

## Research Article

# LGBTQI+ Experiences of HIV Management Services at Primary Healthcare Facilities in Gauteng Province, South Africa

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Lesbian, gay, bisexual, transgender, queer, intersex, and plus (LGBTQI+) people are still discriminated against in South Africa, irrespective of their protection by the constitution of South Africa. The study explores the experiences of LGBTQI+ people when accessing HIV management services at public primary healthcare (PHC) facilities in Gauteng Province. Interpretive phenomenological analysis (IPA) was used. Data were collected through in-depth face-to-face interviews with six individuals who self-identified as LGBTQI+. The interviews were audio recorded with the permission of the participants. The data were transcribed verbatim and analyzed using the IPA framework. The findings indicate that LGBTQI+ people are marginalized, discriminated against, and stigmatized in the public PHC system, exposing them to unequal access to healthcare services. The heterocentric system disadvantages them from accessing specific HIV management services and appropriate preventive commodities. The study concludes that gender diversity, inclusion and sensitivity in healthcare provision, and specific LGBTQI+ training for healthcare providers, are crucial components of ensuring LGBTQI+ people's access to quality HIV management services.

## 1. Introduction

Social exclusion, discrimination, violence, and criminalization are some social determinants for lesbian, gay, bisexual, transgender, questioning/queer, intersex, and plus people's (LGBTQI+) poor health outcomes [1]. The 2016 South African Demographic and Health Survey showed that 21% of women over the age of 18, including those in same-sex relations, experience intimate partner violence that exposes them to chances of contracting HIV [2]. Despite efforts toward HIV/AIDS awareness raising and prevention strategies, men who have sex with men (MSMs) increasingly engage in high-risk sex. These lifestyles and unprotected sex behaviors are some of the factors contributing to the high rates of HIV transmission among the LGBTQI+ community [3].

The negative attitudes of healthcare professionals toward LGBTQI+ people lead to a high level of stigma and social discrimination, compromising the response of governments to the HIV epidemic among LGBTQI+ people [4]. In comparison with the general population worldwide, LGBTQI+ people often face barriers to accessing appropriate healthcare,

and they are less likely to receive competently and safely delivered HIV services [5]. The Unified Budget Results and Accountability Framework (UBRAF) invests in getting governments to be proactive and accountable in implementing human rights-based policies that eradicate stigmatization and discrimination against minority key populations (KPs). LGBTQI+ individuals are among the KPs. According to UBRAF, 6.3% of countries have measures to reduce stigma and discrimination in healthcare facilities, and 61% have pre- and in-service training for healthcare workers that is designed to include gender-sensitive stigma and discrimination reduction. Approximately, 60% of the countries have operational measures in place to redress stigma and discrimination cases in the healthcare environment [6].

The latest statistics estimate the overall HIV prevalence rate among the South African population at approximately 13.7%. The number of people living with HIV was estimated at 8.2 million in 2021. Since 2007, the estimated number of AIDS-related deaths has declined consistently from 274,501 to 79,420, reflecting a slight increase in 2021 to 85,154. Access to antiretroviral treatment has significantly altered

the pattern of mortality and extended the life span of many in South Africa over time [7]. The 2019 United Nations statistics highlight South Africa as having the fourth-highest adult HIV prevalence rate in Africa [8]. The 2018 Fiscal Year Program data indicated that 3.6 million HIV tests had been administered through the support of the Centers for Disease Control and Prevention in South Africa. This resulted in a 99% annual target achievement, with a 7% positivity rate. In the fiscal year 2017, the country achieved 98% coverage of HIV testing and reported that the number of people receiving antiretroviral therapy (ART) was 4,625,410. The Centers for Disease Control (CDC) in South Africa supported prevention activities that reached 88,240 individuals classified as KPs [9]. The 2016 World AIDS Conference held in South Africa made a strong call for KPs to be included in intervention strategies, emphasizing the importance of national responses to create conducive environments for KPs, and to increase their access to all services, including healthcare [10].

This identified need motivated the exploration of the experiences of LGBTIQ+ people when accessing HIV management services at public primary healthcare (PHC) facilities in Gauteng. LGBTIQ+ people are subjected to social erasure in many communities and formal socioeconomic structures. The researchers thus found it compelling to explore the LGBTIQ+ people lived experiences as they access services in the PHC context.

## 2. Materials and Methods

**2.1. Study Design.** An interpretive phenomenological analysis (IPA) design was used for this study. An IPA is a qualitative design to examine and interpret people's accounts of their significant life experiences and how they make sense of these life experiences [11, 12]. The researchers found IPA suitable for this study since they were interested in understanding the lived experiences of LGBTIQ+ people when accessing HIV management services at public PHC facilities. In the context of this study, HIV management services encompass the prevention and treatment of sexually transmitted infections (STIs), the suppression of HIV in the infected individuals, and stopping the progression of HIV disease and reinfections. The management of HIV includes the utilization of contraception and prevention strategies such as condoms, dental dams, and finger condoms; the administration of ART, preexposure prophylaxis (PrEP) and postexposure prophylaxis (PEP); adherence to treatment; and routine monitoring.

