The Open Nursing Journal

Content list available at: https://opennursingjournal.com

RESEARCH ARTICLE

Preparedness of Professional Nurses Rendering HIV Healthcare Services to LGBTIQ+ People in Gauteng Province, South Africa

Desirée Morakane Mulemfo[1,*] and Azwihangwisi Helen Mavhandu-Mudzusi[1]

[1]*Department of Health Studies, University of South Africa, Preller Street, Muckleneuk Ridge, Pretoria, South Africa*

Abstract:

Background:

Access to HIV services by LGBTIQ+ individuals is the key to the Agenda for Zero Discrimination in Healthcare settings. As professional nurses are key drivers of HIV healthcare services in government/public settings, there is a need to understand their preparedness for rendering services to LGBTIQ+ individuals who can be considered dual marginalized because of HIV status and being gender or sexual non-binary. However, there is a scarcity of studies focusing on the preparedness of healthcare providers to render HIV services to LGBTIQ+ individuals.

Objective:

The purpose of this study was to gain an in-depth understanding of the professional nurses' preparedness in rendering HIV healthcare services to LGBTIQ+ people at public primary healthcare clinics in Gauteng.

Methods:

This qualitative study followed an interpretative phenomenological analysis design. In-depth semi-structured interviews were conducted with nine participants recruited through criterion purposive sampling. The sample size was determined by data saturation. Data were transcribed verbatim and thematically analyzed, guided by the Interpretive Phenomenological Analysis framework for qualitative data analysis.

Results:

Findings indicate that professional nurses lack information regarding LGBTIQ+ communities. Furthermore, they have limited knowledge and skills for preventing and managing HIV in these communities. This is because of a lack of formal training about LGBTIQ+ people's unique HIV conditions, specific socio-medical interventions, and necessary preventive materials.

Conclusion:

Lack of formal preparation of professional nurses regarding LGBTIQ+ individuals and their healthcare needs might hinder the achievement of the desired zero new HIV infections and zero HIV-related death. The researchers thus recommend the inclusion of LGBTIQ+ communities and their healthcare needs in the nursing curriculum and upscaling nurses to render LGBTIQ+-friendly healthcare services.

Keywords: HIV healthcare services, Inequalities, Interpretative phenomenological analysis, LGBTIQ+ health, Preparedness, Primary healthcare, Professional nurses.

Article History	Received: April 28, 2022	Revised: September 03, 2022	Accepted: October 24, 2022

1. INTRODUCTION

Access to healthcare services, including HIV prevention by all individuals, is the key to winning the battle against Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Virus (AIDS). Primary healthcare (PHC) is the first level of healthcare at which most patients access the health system. It is committed to increasing access to quality care and improving healthcare delivery, and providing clear guidance to support equitable access to essential healthcare services by focusing on access, equity, efficiency, quality and sustainability [1]. In South Africa, the PHC approach was adopted at Alma Ata in 1978; it is a nurse-based healthcare system. The PHC Re-engineering Program strengthens nurses' role in the healthcare system as they contribute to family

* Address correspondence to this author at the Department of Health Studies, University of South Africa, Preller Street, Muckleneuk Ridge, Pretoria, South Africa; Tel: +27 (0)71 402 4120; +27 (0)12 429 2055;
E-mail: mulemfod@yahoo.com

health. Research emphasizes that the role of the nurses at the PHC level is paramount in this regard [2].

In the fiscal year 2017/18, an acceleration plan was initiated to improve health outcomes and achieve the 90-90-90 targets aimed at ending the global AIDS epidemic. These targets involve identifying 90% of people living with HIV through expanded testing, placing 90% of those identified as HIV positive on antiretroviral therapy (ART) and ensuring that 90% of those on therapy achieve undetectable viral loads [3]. The outcomes saw over 4.1 million people living with HIV retained on treatment and over 13 million people tested for HIV [4]. The National Department of Health (NDoH) and the National Treasury launched the Ideal Clinic (IC) initiative in 2013 to systematically reduce deficiencies in PHC clinics in the public sector. At the end of 2018, 1 507 facilities qualified as ICs [4]. However, a study conducted by Treatment Action Campaign (TAC) in Gauteng indicates that ensuring access to quality healthcare services and treatment for everyone living with HIV and TB depends on the availability of enough qualified and committed workforce [5]. It was stated that human resource shortages cause long waiting times, patients being turned away from clinics, a higher risk of death, and increased pressure on the few available staff. This study reports that 25% of health facility staff was generally friendly; 70.8% of the staff was recorded as sometimes friendly, and 4.2% of the staff was considered not friendly. These attitudes, classified as "Bad staff attitudes," were reportedly witnessed in all cadres in the healthcare system and attributed to factors that affect patients' ability to access healthcare [6]. These attitudes were focused on the general population living with HIV without considering other vulnerabilities, such as being gender or sexually diverse. Studies indicated that healthcare providers have negative attitudes toward the lesbian, gay, bisexual, transgender, intersex, queer, and plus (LGBTIQ+) community which is considered to be one of the vulnerable populations to HIV regardless of their HIV status [7]. Moreover, LGBTIQ+ people experience stigma and discrimination in most communities. The negative attitude towards LGBTIQ+ individuals is not only portrayed in the community but also extends to public institutions [7]. One such institution is healthcare. The negative attitudes affect their access to services, including healthcare. There is evidence that LGBTIQ+ individuals are sometimes mistreated, harassed, discriminated against or even denied access to healthcare services [8]. Very few healthcare providers are properly trained about transgender health issues [5]. This leads to limited healthcare access and negative healthcare encounters for transgender people. A study presented evidence of a chain of homophobia linked to poor health outcomes for men who have sex with men (MSM); they face more challenges associated with marginalization and oppression across the health sector [6].

However, several studies report on the general challenges of LGBTIQ+ individuals in accessing health care services without specifically focusing on HIV services. Access to HIV services by LGBTIQ+ individuals is the key to the Agenda for Zero Discrimination in Health-Care settings to affirm governments' commitment to redress inequalities in health practices that undermine key populations, such as LGBTIQ+ people living with HIV [9]. As professional nurses are the key drivers of HIV healthcare services in government/public settings, there is a need to understand their readiness to render such services to LGBTIQ+ individuals who can be considered dually marginalized because of HIV status and being gender or sexually non-binary. Against this background, this paper presents the preparedness of professional nurses to render HIV healthcare services to LGBTIQ+ people at public PHC clinics in Gauteng province, South Africa.

