

Of the 67 respondents, 57 and 55 felt that the inclusiveness of health facilities and the availability of lesbians and bisexual women-specific SRH services, respectively, influenced their choice in deciding which service to use. Moreover, of the five variables analyzed in relation to the outcome of interest, four (availability of lesbian and bisexual women-specific SRH services, health worker friendliness, inclusiveness of health facilities, and cost of SRH services) demonstrated a significant association with the outcome at a p-value of less than 0.05. Additionally, a multiple logistic regression analysis was conducted, which further identified that three of these variables remained statistically significant in their association with the outcome. Table 3 presents the results.

Factors that have an influence the choice of Institution

Most respondents (56 out of 67) cited that the inclusiveness of health facilities influences their choice of institutions where they access SRH services. More than 49 respondents felt that the existence of gender identity nondiscrimination policies influenced their choice of institution. In addition, when multiple logistic regression analysis was conducted to examine the relationship between the factors that influence the choice of institution and the outcome variable "delay of

Table 2. Cross-tabulation of demographics by outcome delay of accessing services.

Demographic characteristics		Outcome delay of accessing services		Chi test, *p*-value	MIR-OR	MIR-95% CI	MIR *p*-value
		No	Yes				
Age	Under 20	0	1	0.039	***	***	***
	20–24	4	4		0.294	0.00–0.00	1
	25–29	9	14		0.545	0.074–4.007	0.551
	30–34	2	7		0.863	0.224–3.321	0.83
	35 and above	10	16		2.022	1.293–13.957	0.475
Sexual orientation	Lesbian	11	18	0.536	0.611	0.410–3.332	0.773
	Bisexual	11	21		1.167	0.104–3.578	0.585
	Queer	3	3				0.769
Highest level of education	Primary	3	4	0.006	***	***	***
	High school	10	17		0.837	0.792–10.085	0.031
	Tertiary	12	21		0.774	1.201–20.343	0.007
Religion	None believer	1	1		***	***	***
	Christianity	23	41		3.203	1.345–20.053	0.002
	ATR	1	0				1.000
Employment status	Unemployed	3	8	0.03	***	***	***
	Employed	9	14		2.999	1.507–17.721	0.026
	Self-employed	5	11		1.372	0.266–7.064	0.007
	Student	8	9		2.957	0.502–17.428	0.231
SRH services access place	Private	9	20	0.006	1.595	1.502–5.071	0.042
	Public	16	22		***	***	***

***NB represents Comparison Group.

Table 3. Cross-tabulation of factors influencing choice of SRH service by outcome delay of accessing services.

Factors that contribute to choice of SRH		Outcome delay of accessing services		Chi test, *p*-value	MIR-OR	MIR-95% CI	MIR *p*-value
		No	Yes				
Availability of specific SRH services	Disagree	5	7	0.01	***	***	***
	Agree	20	35		5	2.391–28.354	0.003
Friendliness of health workers	Disagree	6	6	0.006	***	***	***
	Agree	19	36		6.2	1.791–38.477	0.032
Inclusiveness of health facilities	Disagree	2	9	0.04	***	***	***
	Agree	23	33		4.612	1.712–29.857	0.010
Cost of SRH services	Disagree	10	17	0.001*	***	***	***
	Agree	15	25		1.930	0.931–22.753	0.896
Knowledge of SRH services	Disagree	6	13	0.373	***	***	***
	Agree	19	29		1.299	0.370–4.556	0.683

***NB represents Comparison Group (The comparison group in this case refers to the group that was used as the benchmark for the crosstabulations and interpretations made relative to the group).

accessing services," the results revealed that the variable "Inclusiveness of health facilities" was statistically significant and associated with the outcome variable. This indicates that the level of inclusiveness within health facilities has a notable impact on delays in accessing services. When health facilities are more inclusive, they are associated with a decreased likelihood of delays in accessing services. Table 4 presents the results.

Challenges faced by lesbians and bisexual women when accessing SRH services

About 63 out of 67 respondents reported that they had experienced stigma, discrimination, or victimization at the hands of healthcare providers when accessing SRH services. Only 10 respondents cited that the unavailability of specific sexual and reproductive health resources was not a challenge for

Table 4. Cross-tabulation of factors that have an influence on the choice of institution by outcome delay of accessing services.