**2.2. Study Setting.** The study was conducted at urban public PHC facilities offering HIV/AIDS management services to LGBTIQ+ individuals in Gauteng, South Africa. Gauteng is the smallest of South Africa's nine provinces and the most overpopulated. The province has about 15.8 million people (26.3%), 26.7% of the total South African population [7]. Two public PHC facilities offering HIV management services, located in the Johannesburg and Tshwane municipalities, were involved.

**2.3. Study Population.** The study population comprised LGBTIQ+ self-identifying individuals who accessed HIV

management services at public PHC facilities. The inclusion criteria were as follows: an individual who self-identifies as lesbian, gay, bisexual, transgender, intersex, queer, and/or plus gender nonconforming, aged 18 years and older, and utilizing or having previously utilized HIV/AIDS management services at one of the identified public PHC clinics in Gauteng within the last 2 years, regardless of HIV status.

**2.4. Recruitment of Participants.** The main concern regarding individual participants was that they should have experienced a similar phenomenon and were able to share their rich accounts. The participants in this study, thus, represented LGBTIQ+ people as a KP, enabling the researchers to gauge and better understand their perceptions of their lived experiences [12, 13]. The recruitment occurred throughout the data collection period [14]. The researchers were permitted to put up open invitations at the PHC facilities for interested LGBTIQ+ individuals to contact the researchers through SMS, WhatsApp messages, and Please Call Me notifications. Information sheets were left with the receptionists for interested participants. In line with the snowball recruitment method, after their interviews, initial participants recommended other potential participants who met the inclusion criteria. The participants were assured protection of their anonymity and personal details, and confidentiality.

**2.5. Data Collection.** The data were collected using face-to-face in-depth interviews that were audio recorded with the permission of the participants. The data collection was guided by an interview guide composed of grand tour questions and some guiding probes. The use of an interview guide was piloted with two participants who were not part of the study. This process assisted the researchers in refining the interview guide with minor adjustments. The response to the grand tour question led to open-ended and unstructured questions as well as possible probes to facilitate further clarification. A total of six participants who utilized HIV management services at the PHC facilities were interviewed using the grand tour question, which was formulated as follows: May you kindly describe your personal experiences as an LGBTIQ+ self-identifying person acquiring HIV management services at this PHC facility? This interview format allowed the researchers to gain more knowledge about the lived experiences of LGBTIQ+ participants from their viewpoints. Although some of the participants were also fluent in other official South African languages, the interviews were conducted mainly in English because all the participants had an adequate understanding of the language and did not need any translation. An office was allocated at each facility to ensure privacy during the interviews. The purpose of the study and the interview process was explained. The SOLER technique (which is an effective actively listening interview method) was followed to ensure empathetic presence, active listening, observation, and understanding of the person's world [15, 16]. Prompts and probes were used to encourage the participants to talk in more depth and to solicit elaboration on or clarification of the statements made. Each interview session lasted about 4–60 min. Field notes were also kept. Data were collected from the 10<sup>th</sup> of September to the 14<sup>th</sup> of November 2020.

Six LGBTQI+ participants, therefore, made up the sample. A sample size of six is considered sufficient in qualitative studies of this nature [17–19]. This is corroborated by DeJonckheere and Vaughn [20], who indicates that a sample of 6–20 is appropriate for a phenomenological study.

**2.6. Data Analysis.** The researchers transcribed raw data from the interview audio recordings into written text within 48 hr of each interview. An IPA framework was used for data analysis. The focus of IPA is to examine the lived experience of the individual by drawing from the concepts of phenomenology, hermeneutics, and ideography [21]. Through these three aspects, the researchers were able to make sense of and understand the phenomenon of the study and considered the unique experience of each participant and their specific context in order to personalize their narrative. This facilitated the researcher's in-depth understanding of LGBTQI+ people's experiences as they accessed HIV services at PHC facilities. Two researchers analyzed the transcripts independently using an IPA framework. A third person (an expert in qualitative research), acted as an independent co-coder and conducted the open coding of each transcript. Each researcher read each transcript several times and listened to the audio recording a few times. The following seven IPA steps were utilized in the data analysis [22]: (1) transcription and data familiarization, (2) initial note-making, (3) identification of significant statements, (4) clustering themes, (5) a fresh treatment of new interview transcripts, (6) searching for patterns, and (7) interpretation. The researchers went through the steps collaboratively and reached a consensus on the final theme. The IPA two-stage interpretation process was also followed, whereby the participants were making sense of their world as they shared their own experiences and the researchers tried to understand the meanings of their attributions and, therefore, their world [23].