2. MATERIALS AND METHODS

2.1. Research Design

This qualitative study used interpretative phenomenological analysis (IPA) design to gain insight into the preparedness of professional nurses' rendering HIV health services to LGBTIQ+ people at public primary healthcare clinics in Gauteng province. Some of the influential scholars of IPA include Heidegger, who believes that researchers are part of the research, and Merleau-Ponty, who postulates that interpretation comes from people's perspectives as living beings [10]. The researchers envisaged that this design would enable them to explore participants' preparedness and the attributed meanings. As IPA has a double hermeneutic character, while the participants were interpreting their preparedness, the researchers were similarly interpreting and analyzing how participants viewed and perceived their preparedness in rendering HIV services to LGBTIQ+ individuals. The researchers were thus not keen on the descriptions but more interested in the participants' contextual experiences [11].

2.2. Setting

The study was conducted in six selected clinics in Gauteng Province, South Africa. Gauteng province is considered most relevant as it is where most individuals who identify as LGBTIQ+ from both South Africa and other African states are found. Most of the LGBTIQ+ individuals utilize local public clinics to access their HIV-related services, including pre-and post-exposure prophylaxis and antiretroviral therapy.

2.3. Population, Sample, and Sampling Strategy

The study population consisted of professional nurses working at the clinics in Gauteng province. All categories of professional nurses were part of the population. In South Africa, professional nurses are registered nurses with four years of training in the South African context, qualified with a 4-year baccalaureate degree at university [12]. A professional nurse could also hold a diploma or equivalent NQF 6 qualifications in nursing (community health science or psychiatric nursing and midwifery) and register with the South African Nursing Council (SANC) as a professional nurse [13]. The following inclusion criteria were used: being employed at public primary healthcare clinics in Gauteng province, having rendered services to LGBTIQ+ people, working at the PHC facilities for at least two years, and being willing to participate.

The criterion purposive sampling method was used to recruit the study participants. This type of sampling allowed

the researchers to select individuals who met the characteristics that the researchers sought to study [14]. Nine professional nurses participated in the study. The sample size was determined by data saturation. Data saturation is when the participants are not coming up with any new information but only repeat what has already been mentioned by the previous participants [14]. Saturation was reached with the seventh participant, but two additional participants were further interviewed to make sure that what the researchers had is exhaustive information.

2.4. Data Collection Instrument

Data collection was done using semi-structured individual interviews guided by the interview guide. Before conducting the interviews, a pre-test of the interview guide was conducted by the first author on one of the professional nurses at a public PHC clinic. The pilot interview was audio-recorded. The audio recording was transcribed verbatim. The piloting of the data collection instrument helped the researcher to be aware of the wording of questions, areas of clarification of the main questions, and possible follow-up questions. The phrasing of the questions and the interview guide language were tested, checking their appropriateness and suitability to the target groups' vocabulary [15]. The interviewing skills were also assessed to ensure quality and the importance of posing questions and statements in a manner avoiding ambiguity and ensuring that the questions were interpreted in the same way by different participants. This pilot also allowed the researcher to test the trustworthiness of the instrument. Both researchers were satisfied with how the questions were asked and responded to.

2.5. Data Collection Process

Gauteng province District Research Committees (DRCs) approved the study; the researchers made presentations to the regional managers to explain the study intentions and logistic requirements at the facilities involved. Meetings were held through telephone conference calls, Zoom, or face-to-face with facility managers of selected clinics. The recruitment of participants was managed with the cooperation of the facility managers.

The researchers employed the snowball technique because the targeted group was not easy to access. This sampling method enabled initial participants to recommend other possible participants that they thought met the set criteria. During the initial contact, the researchers explained the participant information sheet and the consent form's details to ascertain that professional nurses participated without coercion and explained their right to withdraw from participation if they do not feel like they want to continue.. The first author explained to each professional nurse participant that the purpose of the study was to explore their preparedness as healthcare providers of HIV healthcare services to LGBTIQ+ people at public PHC clinics. The researcher also elaborated that the results of the study will be published in relevant journals. All the participants signed the consent form before their interviews.

Each facility allocated an office for the researcher to conduct the individual interviews, ensuring privacy. The researcher conducted face-to-face, in-depth interviews to ascertain participants' perspectives concerning the research topic [16]. The interview format allowed the researchers to know more about the phenomenon under study from the viewpoint of the participants. Part 1 of the interview guide consisted of demographic information requirements. Part 2 was made up of a grand tour question about their personal preparedness and interactions when rendering HIV healthcare services at the clinics. The question was formulated as follows: Can you kindly describe your individual preparedness for providing HIV healthcare services to LGBTIQ+ self-identifying persons requiring HIV healthcare services at this clinic? This was followed by probes, such as: What preparation did you have for managing LGBTIQ+ individuals? How did you get the information regarding LGBTIQ+ individuals? What is your greatest challenge when dealing with the LGBTIQ+ community? Prompts and probes were used to encourage participants to elaborate on their responses and clarify specific information [17].

The participants were encouraged to share about issues of their preparedness that they identified as significant to them as individuals. While the researcher guided the focus of the interviews, each participant was allowed to lead the direction of their interview. The researcher validated the participant’s accounts without being agreeable or judgmental of their stories and verified their verbal expressions and non-verbal gestures where necessary [18]. Field notes were registered to ensure that the researchers recorded what they saw and experienced, which could not be audio recorded [16]. The interview sessions with each participant variably lasted for about a minimum of 45 to a maximum of 60 minutes.

To reduce the bias prone to non-probability sampling, researchers ensured that the participants were representative, and diverse [19].

2.6. Measures to Ensure Trustworthiness

Rigor and trustworthiness were secured as recommended for qualitative studies [20]. Trustworthiness was ensured through in-depth engagement with participants by establishing data over time and through triangulation. Dependability assurance entailed repeated coding and recoding and comparison of themes and sub-themes with the co-coder and an independent coder. Each interview was audio-recorded, and field notes were taken in the process of data collection to ensure conformability. Authenticity was enhanced by the insertion of verbatim extracts from the interviews when presenting the results. Participants reviewed transcribed interviews for content verification and accuracy to establish study credibility and dependability. Member checking was also conducted, whereby the researchers shared the findings with participants for validation.

2.7. Data Analysis

Each interview audio recording was transcribed into written text within 48 hours, stored, and protected with a

password. Data coding was done by the researchers and an independent co-coder. Interpretive phenomenological analysis (IPA) was used to analyze the data, following the IPA 7-Step Analysis, which included: (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 [6]. The researchers repeated the steps collaboratively to reach a consensus about the final themes. In line with IPA, a two-stage interpretation process was followed, as participants were making sense of their world and narrating their own experiences, and the researchers tried to understand the meanings attached in consideration of the given context [17].

