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"You get HIV because there is no hope" a rapid qualitative assessment of the HIV vulnerabilities of transgender women in three South African metros

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ABSTRACT

Introduction: Epidemiological data show that transgender women are disproportionately affected by Human Immunodeficiency Virus (HIV). Data in South Africa on the HIV vulnerabilities of transgender women are sparse. This paper qualitatively explores the structural, personal, and economic factors that contribute to making South African transgender women vulnerable to HIV and other sexually transmitted infections (STIs).

Methods: We conducted a rapid qualitative assessment in the Cape Town, Johannesburg, and Buffalo City metropolitan municipalities to frame the HIV risk vulnerabilities of transgender women. Purposive sampling was used to recruit study participants. We conducted 25 key informant interviews, five focus group discussions, and 26 in-depth interviews with transgender women. Atlas.ti.8 was used to facilitate qualitative data analysis.

Study findings: These data illustrate a pervasive theme of social rejection, discrimination, and everyday victimization among transgender women. The ubiquitous presence of stigma and rejection leads to internalized stigmatization, which affects the social and mental well-being of transgender women, who often turn to alcohol and illicit drug use to alleviate negative emotions. We found that transgender women may engage in high-risk sexual activities like sex work where they can express and affirm their gender identity. In this context, transgender women engaging in high-risk sexual activities found it challenging to access pre-exposure prophylaxis (PrEP). Stigma also leads to reluctance to use public healthcare services. Despite experiencing stigma and discrimination, qualitative data highlights the resilience of transgender women in the study.

Conclusions: Qualitative data demonstrate that HIV risk for transgender women is complex. Multi-level community-led interventions grounded in empowerment are also required to address interpersonal, biological, structural, and community risk. Successful interventions should address stigma and draw upon the resilience of transgender women. Peer-driven interventions may motivate personal responsibility to use high-impact HIV prevention and treatment services.

KEYWORDS
Transgender women; South Africa; HIV; healthcare stigma; social rejection

Introduction

Globally, transgender women are at elevated risk for human immunodeficiency virus (HIV) acquisition (Herbst et al., 2008; Operario et al., 2008; Poteat et al., 2016; Poteat et al., 2016). High rates of sexually transmitted infections (STIs) have been reported among transgender women in studies conducted in the United States of America (USA), including syphilis and herpes, which are both ulcerative genital diseases that increase the risk of HIV acquisition (Poteat et al., 2014; Silva-Santisteban et al., 2012). In a recent HIV prevalence survey conducted in South Africa, estimates showed that amongst 887 sexually active transgender women, 63.3% were living with HIV in Johannesburg, 46.1% in the Buffalo

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City metropolitan municipality, and 45.1% in Cape Town (Cloete et al., 2023).

Transgender women who have sex with cisgender men may engage in receptive anal intercourse—an efficient route for acquiring HIV infection (Leon et al., 2016; Silva-Santisteban et al., 2012). While biological risks are important, they are insufficient to explain the elevated prevalence of HIV among transgender women. HIV risk in transgender communities is embedded in multiple co-occurring public health problems (Poteat et al., 2014). Researchers have demonstrated that various health and other challenges are syndemics to HIV risk and HIV treatment outcomes for transgender women (Brennan et al., 2012; Logie et al., 2020; Operario & Nemoto, 2010; Parsons et al., 2018; Poteat et al., 2016; Reback et al., 2019), including homelessness (Yu, 2010), drug use (Cotaina et al., 2022), everyday victimization, violence (Chakrapani et al., 2022) experiences of stigma and discrimination at schools/universities (Beemyn et al., 2005; Hafford-Letchfield et al., 2017; Mavhandu-Mudzusi & Ganga-Limando, 2015; Wolff et al., 2017) and when accessing healthcare (Bircher, 2016; Muller, 2013; Müller, 2017; White Hughto et al., 2015) because of transgender identifications. Hence, overlapping social, cultural, legal, and economic factors further marginalize transgender women (UNAIDS. , 2017). The ubiquitous presence of stigma, discrimination, and social rejection leads to internalized stigmatization, affecting the social and mental well-being of transgender women, who often turn to engaging in sex work, and alcohol and illicit drug use to alleviate negative emotions. These challenges are exacerbated by a lack of legal recognition of their gender identity and the absence of anti-discrimination laws that explicitly include transgender people (UNAIDS, 2017).