**2.7. Measures to Ensure Trustworthiness.** Measures were taken to ensure trustworthiness and rigor. Trustworthiness refers to the degree of confidence in data interpretation and methodology used to confirm the quality of a study [24]. The data were collected by the first author, who is experienced in working with KPs. The researchers did a lot of introspection and internal examination to explore personal feelings, experiences, and biases, and all of these were bracketed to enhance objectivity [25]. An independent peer researcher, who is also experienced in qualitative research but who was not part of the study, listened to the audio-recorded interviews and reviewed, and assessed the transcripts to review the emerging and final categories from those transcripts and the final themes of the study. A consensus was reached on the final content of the transcripts. Dependability was ensured by coding and recoding, repeatedly, comparing the themes and categories with a co-coder. To ensure that the analysis accurately reflected the participants' lived experiences and to enhance authenticity, verbatim extracts from the interviews were utilized [26]. To establish the credibility and dependability of the study, the research findings were validated through the process of member checking and the participants confirmed that the findings reflected their

feelings and experiences. During the generation of themes, the researcher had a peer-review process with a senior researcher who reviewed and challenged the analysis to ensure the rigor and credibility of the data analysis.

**2.8. Ethical Considerations.** All human research procedures were followed according to the Helsinki Declaration of 1975, as revised in 2013. Ethical approval for this study was granted by the College of Human Sciences Research Ethics Committee at the University of South Africa (reference number: HSHDC 986/2020) on June 5, 2020. Permission to conduct research at public PHC facilities was granted by the Provincial Health Research Committee of Gauteng. Authorization to access PHC facilities was issued by the District Research Committees (DRCs) in the province, including the Johannesburg DRC and the Tshwane DRC. The issues of power and influence were closely monitored to prevent any form of abuse by referral sources on the part of LGBTQI+ participants. The participants contacted the researchers without coercion [27]. Informed consent was obtained from all the participants in the study. This study followed ethical principles to protect the rights of the research participants. To enhance confidentiality and anonymity, participants' allocated numbers and age ranges (instead of true names and exact ages) were utilized. In addition, the names of the PHC facilities were not mentioned. The research information sheet was discussed with individual participants. Each participant signed the consent form in agreement with the conditions to participate in the study [27]. It was explained that the participants could withdraw their participation at any time. All the consent forms containing the signatures of the participants, collected raw data, and transcribed scripts were locked in a safe place and soft data documents were stored in a password-protected device.

### 3. Results

The sample of people who self-identified as LGBTQI+ consisted of six participants aged between 20 and 49 years. All of them accessed services at public PHC facilities in Gauteng. They all had different marital statuses, educational achievements, and employment statuses. Among the six participants, four were gay, one was a lesbian, and one was a transgender woman. Only one participant was unemployed. Table 1 shows the LGBTQI+ participants' biographical data.

The accounts of the experiences of LGBTQI+ participants culminated in four themes and related subthemes, as presented in Table 2.

**3.1. Theme 1: Healthcare Environment.** This theme shows the healthcare environment as described by the participants. The emergent subthemes of this theme are long waiting periods, overcrowded healthcare facilities, and noninclusive preventative care. The subthemes are discussed in detail below.

**3.1.1. Long Waiting Periods.** This subtheme describes how LGBTQI+ patients had to wait long periods at public PHC facilities to be assisted by healthcare providers. LGBTQI+ participants described expectations for people to wait in long queues for long periods to access services at PHC

TABLE 1: Biographical data of LGBTQI+ participants.

Participants	Age (years)	Self-ID	Marital status	Qualification	Employment status
Participant 1	30–39	Lesbian	Divorced	Higher education	Employed
Participant 2	40–49	Gay	Single	Matric	Unemployed
Participant 3	30–39	Transgender woman	Engaged	Matric	Employed
Participant 4	30–39	Gay	Single	Higher education	Employed
Participant 5	20–29	Gay	Single	Matric	Self-employed
Participant 6	40–49	Gay	Single	Higher education	Employed
Total no. of LGBTQI+ participants	Age (years)	Self-ID	Marital status	Qualification	Employment
6	20–29: 1	4 gays	4 single	3 matric	4 employed
	30–39: 3	1 lesbian	1 divorced	3 higher education	1 self-employed
	40–49: 2	1 transgender woman	1 engaged		1 unemployed

TABLE 2: Themes and subthemes.