2.8. Ethical Considerations

The study considered due ethics processes to protect the research participants' rights. The Unisa Health Studies Higher Degrees Ethics Review Committee approved ethical clearance (ERC Reference: HSHDC/986/2020). The Provincial Health Research Committee (PHRC) for Gauteng granted permission to conduct research at the PHC clinics. District Research Committees (DRCs), including the Johannesburg DRC, the Tshwane-DRC, including Metsweding Health Region, and the Ekurhuleni DRC authorized access to the clinics. The real names of participants were replaced by pseudonyms to protect anonymity and confidentiality, and the names of the primary healthcare clinics were not disclosed. The researchers transcribed the data themselves, and an independent person who had access to the data signed a confidentiality agreement.

After researchers provided and discussed the research information sheet with individual participants, they signed the consent form in agreement with the conditions to participate in the study, including that they could withdraw their participation at any time. There was no coercion to participate in the study. All documents, including consent forms containing the signatures of participants, collected raw data, and transcribed scripts, were locked in a safe place. Electronic data documents were protected by an access password.

3. RESULTS

3.1. Biographical Information

The following are some of the depicted biographic characteristics of the professional nurses' sample that were captured by the biographic part of the interview guide:

Amongst the nine professional nurses who participated in this study, two were males, one self-identified as trans-female, and six were females; they were of different racial and ethnic groups. One was South African of Cape Malay descent; eight were of Black South African origin; two were Batswana, three were Zulus, one was Ndebele, one was Xhosa, and one was Mosotho. They all had a good command of the English language. The researchers deemed it important to state these factors as the study was sensitive to participants' preparedness personal lived experiences and their unique contexts. Cross-cutting issues may influence and be influenced by the culture, education, religion, race, gender identity/and sexual orientation of participants Table **1**.

3.2. Summary of Professional Nurses' Results

Professional nurses' data from their transcribed interviews produced themes and emergent sub-themes, as presented in Table **2**.

Table 1. Biographical data of participants.

Participant (Sister)	Age (Yrs.)	Place of Origin	Marital Status	Qual.	Profession	Experience (Yrs.)	Religion	Current Position
Ama	30-39	GP	M	Dip.	PN	5	C	TL
Benedict	20-29	GP	S	PG	PN	2	C	DM
Carol	20-29	GP	S	Dip.	PN	2	C	NC
Dineo	50-59	L	D	Dip.	PN	10	N/D	RN
Ella	30-39	MP	S	UG	PN	10	C	NIMART
Fifi	50-59	NW	M	Dip.	PN	12	C	NC
Gina	50-59	L	S	PG	PN	11	C	TL
Hope	20-29	KZN	S	UG	PN	2	C	NIMART
Ikaneng	20-29	GP	S	PG	PN	8	C	TL
Total No. of Participants	**Age (Yrs.)**	**Origin**	**Marital Status**	**Qual.**	**Profession**	**Experience (Yrs.)**	**Religion**	**Current Position**
9	20-39:4 30-49:2 50-59:3	4 GP 2 L 1MP 1NW 1KZN	6 S 2 M 1 D	4 Dip. 2 UG 3 PG	9 PN	12 Yrs.: 1 11 Yrs.: 1 10 Yrs.: 2 8 Yrs.: 1 5 Yrs.: 1 2 Yrs.: 3	8 C 1 N/D	3 TL 2 NIMART 2 NC 1 RN 1 DM

Note: Biographic variables and codes used
Participant: Professional nurse (Sister)
Place of Origin: GP (Gauteng Province), MP (Mpumalanga Province), FS (Free State Province), L (Limpopo Province), NW (North-West Province), KZN (Kwa Zulu Natal Province)
Marital Status: S (Single), M (Married), D (Divorced), E (Engaged)
Qualification (Qual.): Dip. (Diploma), UG (Undergraduate Degree), PG (Post Graduate Degree)
Religion: C (Christian), N/D: (Not Disclosed)
Current Position: TL (Team Leader), DM (Deputy Manager), PN (Professional Nurse), NC (Nurse Clinician), RN (Registered Nurse), NIMART (Nurse Initiated Management of Anti-Retroviral Therapy)

Table 2. Participants' themes.

Theme	Sub-theme
Lack of information	No training
	Limited knowledge about the protective materials needed for LGBTIQ+ individuals
	Limited experience regarding the healthcare of LGBTIQ+ individuals
Not knowing how to address LGBTIQ+ people's related issues	Limited knowledge about different groups among LGBTIQ+ people
	Limited experience related to managing LGBTIQ+ clients
	Inability to introduce topics related to LGBTIQ+ sexual discussions
Sources of information	Media
	Word of mouth
	LGBTIQ+ patients who are willing to share
	Life experience as an LGBTIQ+ individual

3.3. Overview of Professional Nurses' Themes

The data from professional nurses comprised the following themes: Lack of information, not knowing how to address the LGBTIQ+ people's related issues, and sources of information, as well as their emergent sub-themes.

3.3.1. Theme 1: Lack of Information

This theme focuses on the professional nurses' information concerning LGBTIQ+ people's health issues. Participant professional nurses indicate that they do not have significant health information to provide adequate healthcare interventions to LGBTIQ+ people. The following are the emergent sub-themes: No training, limited knowledge about the protective materials needed for LGBTIQ+ individuals and limited experience regarding the healthcare of LGBTIQ+ individuals.

3.3.1.1. No Training

Professional nurses reported that they have never received any training in specific reference to LGBTIQ+ people's healthcare. They had no diversity training during their professional preparations or as part of in-service training. Participants explained this factor with the following statements:

"I have not received any training on how to provide services to the LGBTIQ+ community. There was never any training in this matter at school or work" (Sister Hope)

"I did not learn much about the LGBTIQ+ individuals. I feel like I need to know more to make it easier to help them. Like now I can see that I do not know much about them." (Sister Carol)

Participants believed that the lack of training was a direct cause of their existing knowledge gaps regarding LGBTIQ+ people's health issues and healthcare needs. Apart from their reports that they do not have problems with rendering healthcare services to LGBTIQ+ patients, some seemingly understand that their limitations disadvantaged the LGBTIQ+ people in gaining access to appropriate services.