In South Africa, however, transgender people are protected. The equality clause in the South African Constitution prohibits discrimination based on sexual orientation and gender (identity) and, in principle, protects the rights of lesbian, gay, bisexual, transgender, intersex, and queer+ (LGBTIQ+) people (Parliament of the Republic of South Africa, 1996). In addition, the Alteration of Sex Description and Sex Status Act 49 of 2003 enables transgender women to align their legal gender marker to their lived gender identity on condition of "surgical or medical treatment or by evolvement through natural development resulting in gender reassignment" (Alteration of Sex Description & Sex Status. Act 49 of 2003 and Pub. L. No. 26148, 26148, 2003). South African HIV policy supports appropriate health responses for transgender women, including the National Strategic Plan on HIV, Tuberculosis (TB), and STIs (2023–2028) (DoH, 2023). Translating an appropriate health response for transgender women into practice culminated in establishing transgender health clinics in 2019 in four cities in South Africa (Cloete et al., 2023).

Regardless of the legislative protections afforded to transgender South Africans, research shows that transgender people continue to experience stigma and discrimination in various contexts (Mbeda et al., 2020; Ouspenski, 2013; Patel, 2017; Scheibe et al., 2016; Tonia Poteat, Mannat Mali, Leigh Anne van der Merwe, Allanise Cloete, Dee Adams, Bareng Nonyane, 2020). Resilience is a crucial element for transgender women who are vulnerable because of race, gender, social position, and socioeconomic and political status. According to Ledesma (2014), people are resilient when they can overcome adversity and shift from coping to flourishing (Ledesma, 2014). Evidence suggests that individual, interpersonal (Degroote et al., 2014; Zhao et al., 2019; Earnshaw et al., 2013), and contextual or structural factors (Carrasco et al., 2017; Hussen et al., 2014) influence resilience. Other studies have shown that social support from family and friends also contributes to resilience building (Brown et al., 2021; Emlet et al., 2017).

Logie et al. (2018) measured the impact of resilience on personal competence and self-acceptance (Logie et al., 2018). Their findings indicate that resilience is a protective characteristic with advantages for mental and physical health HR- QoL (Logie et al., 2018). Furthermore, Bockting (2013) concur that transgender women, with and without HIV infections, thereby produce increased resilience, favorable mental health conditions, and emotional stability (Bockting et al., 2013). Hence, the core focus of resilience is usually centered on the self, but a shift to community

and family as support networks can help them become self-accepting and alleviate inner struggles.

In this paper, we aim to explore the structural, personal, and economic factors that make transgender women vulnerable to HIV infection in urban metros of South Africa. At the same time, while we are describing oppressive structures and experiences contributing to the social and economic vulnerabilities of transgender women, we are also drawing from moments of resilience that transgender women make use of to navigate stigmatization, violence, and everyday economic struggles.

Methodology

This study employed rapid qualitative assessment methods, including key informant interviews (i.e. experts in the field of HIV and "trans-issues"), detailed focus group discussions (FGDs), and in-depth interviews with transgender women as part of a more extensive HIV bio-behavioral survey conducted with transgender women in the Cape Town, Johannesburg, and Buffalo City metropolitan municipalities of South Africa (van der Merwe et al., 2023). Study participants were reimbursed R50 (USD 2.65) on completion of the interview as a token of appreciation and reimbursement for travel. We conducted this study within the abovementioned urban metropolitan municipalities because of organizations working with transgender women. For example, Gender Dynamix (GDX) and the Sex Workers' Advocacy and Education Taskforce (SWEAT) are both based in Cape Town; the Social, Health, and Empowerment (SHE) Feminist Collective of Transgender Women of Africa in East London (within the Buffalo City metro municipality) and Access Chapter 2 (AC2) in the Johannesburg metropolitan area.