Themes	Subthemes
Healthcare environment	Long waiting periods
	Overcrowded healthcare facilities
	Noninclusive preventive care
Factors enhancing access to services	Trained healthcare providers
	Nurses dedicated to providing LGBTQI+ health services
	Working in partnership with private organizations
Barriers to accessing HIV management services for LGBTQI+ people	Delayed access to treatment due to COVID-19
	Limited access to gender-affirming procedures
	Gender binary forms
	Silence about LGBTQI+ people's issues
Impact of LGBTQI+ unfriendly healthcare services	Availability of appropriate HIV prevention commodities
	Increased risk of HIV infection
	Defaulting treatment

facilities as unreasonable. They found the public PHC systems and procedures to be contributing to the unfair treatment of patients. The participants explained that the long waits evoked mixed views, feelings of frustration, and sometimes caused anxiety, as illustrated in the following interview extracts:

*Sometimes you find that you wake up early in the morning at five o'clock but stay too long at the clinic. Maybe they are too slow or something, but you will sometimes spend most of the day there. In addition, the clinic is too full. (Participant 1)*

*It takes a very long time to be in the queue and nurses take time to attend to us. I am telling you just thinking that tomorrow I am going to the clinic makes you feel so helpless because you know you are going to spend almost the whole day there. (Participant 2)*

Some participants were of the view that if they had specialized services dedicated to them, they would not have to queue for extended periods waiting to be attended to at the clinics.

*Maybe we can have our own side in the clinic, where we have our own doctors and nurses and we don't have to be with many other patients. (Participant 5)*

Other participants, however, opined that patients needed to be tolerant and accept that long waiting times were part of the system:

*I have heard a lot of complaints about the waiting time, but when I look at it, I realize that people just want to come in and get out of the clinic. They don't want to wait in queues but, in reality, it does not work like that; you have to be patient. (Participant 6)*

**3.1.2. Overcrowded Healthcare Facilities.** This subtheme indicates how overcrowding at PHC facilities affects the patients. The participants shared that the issues of long queues causing overcrowding were ongoing, without alternative solutions. According to them, these reflected poor patient management and poor time management at PHC facilities. They postulated that such occurrences lowered their confidence in the healthcare provided.



*Sometimes you find that you wake up early in the morning at five o'clock but stay too long at the clinic. Maybe they are too slow or something, but you will sometimes spend most of the day here. The clinic is too full. (Participant 2)*

**3.1.3. Noninclusive Preventive Care.** This subtheme connotes the impact of noninclusive preventive healthcare services on LGBTQI+ people. Sexual and reproductive healthcare commodities specific to LGBTQI+ people's needs were found to be lacking at PHC facilities. The participants disclosed that when they could not get the necessary preventive supplies as part of free public PHC services due to stockouts, they were issued prescriptions to purchase supplies from private pharmacists. They shared that since their wellness depended on preventive medication and appropriate preventive commodities, they had to find ways to acquire them, irrespective of their financial realities. They identified this as a contributing factor to treatment defaults and poor infection prevention and control. The following statements demonstrate this issue:

*They are not supplying me with PrEP. I must buy it at a private chemist, but I can't buy it without a prescription, so some doctors just give me a once-off prescription, then I can go and get it. Sometimes I end up just discontinuing PrEP despite knowing that I am at risk of contracting HIV because it is expensive to get those tablets. (Participant 4)*

*Dental dams are important to use for the prevention of infections during sexual intercourse; they allow you protection when you perform oral sex. You don't get them at public clinics. You have to go into a private facility to purchase those for your protection and your consumption. (Participant 1)*

**3.2. Theme 2: Factors Enhancing Access to Services.** This theme is about aspects that enable LGBTQI+ people to gain access to their required services. The following subthemes emerged from this theme: preparing healthcare providers to care for LGBTQI+ people, nurses allocated specifically for LGBTQI+ individuals, and working in partnership with private organizations.

**3.2.1. Trained Healthcare Providers.** This subtheme shows that the environment was conducive for gender-diverse people. LGBTQI+ people shared that they felt well catered when enabled to gain access to PHC facilities that provided for their holistic wellness. They explained that in such exceptional cases, they were exposed to a different environment in public healthcare services. They indicated that receiving services from healthcare providers who had been specially trained in LGBTQI+ people's health issues and treatment needs increased the quality of the services rendered and restored their confidence in the healthcare system. A participant explained it as follows:

*So, the staff has been trained on LGBTQI issues and they have the materials you need and mental healthcare support. There is so far nothing else that might be a need for LGBTQI HIV health that is not covered by the services in this clinic that I have missed. (Participant 6)*

**3.2.2. Nurses Dedicated to Providing LGBTQI+ Health Services.** This subtheme evidences the impact of allocating special nurses for service to LGBTQI+ people. The participants emphasized that it was important for them to have an equally inclusive public healthcare system. In an exceptional case in the Tshwane district, the participants expressed appreciation for a program for LGBTQI+ people where they were treated by specially designated nurses trained to render services to LGBTQI+ patients in the public PHC sector. A participant said:

*I feel that with us, we are fortunate because we have nursing sisters who are specifically dealing with us, and they are trained. If you come to this clinic, they serve the MSM, transgender, and LGBTQI community; these people are well trained to help us, from the gate security to the head of the clinic. (Participant 6)*

The participant emphasized:

*When a nurse understands the life of gay people and knows how to help people who are non-heterosexual, it comes as a blessing because they treat us without judgment and I can see that they know what they are doing. Moreover, because we are treated by specific nurses, we are used to them and we trust them. They help us to be free and to open up about our health issues. (Participant 6)*

**3.2.3. Working in Partnership with Private Organizations.** This subtheme demonstrates the benefits of collaboration between public PHC clinics and private businesses. The participants alluded to the benefits of multidisciplinary public-private stakeholder partnerships; these had proven to be significant to the success of LGBTQI+ people's social and health programming over time. They witnessed that the complementary role that each key stakeholder played in the local health sector strengthened the quality of service. This was expressed as follows:

*It's better for me because now I collect my three months' medication supply from Clicks. I only go to the clinic twice a year to draw some blood and do the screening. I also just go if I feel ill, so I don't have to wait in those long queues. (Participant 2)*

*I am glad that I do not have to go to the clinic every month to collect my medicines. The nurse arranged for me to pick them up at the pharmacy next to my workplace and it is convenient. It*

*saves time; I manage to go during my lunchtime.*  
(Participant 1)

**3.3. Theme 3: Barriers to Accessing HIV Management Services for LGBTQI+ People.** This theme points to obstacles that make it difficult for LGBTQI+ people to gain access to HIV management services at public PHC facilities. Emergent sub-themes were as follows: delayed access to treatment due to COVID-19, limited access to gender-affirming procedures, gender binary forms, silence about LGBTQI+ people's issues, and treatment availability.

**3.3.1. Delayed Access to Treatment due to COVID-19.** This subtheme shows how COVID-19 affected access to medical treatment. The participants were concerned that the advent of COVID-19 had added to the complexities of access to healthcare and treatments that already existed. They related that the lockdown conditions had further slowed down operations at facilities and affected their access to treatment and preventive commodities. The following extracts illustrate this:

*Before COVID-19 I had an appointment at the clinic but like other people, I was afraid to go out and collect medications; I was afraid to mix with others and afraid to get COVID. I ended up gathering some strength to go to the clinic after having gone without taking medication for three weeks.* (Participant 6)

*COVID-19 has come to disturb everything. I am still waiting to see the specialist since the lockdown. They said they would contact me.* (Participant 4)

**3.3.2. Limited Access to Gender-Affirming Procedures.** This subtheme demonstrates how limited access to gender-affirming procedures affects those who need such procedures. A transgender participant felt that the state of public PHC facilities was not user-friendly for them regarding access to hormonal therapy. She believed such treatments should be brought closer to the people, and access to services should be simplified. Participants explained:

*There are a lot of people who want to undergo the transgender procedure, but they tell us about the hospital. We can't start here. If they could try to use one local clinic for such services because it is congested at the hospital. If we want to do transgender treatments, we should get them from the government clinic facilities locally.* (Participant 3).

*I know that many people who want to start hormonal therapy find it difficult. My friend has been trying on and off for about two years now because the local clinic does not give such treatment. It becomes expensive for her because it*

*means she has to travel from our location to town to get such a treatment every time. So, it is not always possible because she is working.*  
(Participant 4)

**3.3.3. Gender Binary Forms.** This subtheme reveals how they are affected by the type of forms used at PHC facilities. LGBTQI+ participants explained that they experienced a superiority complex assumption of heterosexuality that subjected them to its norms and standards regarding administration requirements at PHC facilities. They observed that the nurses and administration staff filled in the gender specification requirement part of the forms according to what they thought they saw or how they perceived the gender of the patient to be, according to the limitations of the gender binary. One of the participants asserted that a wrong assumption was made:

*Some nurses think that I am a man. When they fill out the clinic forms, they tick male. But I am a woman, a transgender woman. I have adopted children who call me mama, and nieces and nephews who call me aunt.* (Participant 5)

Another participant viewed this matter as follows:

*At the clinic, the receptionists and nurses don't even care. They don't ask you how you identify. One day, I examined my file and I saw that on the forms they crossed the box for male, but nobody asked me anything like if I identify myself as male or female or other. They just do what they want.* (Participant 5)

**3.3.4. Silence about LGBTQI+ People's Issues.** This subtheme points to the witnessed silence regarding LGBTQI+ issues. The participants found that healthcare providers avoided discussions around LGBTQI+ people's issues in general and LGBTQI+-related health issues specifically. Nurses and health promoters facilitated presentations about many health topics, except LGBTQI+ people's health matters. These patterns appeared to be discriminatory and made them feel like they were invisible and that the uniqueness of some of their health issues was not acknowledged. They experienced such treatments as systemic discrimination and unequal healthcare services. Participants recounted:

*I have been coming to this clinic for over six years and I respect my clinic appointments; I know most of the nurses now and I am friendly to all of them, but I have never been asked about my sexual orientation, it's like nobody is interested. I am just another number.* (Participant 1)

*Nobody ever talks about LGBTQI at this clinic. There is no education or anything related to homosexuality or transgender. It is like we are not there. It's the first time that I speak to*

*someone at the clinic about LGBTQI stuff and my private life as an LGBTQI person, and I am happy because I can cough out and freely express myself. (Participant 2)*

**3.3.5. Availability of Appropriate HIV Prevention Commodities.** This subtheme communicates the availability of HIV prevention commodities for LGBTQI+ people. The participants acknowledged the positive aspects of public PHC services. However, they noticed gaps in the system regarding the provision of their specific healthcare requirements. They explained that there was no uniformity at PHC facilities regarding LGBTQI+ services; they felt that their healthcare provisions were not strategized for as part of the greater healthcare plan. They contended that they were continuously marginalized as public PHC service users. A participant narrated:

*Not that nothing is being done, but there is space for improvement so that at the end of the day, even as the LGBTQI community, we can feel like part of society. For example, when we get to the clinic, we find the ordinary female condom and the ordinary male condom. You never find dental dams, which are some of the materials that some lesbians can use that help them be protected from certain infections during sexual intercourse. Right now, the available materials are primarily for heterosexual individuals. (Participant 1)*

**3.4. Theme 4: Impact of LGBTQI+ Unfriendly Healthcare Services.** This theme denotes the impact of LGBTQI+ unfriendly healthcare services. Participants referred to hostile responses by healthcare providers toward LGBTQI+ people consulting at PHC facilities. They described feelings of discomfort, humiliation, and neglect when visiting public healthcare facilities, which negatively affected their health responses and outcomes. Two subthemes that emerged were increased risk of HIV infection and defaulting treatment. These subthemes are discussed below.

**3.4.1. Increased Risk of HIV Infection.** This subtheme indicates LGBTQI+ health issues around the increased risk of HIV infection. The participants were considerate of the lack of public awareness of their sexual health issues, including preferred sexual engagement methods among different LGBTQI+ people on the spectrum and relating to risky behavior concerning HIV. Participants alluded to this fact:

*I lacked information and this is why you find that a lot of gay men get exposed to infections such as HIV more than others in the population because not everyone in the population is educated about these things. (Participant 1)*

*Sometimes there are things that I think I cannot do with condoms or dental dams. Oh, ok I can,*

*but it is not the same, I mean it is not so nice. (Participant 4)*

**3.4.2. Defaulting Treatment.** This subtheme shows the causes and effects of defaulting treatment. LGBTQI+ participants reported experiences of inconsistencies in the supply of their treatment, medications, and necessary preventive commodities at public PHC facilities. In instances where they could not secure supplies from the facilities, they had to source them privately. Sometimes they could not afford to buy needed supplies; they therefore reluctantly had to temporarily discontinue taking the medication. These patterns of interruptions led to treatment defaults and abandonment:

*Although I want to always protect myself and prevent HIV infection, sometimes I end up just leaving the PrEP treatment because it is expensive to get those tablets, and that puts me at risk of exposure. (Participant 4)*

*When you get to the dispensary, they tell you that they don't have the medication that the sister or the doctor has prescribed for you. They say it is out of stock at the clinic, or they are waiting for delivery. If you don't get money to buy, you have to wait until you come to the clinic again. (Participant 1)*

## 4. Discussion

This study found that the healthcare environment, factors enhancing access to treatment, barriers to accessing HIV management services for LGBTQI+ people, and the impact of LGBTQI+ unfriendly healthcare services were significant areas of concern. The key findings indicate that LGBTQI+ people experience public PHC services as less invested in their HIV health needs. Studies report that persistent marginalization is a problem for universal HIV treatment for sexually diverse people [28]. The results reveal that what occurs at the public PHC facilities when LGBTQI+ people consult for treatment has a great impact on their experiences of the environment, the behavior of nurses as healthcare providers, administrative operations, examination methods, and the processes involved in healthcare provision. According to the results of the study, LGBTQI+ people's experiences of the quality of public healthcare services are determined by an array of internal and external factors that manifest in the PHC system. They experience bias, discrimination, and stigmatization in the form of misgendering when addressed with a gender, pronoun, or name that is incongruent with their own identity [29]. The lack of knowledge among healthcare providers increases social and structural inequalities in healthcare provision; these also impair healthcare provider-patient interactions [30]. The resulting inadequate healthcare access is exacerbated by heterosexist attitudes and a lack of sensitization to the health needs of LGBTQI+ people on the part of healthcare providers [31]. As a similar study



concluded, healthcare providers should therefore collaborate with LGBTQI+ people to overcome a range of barriers that prevent access to care [30].