3.3.1.2. Limited Knowledge about the Protective Materials Needed by LGBTIQ+ Individuals

This subtheme focused on the limited knowledge that healthcare professionals have about LGBTIQ+ people's specific materials required for adequate prevention and protection against infections. Participants report that they do not have adequate knowledge of different protective commodities for different LGBTIQ+ populations within the spectrum. This is evidenced in the following statement:

"I do not know about lesbians; I do not know about their preventive materials. I never ask them about those kinds of things." (Sister Carol)

"I have never seen that dental dam; I do not know what it looks like or how to use it, so I would not know what to tell the patient, and we do not have it here." (Sister Dineo)

Regardless of the professional nurses' realization of the limited information concerning specific treatments and preventive materials for LGBTIQ+ people, they are cognizant that their continued unawareness may render them incapable of offering LGBTIQ+ patients the required healthcare interventions and appropriate preventive commodities.

3.3.1.3. Limited Experience Regarding the Care of LGBTIQ+ Individuals

This sub-theme relates to professional nurses' concern that they have limited experience in providing healthcare to LGBTIQ+ individuals. Some of them reported that they have limited exposure and interactions with LGBTIQ+ patients and thus limited awareness and knowledge to provide expected healthcare. This is evidenced in the following statements made by participants:

"So far, my experience is limited because I have seen only a few gays. They are not many in this community, or not many come to this clinic; maybe some of them go to other clinics." (Sister Fifi)

Professional nurses believe that they have limited or no experience dealing with LGBTIQ+ people because few LGBTIQ+ clients visit the clinics. Most of them reported that they do not often come across cases of LGBTIQ+ patients and have limited exposure to this category of patients. They viewed their limited experience with LGBTIQ+ patients as a significant barrier to their ability to address LGBTIQ+ related health issues.

3.3.2. Theme 2: Not Knowing how to Address the LGBTIQ+ People-Related Issues

This theme focused on professional nurses' lack of knowledge on how to address LGBTIQ+ people's related matters from a health perspective or a social perspective. Some participants shared that they have difficulty identifying whether a person is homosexual or heterosexual. According to them, they feel uncomfortable when dealing with LGBTIQ+ patients because they do not know how to address the LGBTIQ+ people's issues efficiently. This theme has the following emergent sub-themes: limited knowledge about different groups among LGBTIQ+ people, limited experience related to

managing LGBTIQ+ clients and inability to introduce topics related to LGBTIQ+ sexual discussions.

3.3.2.1. Limited Knowledge about Different Groups Among LGBTIQ+ People

Professional nurses who participated in the study reported that they do not know much about the different population groups within the LGBTIQ+ spectrum. They shared that they encounter challenges of not being well informed about LGBTIQ+ people, their different identities and sexual orientations or expressions, as stated:

"Sometimes you see someone dressed in a certain way or has certain mannerisms, and you are not sure what their sexual orientation is." (Sister Hope)

Sister Hope further explains:

"Some homosexual men can be identified from their mannerisms, but with homosexual women, it is difficult." (Sister Hope)

Some professional nurses reported realizing that LGBTIQ+ people are not homogeneous. They believed that their lack of clarity on LGBTIQ+ people's diverse nature restricts their understanding of these patients' unique health challenges and specific needs.

3.3.2.2. Limited Experience Related to Managing LGBTIQ+ Clients

Professional nurses indicated that they have limited experience with managing LGBTIQ+ clients. They reported that they felt ill-equipped to deal with issues of LGBTIQ+ clients who visited the clinics. They disclosed that when LGBTIQ+ patients present with symptoms related to their unique health conditions, it would often be the health practitioner's first encounter with that specific type of case, and they would not be sure how to manage the client with such a condition, as described:

"I am not sure how to handle some LGBTIQ+ health issues because we do not often deal with the members of that community, so it becomes a real challenge." (Sister Dineo)

"Yeah, it is a matter of you do not know what is offensive or acceptable, like how do you approach certain health matters?" (Sister Hope)

Another professional nurse, however, shared that a professional approach that reflects genuine concern and care could help an LGBTIQ+ patient to openly share personal information to assist the healthcare provider in ensuring appropriate healthcare provision. The following statement demonstrated this sentiment:

"When we had to do the pap-smear, I started asking the patient questions, and she explained that she is transgender female, but she is biologically still a boy and cannot do a pap-smear." (Sister Ella)

While some participants postulated that a frank and open engagement with LGBTIQ+ patients could win their trust and enable them to communicate about their sexuality, others asserted that they are not at ease talking about LGBTIQ+ people's intimate issues.

3.3.2.3. Inability to Introduce Topics Related to LGBTIQ+ Sexual Discussions

Professional nurses mentioned that they struggle to ask LGBTIQ+ patients for more information like background information or medical history. Some also disclosed that they are afraid of appearing judgmental or intruding in the LGBTIQ+ patients' private lives. A participant illustrated a point to this effect through the following statement:

"I have to always encourage safe sex and sometimes encourage them to minimize the number of sex partners. But I feel like it is difficult to convey such a message without being a bit judgmental or being seen as such." (Sister Hope)

Another participant also relayed that context and language sensitivity are crucial when dealing with LGBTIQ+ patients' sex issues:

"When I am talking to any homosexual person, I am familiar with it is easier to say always use a condom; but it is my personal feeling that if I say that to an LGBTIQ person in counselling it might be received as judgmental." (Sister Dineo)

Professional nurses were insistent that they should be provided with gender diversity training, which they believe will enable them to be more culturally sensitive and engage with LGBTIQ+ patients more meaningfully without coming across as disrespectful or judgmental.

3.3.3. Theme 3: Sources of Information

This theme refers to different origins of information used by professional nurse participants to gain information about LGBTIQ+ people's health issues. Professional nurses remark that their used forms of information bases include media sources like television and social media, online/internet content, LGBTIQ+ people they converse with, and some refer to their own life experiences.

3.3.3.1. Media

Some professional nurses expressed a keen interest in finding more information about LGBTIQ+ people's life experiences. They used a mix of different information sources like television and the internet to raise their awareness and inform themselves:

"The little bit that I know I get from TV and social media; this helps to give me a little bit of information." (Sister Ama)

"Like sometimes I get on the phone, and I see something interesting popping up; out of curiosity I try to watch and listen to understand more." (Sister Dineo)

"If I heard something from people or the media or read something, the next time when I see my LGBT friends, I ask like, oh, I saw something or read something; can I ask you for clarification?" (Sister Fifi)

It has been observed that participants who were interested to know more about LGBTIQ+ people's related issues make an effort to look for relevant information to empower themselves.

3.3.3.2. Word of Mouth

Professional nurses indicated that reliable sources, such as close LGBTIQ+ friends, are depended on to qualify or disqualify the validity of information gathered from different informal sources or people's shared stories:

"You do not know if it is true or false. So, when I see or hear something, I ask them." (Sister Dineo)

Participants share that they view information as crucial in the understanding of LGBTI people's health. Some mentioned that the ability to access information is important to improve services to LGBTIQ+ people.