Factors that influence the choice of institution		Outcome delay of accessing services		Chi test *p*-value	MIR-OR	MIR-95% CI	MIR *p*-value
		No	yes				
Assurance that staff receive lesbian and bisexual women sensitivity training	Disagree	6	14	0.652	***	***	***
	Agree	19	28		0.696	0.162–2.994	0.627
Availability of lesbian and bisexual women-specific services	Disagree	4	8	0.009	***	***	***
	Agree	21	34		1.979	1.213–4.491	0.043
Existence of gender identity nondiscrimination policies	Disagree	3	15	0.486	***	***	***
	Agree	22	27		5.626	1.063–29.771	0.042
Availability of lesbian and bisexual women staff	Disagree	9	18	0.322	***	***	***
	Agree	16	24		2.498	0.409–15.261	0.321
Presence of lesbian and bisexual women staff	Disagree	4	12	0.363	***	***	***
	Agree	21	30		0.890	0.264–3.001	0.851
Inclusiveness of health facilities	Disagree	5	6	0.03	***	***	***
	Agree	20	35		4.212	1.031–41.477	0.017
Cost of SRH services	Disagree	7	11	0.322			
	Agree	18	30		1.037	0.298–3.604	0.955
Distance to the institution	Disagree	9	17	0.011	***	***	***
	Agree	16	25		0.775	0.236–2.55	0.675

***NB represents Comparison Group.

meeting their SRH needs. Furthermore, of the seven variables analyzed in relation to the outcome of interest, the variable unavailability of specific SRH resources for LGBT people was significantly associated with the outcome at a *p*-value of less than 0.05. Additionally, the odds ratio for this variable was found to be one, further supporting its significance. Furthermore, it remained less than 0.05, indicating an association between the availability of specific SRH resources for LGBT people and outcomes. The results are presented in Table 5.

Discussion

Lesbians and bisexual women felt that the inclusiveness of health facilities and the availability of lesbians and bisexual women-specific SRH services influenced their choice in deciding which service to use. Coşar[11] agrees with the findings and states that the availability of LGBT-friendly services, friendliness of health workers, and inclusiveness of health facilities promote the uptake of services among lesbian and bisexual women. This leaves the SRH needs of the people unmet.

This study revealed that lesbian and bisexual women can delay SRH services because of the unavailability of lesbian and bisexual women-specific SRH services. These findings are strongly supported by those of Narasimhan et al.[12] and Tabaac,[13] who found that the unavailability of specific sexual and reproductive health resources for LGBT people is a barrier to accessing services.[14] Their findings also revealed that most health systems were planned and implemented in a way that accommodated heterosexual people, as most information and resources did not address the practical SRH health issues confronted by the sexual and gender minority (SGM) populations.

The findings also showed that stigma, discrimination, or victimization at the hands of healthcare providers can also determine the uptake of SRH services by lesbian and bisexual women. A high level of stigma prevents access to and utilization of HIV prevention and treatment services,[15] which agrees with the findings and suggests that access to services is impacted by the unfavorable attitudes of healthcare workers (HIV service providers are frequently poorly equipped to serve key populations, and staff working in programs for these populations may lack the necessary sensitivity, skills, and knowledge).[16,17] In support of these findings, Müller[18] indicates that healthcare workers often stigmatize and discriminate against this population to the extent that they end up avoiding SRH services. Negative experiences with healthcare providers contribute to lesbian and bisexual women's uptake of SRH services. This is also supported by Melo,[19] who found that negative experiences with healthcare providers contribute to the erosion of a sense of safety in the healthcare system, and as a consequence, LGBT people avoid seeking care. These findings echo similar sentiments with Zhao et al.,[14] that under many circumstances, those who access health services report discrimination and ill-treatment by healthcare providers. The study results have important implications for healthcare providers, as they should ensure that their facilities are inclusive and welcoming for all patients, regardless of their sexual orientation or gender

Table 5. Cross-tabulation of challenges faced by lesbians and bisexual women when accessing SRH services by outcome delay of accessing services.