This study found that participants always experienced long queues and slow processes at public PHC facilities, but processes were slower specifically during the COVID-19 lockdown. Some of the patients were asked to return on different dates as their consultations were postponed, limiting the number of people in the facility to comply with lockdown regulations. Others became discouraged by the long queues that were exacerbated by social distancing, returned to work or home, and consequently faced delayed access to treatment. A study conducted in Wuhan (China) also found that the COVID-19 pandemic presented multiple access barriers and challenges to the HIV care continuum [32]. LGBTQI+ people were found to be at greater risk of worse COVID-19 outcomes due to their higher rates of comorbidities compared to non-LGBTQI+ people. Moreover, they traditionally faced barriers to accessing healthcare services as a marginalized population [33].

The findings show that patients stand in queues long before the facility opens and the staff arrived, but they still spend extended periods waiting to be attended to. Some patients risk their jobs when having to wait. The issue of long queues was not unique to this study. A study in Tanzania found that sex workers accessing HIV care services in the public healthcare system arrived at the facility before it opened but still experienced delays in service provision [34]. A Canadian study described the long waiting time to access PHC services as a financial burden to patients and explained that it worsens their health outcomes [35]. LGBTQI+ patients view some behaviors of healthcare providers as a lack of proper communication and as insensitive and noncaring attitudes; and they see it as an exhibition of power dynamics at play, flexing the rights of service providers over those of beneficiaries. A related study [36] found that patients may be affected by perceived characteristics of intimidation and the imbalance of power in healthcare.

This study also found that due to the COVID-19 restrictive measures, participants experienced delays in accessing HIV care as well as treatment interruption. These findings are similar to those of a study in Kenya [37], which found that during COVID-19 sex workers had challenges accessing healthcare services. Another related study found that the COVID-19 pandemic caused disruptions in service provision, resulting in negative effects on HIV care outcomes [38]. Evidence has also demonstrated that the use of telehealth was critical in enhancing adherence support and preventing treatment interruption [39–42]. In the context of COVID-19, there are advocates for the expedition of differentiated service delivery by using strategies such as multimonth scripting and dispensing of ART to prevent interruptions to treatment [43].

This study's findings also indicate that healthcare providers assume that all people are heterosexual and approach healthcare provision from that perspective. They are also informed by common practices in the healthcare system. Similar findings were noted in a Zimbabwean study where

men who had sex with men experienced heteronormative counseling, stigma, and discrimination as they accessed HIV care services [44]. Heteronormativity is a queer theory that privileges heterosexuality [45]. It presumes that heterosexuality is morally superior and a default for everyone, and it reinforces gender binaries and traditional gender roles.

Evidence shows the lack of knowledge and skills among healthcare providers in the health of different population groups on the LGBTQI+ spectrum and their specific healthcare needs. The results corresponding with those of this study reflect a significant interconnection between state functioning and its implications for people's daily living experiences [46]. They further show that government institutions reaffirm heteronormativity, through policies, systems, procedures, and norms, placing restrictions on groups of people to enforce unfair distribution and allocation of resources. The results of LGBTQI+ participants' data in this study reflect that the participants continuously experienced marginalization and exclusion in the public PHC system.

In a similar study, the reproductive justice framework acknowledged interconnected systemic barriers to LGBTQI+ people's healthcare, such as heterosexism, sexism, and racism [47].

The results of previous research corroborated the findings of the study, indicating that most healthcare providers lack basic education about LGBTQI+ people's health and patient care [48]. The study further found that when healthcare providers are not adequately prepared and equipped to deal with the healthcare requirements of LGBTQI+ patients', they cannot effectively identify and manage their unique HIV and opportunistic infections. They fail to understand the direct and related courses of some symptoms that LGBTQI+ people present with because of their lack of context regarding LGBTQI+ people's sexuality and social life background.

Other patients, however, benefited from the public PHC facilities' collaboration with the private sector, as they were able to collect their medical supplies from private pharmacies on specific dates and could therefore avoid dealing with long queues. Although being on the same outsourced program, some participants reported that they still refrained from collecting their medicines from private pharmacies and other collection points due to fear of contracting the coronavirus; they, therefore, defaulted on treatment during that time.

Previous related research revealed that transgender people self-isolate due to transphobia in society and therefore have compromised health outcomes among other transgender-specific factors [49]. Findings of this study further indicate that transgender people described the hormonal treatment as inaccessible to them because they found the processes unclear and the treatment not available at every public PHC facility. The conditions of COVID-19 were found to have exacerbated the issues of access to treatment for transgender people.