3.3.3.3. Patients who are Willing to Share

Professional nurses disclosed that they also rely on LGBTIQ+ patients who are open and ready to share their information with healthcare providers. A participant shared in the following manner:

"You know, sometimes you have questions that you cannot just ask, but you would like to find out more. When you find someone willing to share about their experience openly and not afraid to say things as they are, it helps a lot." (Sister Ama)

Another participant elaborated:

"I sometimes think when you are not knowledgeable about something, then when you get someone willing to share, you find it interesting and want to know more." (Sister Fifi)

Participants emphasized that getting the relevant information from LGBTIQ+ people would enable them to deal with LGBTIQ+ people's health issues from an informed view in a non-judgmental manner.

3.3.3.4. Life Experience

A professional nurse who self identifies as trans-female reported that she has never had any formal training regarding LGBTIQ+ health issues. She shared that she drew most of her knowledge from her personal experiences as an LGBTIQ+ person. She elaborated that she also makes an intentional effort to learn more about related health issues she discovers at work or hears about by reading and talking to other LGBTIQ+ people. She uses this information to assist LGBTIQ+ patients at work whenever possible and appropriate. She explained as follows:

"Sometimes, it depends; for me, because I am trans-female and I live within this community, maybe it is easy to share the information I have. In some cases, I think personal experience also helps me." (Sister Gina)

According to the LGBTIQ+ professional nurse, she accepted that her own life experiences compel her to render services to LGBTIQ+ patients with more understanding and resonance, helping her to become more empathetic.

4. DISCUSSION

This study's results indicate that professional nurses find it challenging to know whether a patient is an LGBTIQ+ person or cisgender heterosexual [21]. They feel uncomfortable asking about LGBTIQ+ people's sexual identities and sexual health in general or specific cases during consultations. Some nurses do not know how to ask about LGBTIQ+ individuals' self-identifications or how they prefer to be referred to. They, therefore, avoid serving LGBTIQ+ people, limiting engagement with them. Findings suggest that nurses avoid LGBTIQ+ people's sexual discussions when addressing HIV prevention issues because they are not knowledgeable about their sexuality or their coital preferences. Some older female nurses report that they find it hard to probe deeper when collecting medical histories of younger LGBTIQ+ patients, as they are not used to talking to younger people about sex and sexuality issues. Other results show that nurses need training to help them learn how to reduce biases and enhance sensitivity in their interviewing skills [22]. Findings, however, indicate that younger professional nurses alluded to their awareness of the conflict experienced between cultural and personal beliefs and professional healthcare practices. In their view, the latter should supersede interactions with LGBTIQ+ people in the clinic setting.

The findings indicate that professional nurses assume that all people are heterosexual and not diverse in their sexuality or gender [23, 24]. they thus continue to use heteronormative approaches to healthcare provision for all patients. The study findings emphasized that healthcare should be based on scientifically informed practices that challenge old practices through evidence-based methods. It is essential to ensure that HIV healthcare practices are inclusive, innovative, dynamic and delivered through multi-disciplinary approaches. Healthcare providers' training on gender diversity as a turn-around strategy can improve the quality of services to LGBTIQ+ people [25]. The lack of LGBTIQ+ people's information amongst nurses increases the disparities in LGBTIQ+ patients' healthcare, given that LGBTIQ+ people have worse healthcare outcomes than the larger population [26, 27].

Research shows that LGBTIQ+ people are disproportionately affected by HIV, but most nurses consider sexual orientation and gender identity not relevant to individuals' clinical healthcare needs, Evidence in earlier studies aligns with this study's findings [28, 29]. Professional nurses believe that they supply LGBTIQ+ patients with sufficient treatment and preventive materials. They are, however, unaware that some of these services do not address some of the LGBTIQ+ patients' unique HIV healthcare and prevention needs and that readily offered male condoms are not suitable for all people within the LGBTIQ+ spectrum. Latex male condoms are regularly available at most public clinics. However, some clinics reported that they do not get supplies of femidoms. Nurses are confident in promoting the consistent and correct use of male and /female condoms as effective methods for reducing the risks of HIV infection and contracting STIs, as well as preventing unwanted pregnancies. Health promoters and nurses regularly organize health talks and demonstrations at clinics to educate the general population about the safe use of condoms. Safe sex education targeting LGBTIQ+ people is generalized, emphasizing the proper use of condoms as the best available protection method against HIV and STIs. Current HIV prevention promotion efforts aimed at LGBTIQ+ people are more focused on MSMs' needs than

those of others in the LGBTIQ+ spectrum [30].

This study results also revealed that most nurses working in public PHC clinics have never seen dental dams; they do not know how they look or how they are effectively used as barriers between mouths and genitals to prevent STIs and HIV transmission [31]. Dental dams are not provided as part of free preventive commodities like male condoms and female condoms in the public healthcare sector. Therefore, nurses find that they cannot adequately advise women who have sex with women (WSW) to adhere to self-protection using dental dams during the sexual engagement, including oral sex. The concept of making dental dams from condoms or latex gloves, which are effective 'do it yourself' (DIY) alternatives, remains foreign to most nurses rendering HIV healthcare services to LGBTIQ+ people at public clinics. Research indicates that sex education and practical demonstration of the safe use of preventive materials promote talks between partners and change perceptions and norms about protection and prevention [32].

This study shows that pre-exposure prophylaxis (PrEP) uptake is incredibly low amongst LGBTIQ+ people at the PHC level. Most professional nurses are not confident with the application of PrEP as an effective biomedical HIV prevention strategy for MSMs. Lack of intensive training in this area disadvantages a substantial number of the LGBTIQ+ population whose risks of re-infections could be effectively reduced. However, results of a multivariable analysis in another study indicated an increase in PrEP initiation amongst gay men in recent years and promoted it as a harm reduction strategy [33].

Relatedly, nurses reflect limited knowledge of post-exposure prophylaxis (PEP) administration amongst LGBTIQ+ people. They are familiar with protocols to administer PEP in cases of possible exposure to HIV in female rape cases. However, most of them are not aware of its beneficial usage amongst MSMs and WSW who engage with partners of unknown HIV status or partners who are HIV positive but not virally suppressed, and LGBTIQ+ victims of sexual assaults. These findings were corroborated by a study that found the levels of PEP knowledge and practices among nurses to be exceptionally low [34].