A community-based participatory research approach guided the development and implementation of the study described in detail elsewhere (van der Merwe et al., 2023). The overall aim of the rapid qualitative assessment was to contribute toward a more nuanced understanding of the social and personal contexts that frame HIV risk for transgender women and the broader social settings and structures that place transgender women at high risk for HIV infection. Rapid qualitative approaches typically do not rely on rigid sampling methods like surveillance studies (Naderifar et al., 2017). Instead, it uses more targeted strategies to recruit study participants, such as purposive sampling (Bradshaw et al., 2017).

Key informant interviews

We conducted 25 key informant interviews with government and representatives from civil society, gender and AIDS activists, and transgender women who are considered leaders or 'influencers' within the trans movement of South Africa (Cape Town: $n=7$; Buffalo City metro municipality: $n=10$; Johannesburg: $n=8$). Key informant interviews were identified from our existing relationships with universities, research institutions, non-governmental organizations (NGOs) working within HIV prevention for transgender women, and contacts made by our research staff, and purposively recruited for their relevant expertise and experience working with transgender women; such as HIV researchers, gender activists, community activists, and policymakers. Using the abovementioned inclusion criteria, we generated a list of potential key informants in each metropolitan area. Once we compiled the list, members of the core research team contacted potential key informants and invited them to participate in the study.

Focus group discussions and in-depth interviews

Transgender women were eligible to participate in FGDs and in-depth interviews if they fitted the following inclusion criteria: a) aged 18 years and older; b) (self-reported) consensual sex (i.e. sex is defined as oral, anal, or vaginal sex) within the last six months; c) lived in the Cape, the Johannesburg metropolitan area or the five districts of the Buffalo city metro; d) sex at birth = male; e) current gender = female or transgender/female or identify as "other" than male or man. We screened all study participants for eligibility based on the abovementioned inclusion criteria. Participants were recruited with the support of the NGOs that were part of our Steering Advisory Committee. In total, we conducted five FGDs: one with HIV-positive transgender women

based in Cape Town, two with transgender women support groups based in Johannesburg, and two with transgender women support groups in East London in the Buffalo City metro. We conducted 26 in-depth interviews (i.e. Cape Town: $n=8$; East London in the Buffalo City metro: $n=12$; Johannesburg: $n=6$). Transgender women who participated in in-depth interviews were recruited *via* network-driven recruitment methods.

Data collection

We used semi-structured interview guides during key informant interviews, FGDs, and in-depth interviews. In the key informant interviews, we explored (i) personal and social challenges, (ii) experiences of stigma and discrimination, and (iii) existing HIV prevention programs available for transgender women. In the FGDs, we explored the following: (i) the life of transgender women in each metro; (ii) social gender positioning; (iii) love and sexual relationships; (iv) the use of drugs and alcohol; (v) social support networks that transgender women belong to; and (vi) HIV prevention services currently available. The semi-structured interview guides used in the in-depth interviews with transgender women explored the following: (i) the life of transgender women; (ii) HIV risk perception; (iii) mechanisms used to protect themselves against HIV acquisition; (iv) HIV prevention services currently available; and (v) the use of drugs and alcohol.

Interviews were audio-recorded and conducted in the participant's language of choice. All interviews were conducted in the most convenient place for the study participant, where confidentiality and privacy are respected.

Data analysis

The interviews were transcribed verbatim and translated into English, where necessary, by an accredited service provider. Each co-investigator checked the accuracy of the translations and was proficient in the local languages. Data were de-identified during the translation and transcription process. Core research team members removed all identifying information from all transcripts.

We used Atlas.ti.8 to facilitate qualitative data analysis. The first three authors led the qualitative data analysis in this paper. The following six steps were used with some adaptations to Braun and Clarke (2006) (Braun & Clarke, 2006) process of qualitative data analysis: (1) Familiarize yourself with the data: In this step, we read and re-read all the transcripts to help familiarize ourselves with the data; (2) Create preliminary codes: In this step, we applied codes to specific excerpts representing ideas in the interviews to initiate a preliminary code list. We stayed as close to the data as possible when doing initial coding; (3) Established consensus on the codes used; (4) Developed a draft codebook; (5) Code subsequent transcripts using the codebook; and (6) Theme identifying step: In this step, researchers reviewed the codes in the codebook and grouped the codes into themes. Even though qualitative data analysis is described in the abovementioned steps, qualitative coding and analysis did not begin when all the data were collected; it was an iterative process:

Seven themes were observed from the data: Social rejection, homelessness, violence, and everyday victimization; Gender affirmation, sex work, and negotiation for safer sex; Substance use; Transgender women's Perception of HIV risk and vulnerability to TB; PrEP and other prevention resources; Experiences of healthcare stigma and Fostering resilience through support from family, friends, and peers. The participants were not directly asked about resilience. Still, it emerged from the data.