LGBTQI+ people also face challenges when filling in forms at facilities, as these forms exclude their identification. The participants' information shows that the facility administrators, receptionists, and nurses do not consider patients' concerns regarding their gender identity when completing forms. They solely decide if the person they see is male or



female, without considering that the individual might not identify with the gender binary. Such presumptions can be perceived as assertions of heterosexual bias in the PHC system and a form of LGBTQI+ people's oppression or erasure. As found in other related studies, participants indicated that they preferred that the staff ask how they identified themselves [50, 51].

LGBTQI+ people feel forced to make means to stay on treatment and purchase appropriate preventive material, even when it is sometimes beyond their financial capacity [52]. The authors report that the conservatism of government leaders has an impact on health policy processes, budgets, and implementation priorities. The findings show that LGBTQI+ people feel humiliated and perceive their healthcare needs as neglected when they find that their required medicines and preventive materials are not available at public PHC facilities. This contributes to research findings that indicate a need for focused attention to transgender and intersex people's gynecological and urological prevention measures [53].

According to the results, unfriendly clinical environments and services cause LGBTQI+ people some discomfort and they view such service delivery as insensitive and marginalizing. Another study established that poor treatment by healthcare providers increased health disparities in LGBTQI+ people [54]. The results of this study also show that the negative comportment of healthcare providers has an adverse impact on LGBTQI+ people's health outcomes. Homophobic attitudes, judgmental remarks, and nonengaging attitudes are experienced by LGBTQI+ patients, such as rejection and exclusion, structurally representing discriminatory, unsafe, and unfriendly spaces.

## 5. Recommendations

Other researchers who are interested in this research area may conduct the same study, basing it on a larger sample size.

LGBTQI+ people need to have adequate access to quality healthcare treatment and their required specific preventive materials at all public PHC facilities. The community should help to promote the facilities as safe spaces for LGBTQI+ people. Educative health promotion materials and discussions should include LGBTQI+ people's health issues. LGBTQI+ training for healthcare providers can also empower them to render good quality health services with compassion, understanding, and care [55]. At national, provincial, district, and facility levels, decision-makers, and service providers need to demonstrate commitment to ensuring equality in PHC service provision.

Health strategists should ensure that LGBTQI+ people's sexual and reproductive health programs are sensitively responsive to their specific needs, including HIV management services, family planning, sexual and reproductive health screening, and dispensing of PrEP and PEP [31]. Dental dams, finger condoms, and lubricants should therefore be freely supplied to LGBTQI+ people at all public PHC facilities. Access to gender-affirming procedures and

hormonal treatments is significant for transgender people. There should be consistency in their treatment provision at the PHC level. The use of these commodities has proven to be an effective safe sex practice that is critical for the prevention of HIV and other STIs [56].

## 6. Conclusions

The findings of this study demonstrate the need to design interventions that meet the diverse and unique HIV health needs of LGBTQI+ people in PHC settings. Discrimination against LGBTQI+ people in PHC is systematic, and the healthcare services are found to be heterocentric by design; operations and practice, therefore, follow the same pattern [57]. These approaches exclude LGBTQI+ people from gaining access to the necessary and appropriate healthcare interventions. Furthermore, the oblivious attitudes and behaviors of healthcare providers add to the health access barriers of LGBTQI+ people. The public PHC system needs to create a healthy, safe, and enabling environment for LGBTQI+ people at the facilities. The administration, as the first point of access, needs to be transformed. Documentation and forms should be adapted to be inclusive of all population groups and allow nonheterosexual people to suitably identify themselves. The lack of diversity training is a major part of LGBTQI+ people's negative experiences at public PHC facilities [58]. Healthcare providers and support staff need applicable training and relevant skills to be able to provide appropriate services to LGBTQI+ people. This study concludes that the public PHC system should protect the human rights of LGBTQI+ people and ensure that they can access quality healthcare services designed to sensitively respond to LGBTQI+ people's specific HIV health treatment and appropriate preventive commodity needs.

## Data Availability

The data that support the findings of this study are available from the corresponding author on special request. The requests may be directed to the following email address: mulemfod@yahoo.com.

## Additional Points

*Limitations.* This study was conducted in two health facilities in Gauteng during the COVID-19 Level 1 lockdown restrictions in South Africa. The lockdown conditions affected some of the initially interested participants and preventing them from participating in the study. Some PHC facilities declined to participate in the study, as they indicated that they did not have LGBTQI+ patients or clients. The literature is limited in terms of exploratory studies aimed at understanding the experiences of LGBTQI+ people who access services for HIV management services at public PHC facilities in South Africa. The results cannot be generalized to other LGBTQI+ people in other populations and settings.

## Conflicts of Interest

The authors declare that they have no conflicts of interest.

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