Professional nurses need training on the concept of undetectable equals untransmittable (U=U). It is one of the areas that this research identified as presenting a vast knowledge gap among nurses. Their lack of information regarding the scientific discovery that there are people who live with HIV but have an undetectable viral load in the blood and that they can maintain this status by strict adherence to antiretroviral therapy (ART). It is crucial that nurses should be equipped with such updated knowledge to be able to raise awareness and robustly promote testing, early diagnosis and early initiation of treatment. They will also be able to advocate for treatment adherence and the availability of appropriate preventive materials for the general population and all LGBTIQ+ people to maintain the inactive transmission of the virus to others. Clinical evidence has established that U=U relies on a prompt treatment start to suppress the virus and eventually eliminate its transmission [35].

The results are congruent with WHO's declaration that Universal Health Coverage (UHC) success is dependent on the implementation of human rights-based approaches and investments in gender equality and equity [36]. These imply that it is impossible to achieve the envisaged UHC if fundamental requirements of availability, accessibility, acceptability, and quality under the right to healthcare are not in place.

The findings reveal that professional nurses find it challenging to deliver culturally competent HIV healthcare without adequate gender diversity knowledge and the necessary sensitivity required to meet LGBTIQ+ people's specific healthcare needs. They cannot deny that LGBTIQ+ people feel prejudiced and stigmatized in the PHC environment. There is a continued need for the creation and promotion of clinics as safe community spaces for vital response to HIV healthcare, for awareness raising and dissemination of information about HIV, for reduction of stigma, and for empowering LBTIQ+ individuals to fearlessly express their identity and sexuality. The environment should promote care and be conducive to the protection of privacy and confidentiality, affirming LGBTIQ+ people's gender identities and sexual orientations. Some nurses are oblivious to the effects of their behavior in the health facility environment that it can influence or threaten a sense of security, connection and belonging among LGBTIQ+ people. Similar research supports that such spaces are key settings for LGBTIQ+ healthcare promotions that are critical in response to HIV [37].

Reports reflect that nurses are aware of patients' hesitations to seek help from clinics, fearing the double stigma of identifying as LGBTIQ+ and living with HIV, judgments, blame and secondary victimization. Results in this study also support previous findings pointing out that nurses are ill-informed about the impact of their attitudes on their healthcare delivery to LGBTIQ+ people [23]. A study concurs that healthcare providers are inclined to gender and sexuality biases founded on cultural stereotypes that have been embedded in their belief systems since they were young [38]. Their personal beliefs, socialization, learned behaviors and assimilated stereotypes about LGBTIQ+ people get transferred to their work world. They undermine the potential of their perceptions and behavior to influence the responses of patients toward treatment.

The results highlighted that in cases where nurses are interested in LGBTIQ+ issues and have some level of awareness concerning their mental health vulnerabilities, they made time to render counseling to LGBTIQ+ patients who need psycho-social support. Minority stress, often caused by discrimination, stigma, prejudice amongst other factors, depression, and suicidality were identified as predominant mental health issues in most cases, which were congruent to other studies [39, 40]. Isolation stress and anxiety have noticeably increased due to COVID-19 restrictions, as also reported in related research [41]. Other nurses do not feel competent to deal with LGBTIQ+ mental health issues and thus refer them to social workers employed by non-government organizations (NGOs) closely collaborating with the clinics. The PHC clinics only offer mental health screening services.

The study found that nurses reported incidents of emergency healthcare interventions due to excessive alcohol intake; these included self-inflicted injuries and injuries caused by violent attacks by strangers and intimate partners. The findings emphasize that substance abuse-related health promotion initiatives and campaigns are designed to reach the broader population and do not target LGBTIQ+ people's specific substance dependency and abuse issues. Therefore, healthcare services pay less essential attention to the high rates of drug and alcohol abuse among LGBTIQ+ people, although it is well established that they are at a greater risk for substance abuse affecting their mental health compared to heterosexual people. Other research shows that the majority of LGBTIQ+ people, including those living with HIV, use alcohol and drug dependency as a coping mechanism [42].

Evidence indicates that some nurses take the initiatives to learn about LGBTIQ+ health issues independently [43]. They use a mix of contemporary and conventional methods to raise their awareness and address their knowledge gaps. Results show that television, radio, the internet, and social media sites are a mixture of informal learning platforms that professional nurses depend on to derive information about gender diversity issues; they also use word-of-mouth strategies. Some professional nurses turn to their LGBTIQ+ friends and acquaintances outside the healthcare sector to gain new information. There is further indication that some nurses also improve their awareness by engaging more meaningfully with LGBTIQ+ patients, willing to share information with them and answer direct questions openly. Inclusive healthcare delivery strategies ensure that services are appropriate to LGBTIQ+ people and that they feel secure and, therefore, willing to disclose their health concerns to attending healthcare providers [44].

Findings also reveal that there are professional nurses who sometimes ask LGBTIQ+ people questions to satisfy their curiosity [45]. Moreover, an LGBTIQ+ professional nurse disclosed that she seldom gets any questions from her colleagues, so she also does not often offer LGBTIQ+ people-related information unless specifically asked. However, she feels uninhibited about sharing information with LGBTIQ+ people; she shares HIV healthcare and prevention-related information and social support advice, drawing from her familiarity with their general life contexts.

Findings indicate that institutionalized heteronormativity and lack of nurse training on LGBTIQ+ health issues at the PHC level subject LGBTIQ+ people to structural barriers, such as gender access inequalities, prevention commodity inequities, systemic gender binaries, LGBTIQ+ invisibility in promotion materials and messaging, and gender insensitive language. Even though the South African constitution and Human Rights protect LGBTIQ+ people, translation on the ground is vital. Nurses must be equipped with relevant knowledge to uphold the rights of LGBTIQ+ people in healthcare service delivery. Like all other healthcare professionals working in South Africa, nurses are bound by professional codes of conduct prohibiting discrimination based on the provisions of the constitution [46]. Health equity strategies should aim to provide services in the right, fair and just manner. It is essential that PHC-based HIV healthcare services are connected, coherent and consistent. Nurses' respect for LGBTIQ+ patients' rights and sensitive delivery of healthcare interventions without judgment and negative attitudes are imperative to ensure effective program implementation at the clinic level [47].

This study provides a unique opportunity to understand professional nurses' experiences from their own perspectives. It comprised a diverse sample recruited from a range of locations and used in-depth interviews, which enhanced the richness and generalizability of the results.

CONCLUSION

The lack of skills training and knowledge of nurses concerning LGBTIQ+ people's HIV healthcare needs and inadequate provision of preventive commodities at PHC clinics have detrimental effects on this community. It also worsens the health outcomes of LGBTIQ+ individuals and leads to unnecessary complications of opportunistic infections. Nurses' training and skills equipment in LGBTIQ+ people's HIV healthcare provision, appropriate preventive measures and effective use of commodities are imperative. An integrated person-centered healthcare strategy and practice focusing on LGBTIQ+ people's HIV healthcare provision at the PHC level is critical. The LGBTIQ+ population in South Africa needs enhanced awareness raising and information about HIV healthcare issues and prevention. Future research will include a larger representation of LGBTIQ+ healthcare providers in the sample.