Reflexivity

Whether the researcher is an insider, sharing the characteristic, role, or experience under study with the participants, or an outsider to the commonality shared by participants, the personhood of the researcher, including their membership status with those participating in the research, is an essential and ever-present aspect of the investigation (Dwyer & Buckle, 2009). All researchers who conducted interviews were proficient in the major languages spoken in each metro where the study occurred.

In each participating metro, cisgender women ($N = 5$) and men ($N = 1$) conducted most key informant interviews, FGDs, and in-depth interviews. However, one of the co-investigators, the founder and director of the first trans-led organization in South Africa, is a transgender woman who conducted FGDs and in-depth interviews with transgender women, but only in the Buffalo City metro. Researchers should contemplate certain similarities that study participants may have due to commonalities such as language, race, and culture, which may make them an 'insider' to some extent. However, identification as a cisgender woman or man may result in being seen as an 'outsider' at the same time. In addition, all researchers completed a post-graduate education, which placed them as middle class, reinforcing an 'outsider' status to many of our participants' working-class situations. All members of the research team are supportive of extended rights and recognition for transgender women. As stated above, we worked closely with and saw ourselves as supportive of the organizations serving and representing transgender women.

Ethical considerations

We obtained ethics approval from the Human Sciences Research Council (HSRC's) Research Ethics Committee (REC) (Protocol No REC 7/17/06/15) as well as Human Subjects Review approval from the US Centers for Disease Control and Prevention (CDC).

Study findings

Social rejection, homelessness, violence, and everyday victimization

We found that transgender women who openly express their gender identity and transition to their preferred social gender position may face social rejection from close family members. This often results in individuals leaving the relative safety of their childhood home due to feeling socially unaccepted. In the following excerpt below, a transgender woman shared her experience of encountering difficulties with her family because of her trans identification and, hence, leaving home at a young age. Strict religious beliefs informed her family's response.

> At a very young age, I came to Johannesburg. I struggled with my family accepting and understanding my gender identity. And instead of them asking me what I wanted in life, they just told me this is not how I will live. We are Christians. Specific rules bound us. My parents gave me an option: shape up or ship out. Because they can't live with such a person (Key informant 2: Gauteng)

Transgender women struggle to find a space where they are accepted and often end up on the streets, becoming homeless. Some transgender women who are rejected by their families and left homeless respond constructively to form support communities of their own but remain vulnerable.

> So, when relationships with family degenerate because transgender women are expressing their gender identity or trying to figure out their gender identity, they often spend much time outside the home and might leave home at a young age. So, Laetitia* for instance, told me her own story, left home around 14, and other transwomen have also found themselves on the streets at a young age (Key informant 1: Cape Town)

Homelessness meant transgender women were more vulnerable to everyday violence and victimization. Study participants reported that the HIV vulnerabilities of transgender women are exacerbated when they are homeless. For example, a 19-year-old transgender woman who has been homeless since she was 14 years old recalled a brutal attack as a consequence of being homeless. The participant described her experience as traumatic and that the sexual encounter was non-consensual. This incident highlights the powerlessness and vulnerabilities experienced by the participant, of which threats against her and feelings of shame, fear, and humiliation silenced her from speaking out.