Variable		Outcome delay of accessing services		Chi test *p*-value	MIR-OR	MIR-95% CI	MIR *p*-value
		No	Yes				
Low levels of education and knowledge of Sexual and Reproductive Health	Disagree	10	8	0.502	***	***	***
	Agree	15	34		0.242	0.064 – 0.916	0.037
Stigma, discrimination or victimization at the hands of healthcare providers	Disagree	2	2	0.029	***	***	***
	Agree	23	40		4.101	1.101 – 11.987	0.009
Unavailability of specific sexual and reproductive health resources for lesbians and bisexual women	Disagree	7	3	0.036	***	***	***
	Agree	18	39		3.181	1.036 – 30.913	0.038
Inadequate availability of well-equipped treatment centers	Disagree	4	6	0.036	***	***	***
	Agree	21	36		1.809	1.150 – 14.374	0.038
High cost of drugs	Disagree	10	15	0.123	***	***	***
	Agree	15	27		1.097	0.319 – 3.769	0.883
Fear of healthcare providers	Disagree	5	14	0.371	***	***	***
	Agree	20	28		1.823	0.473 – 7.027	0.383
Criminalization of same sex marriages	Disagree	5	15	0.848	***	***	***
	Agree	20	27		2.524	1.622 – 10.245	0.019

***NB represents Comparison Group.

identity. This can be achieved by providing training to healthcare workers on LGBT issues, creating a safe and welcoming environment for LGBT patients, and offering gender-neutral services.[18]

The findings also indicated that low levels of education and knowledge of SRH among lesbian and bisexual women could be a challenge when accessing SRH services. The knowledge gap regarding SRH among lesbian and bisexual women has reduced the demand for HIV and other SRH services.[20,21] Hubach et al.,[22] share the same sentiments that there are low levels of education and knowledge of SRH among the LGBTQ+ group.

Strengths and limitations of this study

The manuscript might greatly benefit the community by highlighting the magnitude of the problem being faced by lesbian and bisexual women, which they can work toward addressing. The study may also be useful for informing policymakers in health, academia, and civil society organisations (CSOs) that focus on lesbian and bisexual women. The study concentrated on participants in the urban setting of Bulawayo who had ties or relationships with the Sexual Rights Centre and Voice of the Voiceless, and were open about their sexuality. This could have resulted in those who had not disclosed being excluded, and their voices not being heard. As a result, the participants in this study had already made their sexual preferences known, had been sensitized about their rights in general, and were readily available to share their challenges with health systems seeking SRH services.

Conclusion

From the study findings, it can be concluded that factors such as clinical settings, lack of specific SRH services for lesbians and bisexual women, and gender identity nondiscrimination policies influence the uptake of SRH services by lesbian and bisexual women. Health service providers' attitudes, stigma, and discrimination discourage them from seeking SRH services, reducing the demand for those services. This has also resulted in lesbian and bisexual women having preferences for their health facilities, particularly those who are sensitive to inclusion. As such, uptake can be improved by strengthening the linkages between clinics and sexual health education programs, providing lesbian and bisexual women-friendly clinical services, and ensuring that they have sufficient information, skills, and support to access care.

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Authors contributions

MYK conceptualized the research idea and drafted the manuscript. WNN coordinated the manuscript writing process, guided the writing process, and revised the draft manuscript. Both authors have read and approved the manuscript.

Availability of data and material

Not applicable.

Declaration of conflicting interests

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Ethical approval and consent to participate

This study was approved by the Institutional Review Board of the National University of Science and Technology in Bulawayo, Zimbabwe (ethics number: NUST/IRB/2023/76).

Consent for publication

An information sheet detailing the purpose of the study was available to the participants before they sought consent for their participation. Written consent was obtained from all the participants.

Trial registration

Not applicable.

ORCID iDs

Methembe Yotamu Khozah https://orcid.org/0009-0006-6100-5958
Wilfred Njabulo Nunu https://orcid.org/0000-0001-8421-1478

Supplemental material

Supplemental material for this article is available online.

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