AUTHORS' CONTRIBUTION

All authors substantially contributed to the conception of the work. DMM (Ph.D.) acquired data. AHM (Ph.D.) supervised the analysis and interpretation of data. DMM drafted the manuscript. The authors are accountable for all aspects of the work.

LIST OF ABBREVIATIONS

AIDS	=	Acquired Immune Deficiency Virus
HIV	=	Human Immunodeficiency Virus
IC	=	Ideal Clinic
IPA	=	Interpretative Phenomenological Analysis
LGBTIQ+	=	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, and Plus
MSM	=	Men Who Have Sex With Men
NDoH	=	National Department of Health
PHC	=	Primary Healthcare
SANC	=	South African Nursing Council
TAC	=	Treatment Action Campaign
WSW	=	Women Who Have Sex With Women

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

Ethical clearance was issued by the Unisa Health Studies Higher Degrees Ethics Review Committee approved Ethical clearance (ERC Reference: HSHDC/986/2020) on 5th June,

2020.

HUMAN AND ANIMAL RIGHTS

No animals were used in this research. All procedures performed in studies involving human participants were in accordance with the ethical standards of institutional and/or research committees and with the 1975 Declaration of Helsinki, as revised in 2013.

CONSENT FOR PUBLICATION

Informed consent was obtained from all participants.

STANDARDS OF REPORTING

COREQ guidelines were followed.

AVAILABILITY OF DATA AND MATERIALS

The data that support the findings of this study are available from the corresponding author, [DMM], on special request.

FUNDING

None.

CONFLICT OF INTEREST

The authors declare no conflict of interest, financial or otherwise.

ACKNOWLEDGEMENTS

The researchers would like to acknowledge and thank all the public PHC clinics that participated in the study and all individual professional nurse participants for their contribution.

REFERENCES

[1] National Department of Health. Standard treatment guidelines and essential medicines list for South Africa 2020. Available from: https://www.kznhealth.gov.za/pharmacy/PHC-STG-2020. pdf

[2] Strasser S, London L, Kortenbout E. Developing a competence framework and evaluation tool for primary care nursing in South Africa. Educ Health (Abingdon) 2005; 18(2): 133-44. [http://dx.doi.org/10.1080/13576280500145615] [PMID: 16009609]

[3] Jamieson D, Kellerman SE. The 90 90 90 strategy to end the HIV Pandemic by 2030: Can the supply chain handle it? J Int AIDS Soc 2016; 19(1): 20917. [http://dx.doi.org/10.7448/IAS.19.1.20917] [PMID: 27370169]

[4] National Department of Health. 2018. Available from: https://www.gov.za/sites/default/files/gcis_document/201810/doh-annual-report-2018

[5] National Center for HIV/AIDS. 2021. Available from: https://www.cdc.gov/hiv/pdf/group/gender/transgender/cdc-hiv-transgender-factsheet

[6] Anova Health Institute. 2013. Available from: https://www.anovahealth.co.za/category/publications-and-manuals/

[7] Mavhandu-Mudzusi AH. Impact of stigma and discrimination on sexual well-being of LGBTI students in a South African rural university. South African Journal of Higher Education 2017; 231(4): 08-18.

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

[9] Amon JJ. Ending discrimination in healthcare. J Int AIDS Soc 2020; 23(2): e25471. [http://dx.doi.org/10.1002/jia2.25471] [PMID: 32107865]

[10] Peat G, Rodriguez A, Smith J. Interpretive phenomenological analysis applied to healthcare research. Evid Based Nurs 2019; 22(1): 7-9. [http://dx.doi.org/10.1136/ebnurs-2018-103017] [PMID: 30504450]

[11] Alase A. The interpretative phenomenological analysis (IPA): A guide to a good qualitative research approach. Int J Educ Lit Stud 2017; 5(2): 9-19. [http://dx.doi.org/10.7575/aiac.ijels.v.5n.2p.9]

[12] Blaauw D, Ditlopo P, Rispel LC. Nursing education reform in South Africa – lessons from a policy analysis study. Glob Health Action 2014; 7(1): 26401. [http://dx.doi.org/10.3402/gha.v7.26401] [PMID: 25537941]

[13] Professional-Nurse-Health-The DPSA Vacancies 2016. Available from: https://www.southafrica.newjobvacancies.org/medical-health hospital/professional-nurse-health-the-dpsa/

[14] Creswell JW, Creswell JD. Research design: Qualitative, quantitative, and mixed methods approach. Nebraska: Sage publications 2017.

[15] Polit DF, Beck CT. Qualitative data analysis. Nursing research: Generating and assessing evidence for nursing practice 2012; 9: 556-81.

[16] McIntosh MJ, Morse JM. Situating and constructing diversity in semi-structured interviews. Glob Qual Nurs Res 2015; 2 [http://dx.doi.org/10.1177/2333393615597674] [PMID: 28462313]

[17] Moerman GA. Probing behaviour in open interviews: A field experiment on the effects of probing tactics on quality and content of the received information. Amsterdam: Vrije Universiteit 2010.

[18] Egan G. The skilled helper: A problem-management and opportunity-development approach to helping. Belmont: Cengage Learning 2013.

[19] Master class staff Science and tech: How to avoid sampling bias 2022. Available from: https://www.masterclass.com/articles/sampling-bias#what-is-sampling-bias

[20] Polit D, Beck C. Essentials of nursing research: Appraising evidence for nursing practice. Philadelphia: Lippincott Williams & Wilkins 2020.

[21] Moule P, Aveyard H, Goodman M. Nursing research: An introduction. California: SAGE 2016.

[22] Bauer GR, Scheim AI, Deutsch MB, Massarella C. Reported emergency department avoidance, use, and experiences of transgender persons in Ontario, Canada: results from a respondent-driven sampling survey. Ann Emerg Med 2014; 63(6): 713-720.e1. [http://dx.doi.org/10.1016/j.annemergmed.2013.09.027] [PMID: 24184160]

[23] Zeeman L, Sherriff N, Browne K, *et al.* Health4LGBTI Network. A review of lesbian, gay, bisexual, trans and intersex (LGBTI) health and healthcare inequalities. Eur J Public Health 2019; 29(5): 974-80. [http://dx.doi.org/10.1093/eurpub/cky226] [PMID: 30380045]

[24] Smith JA, Flowers P, Larkin M. Interpretative phenomenological analysis: Theory, method and research. London: SAGE Publications 2009.

[25] Wade RM, Harper GW. Young Black gay/bisexual and other men who have sex with men: A review and content analysis of health-focused research between 1988 and 2013. Am J Men Health 2017; 11(5): 1388-405. [http://dx.doi.org/10.1177/1557988315606962] [PMID: 26400714]

[26] Marques AM, Nogueira C, de Oliveira JM. Lesbians on medical encounters: Tales of heteronormativity, deception, and expectations. Health Care Women Int 2015; 36(9): 988-1006. [http://dx.doi.org/10.1080/07399332.2014.888066] [PMID: 24498920]

[27] Garrison NO, Ibañez GE, Sabin JA, Riskind R. Attitudes of health care providers toward LGBT patients: The need for cultural sensitivity training/Sabin and Riskind Respond. Am J Public Health 2016; 106(3): 570. [http://dx.doi.org/10.2105/AJPH.2015.303010] [PMID: 26885965]

[28] Elliott MN, Kanouse DE, Burkhart Q, *et al.* Sexual minorities in England have poorer health and worse health care experiences: A national survey. J Gen Intern Med 2015; 30(1): 9-16. [http://dx.doi.org/10.1007/s11606-014-2905-y] [PMID: 25190140]

[29] Hunt J, Bristowe K, Chidyamatare S, Harding R. 'They will be afraid to touch you': LGBTI people and sex workers' experiences of accessing healthcare in Zimbabwe—an in-depth qualitative study. BMJ Glob Health 2017; 2(2): e000168. [http://dx.doi.org/10.1136/bmjgh-2016-000168] [PMID: 28589012]

[30] Qiao S, Zhou G, Li X. Disclosure of same-sex behaviors to health-care providers and uptake of HIV testing for men who wave sex with men: A systematic review. Am J Men Health 2018; 12(5): 1197-214. [http://dx.doi.org/10.1177/1557988318784149]

[31] Bailey JV, Farquhar C, Owen C, Whittaker D. Sexual behaviour of lesbians and bisexual women. Sex Transm Infect 2003; 79(2): 147-50.

[http://dx.doi.org/10.1136/sti.79.2.147] [PMID: 12690139]

[32] Fish J, Evans DT. Guest Editorial: Promoting cultural competency in the nursing care of LGBT patients. J Res Nurs 2016; 21(3): 159-62. [http://dx.doi.org/10.1177/1744987116643232]

[33] Geng E, Hargreaves J, Peterson M, Baral S. Implementation research to advance the global HIV response: Introduction to the JAIDS supplement. J Acquir Immune Defic Syndr 2019; 82(3): S173-5. [http://dx.doi.org/10.1097/QAI.0000000000002208] [PMID: 31764251]

[34] Hammoud MA, Vaccher S, Jin F, *et al.* HIV pre-exposure prophylaxis (PrEP) uptake among gay and bisexual men in Australia and factors associated with the nonuse of PrEP among eligible men: Results from a prospective cohort study. J Acquir Immune Defic Syndr 2019; 81(3): e73-84. [http://dx.doi.org/10.1097/QAI.0000000000002047] [PMID: 30973548]

[35] Tshering K, Wangchuk K, Letho Z. Assessment of knowledge, attitude and practice of post exposure prophylaxis for HIV among nurses at Jigme Dorji Wanghuck National Referral Hospital, Bhutan. PLoS One 2020; 15(8): e0238069. [http://dx.doi.org/10.1371/journal.pone.0238069] [PMID: 32857804]

[36] National Institute of Allergy and Infectious Diseases. 2019. Available from: https://www.niaid.nih.gov/diseases-conditions/treatment-prevention

[37] Somerville C. Unhealthy attitudes: The treatment of LGBT people within health and social care services. London: Stonewall 2015.

[38] Philpot SP, Holt M, Murphy D, *et al.* Qualitative findings on the impact of COVID-19 restrictions on Australian gay and bisexual men: Community belonging and mental well-being. Qual Health Res 2021; 31(13): 2414-5. [http://dx.doi.org/10.1177/10497323211039204] [PMID: 34433350]

[39] World Health Organization. Together on the road to universal health coverage: A call to action 2017. Available from: https://apps.who.int/iris/bitstream/handle/10665/258962/WHO-HIS-HGF-17.1-eng.pdf?sequence=1

[40] Wilson C, Cariola LA. LGBTQI+ youth and mental health: A systematic review of qualitative research. Adolesc Res Rev 2020; 5(2): 187-211. [http://dx.doi.org/10.1007/s40894-019-00118-w]

[41] Brennan DJ, Card KG, Collict D, Jollimore J, Lachowsky NJ. How might social distancing impact gay, bisexual, queer, trans and two-spirit men in Canada? AIDS Behav 2020; 24(9): 2480-2. [http://dx.doi.org/10.1007/s10461-020-02891-5] [PMID: 32356033]

[42] Inventor BR, Paun O, McIntosh E. Mental Health of LGBTQ Older Adults. J Psychosoc Nurs Ment Health Serv 2022; 60(4): 7-10. [http://dx.doi.org/10.3928/02793695-20220303-01] [PMID: 35353662]

[43] Demant D, Hides LM, Kavanagh DJ, White KM. Young people's perceptions of substance use norms and attitudes in the LGBT community. Aust N Z J Public Health 2021; 45(1): 20-5. [http://dx.doi.org/10.1111/1753-6405.13053] [PMID: 33252815]

[44] Sabin JA, Riskind RG, Nosek BA. Health care providers' implicit and explicit attitudes toward lesbian women and gay men. Am J Public Health 2015; 105(9): 1831-41. [http://dx.doi.org/10.2105/AJPH.2015.302631] [PMID: 26180976]

[45] Carabez R, Pellegrini M, Mankovitz A, Eliason M, Ciano M, Scott M. "Never in all my years…": Nurses' education about LGBT health. J Prof Nurs 2015; 31(4): 323-9. [http://dx.doi.org/10.1016/j.profnurs.2015.01.003] [PMID: 26194964]

[46] South African National AIDS Council. The South African national LGBTI HIV plan 2017-2022. Pretoria: SANAC 2017.

[47] Müller A. Scrambling for access: availability, accessibility, acceptability and quality of healthcare for lesbian, gay, bisexual and transgender people in South Africa. BMC Int Health Hum Rights 2017; 17(1): 16. [http://dx.doi.org/10.1186/s12914-017-0124-4] [PMID: 28558693]