> It happened to me once in the Gardens [botanical gardens open to the public in the city centre of Cape Town] where I sleep. There was a group of men, and I couldn't fight back because he threatened me with a knife. I have never spoken about it. And he told me he would stab me if I didn't give it to him now. And he said to me that he wanted it without a condom

> because he was clean. And he pressed me into the grass and held my hands down. And he did what he wanted to with me. I didn't report it. Because if I talk about it, I sleep outside, he can come to my place where I sleep at any time (In-depth interview 8: Cape Town)

In addition to having been made more vulnerable to violence and victimization when becoming homeless, in general, transgender women reported that they lack standard protections from society—for instance, members of the police, who often extended the abuse by mocking or not taking complaints seriously when being reported. The excerpt below shows that when transgender women report a crime such as rape and sexual violence, the police tend not to take it seriously. They would mock and tease the complainant instead.

> You are given looks, and those looks will make you feel down. Then they will ask you, "What is the problem?" and you will say, "Someone beat me up, or someone raped me or tried to do such and such." Then they will say, "Who will want to rape you?"…. Then they will laugh, and I will feel down because I am angry and I want to report this, and when I am reporting this, the police make a joke of me. So, we ended up not going to the police and fighting for ourselves (In-depth interview 1: Buffalo City metro municipality)

Transgender women who are homeless are at greater risk of being victimized by the police, also due to them being homeless. Their personal belongings are destroyed and removed by the metro police, and further raids occur. Police raids increase the vulnerabilities of transgender women, and members of the police do not have any concern for the well-being of homeless transgender women.

> But you know the daily struggle to try and negotiate with the metro police, people's belongings are destroyed all the time, and you are homeless, your stuff is confiscated, your ID book destroyed, and all your things can be wiped out overnight. And again, they will do another raid a couple of days later. They do it when it is coldest in winter. They are trying to push people out of the metropolitan municipality and stop people. They are assuming that that will stop people from being homeless, but of course, that is a ridiculous assumption. (Key Informant 2: Cape Town)

Gender affirmation, sex work, and negotiation for safer sex

> Employment is something else. For now, I believe that if only we were to check the stats. None of the government departments has ever employed or has a certain percentage number of transgender people working there. I have never seen a transgender policeman or woman. I have never seen a transgender woman working at Home Affairs. I have never seen one, either a mistress or a teacher for that matter (Key informant 2: Gauteng)

We found that transgender women engaged in sex work as they could often not gain employment elsewhere. The difficulty in obtaining a job extended from the stigma experienced by transgender women in various sectors of society. Transgender women often have lower education and skills training, again due to discriminatory practices, which increases their social and economic disadvantage. According to this study participant below, regardless of one's qualifications, identifying as trans significantly impacts obtaining gainful employment:

> So there are quite huge challenges with accessing job opportunities. Accessing education and so forth. This then means even if you're trans and you're educated, it doesn't make you, you know, the chance of you being employed even in South Africa is still limited as a trans person (Key informant 6: Gauteng)

Hence, sex work became an alternative way of earning money, but again, the stigma attached to being transgender increased their HIV risk. It also made negotiating safer sex more complex, so transgender women are even more vulnerable than cisgender female sex workers.

> In the first place, most of the time, they're lonely. When they get that somebody, trans women don't ask to use a condom, and then they sometimes please that man without any condoms, and the person insists on not having sex without a condom, so to please the man, we do as he says. Because at that moment, he is your man (Key Informant 9: Buffalo City metro municipality)

Other spaces for employment are limited, with some transgender women working in the feminine beauty industry doing hair and nails, which matches their gender identity aspirations, but

remaining in low-skill roles. Some study participants were working in NGOs providing HIV prevention services to transgender women, and within the sample, these were the best off. Outside of the sample, we are aware of some transgender women raised in wealthier families who have professional training, but these numbers are likely to be extremely limited.

> Most of them do sex work not only as an economic thing but also as a way to affirm their gender. Transwomen do hair, nails, makeup, you know those apart from that, there is also like cleaning people's homes, watching people's children, but it is severely limited like on the economic front (Key informant 4: Buffalo City metro municipality)

Because of their financial insecurities and the stigma attached to their identity, some transgender women do not have the agency to negotiate for safer sex:

> Most of the time, when the client comes and says they have R300 (15.60 USD) and they want anal sex without a condom, I think it is a way that I engage in sex, so I think to myself that I should take it as it is much more money than I would make if I insisted on condoms (In-depth interview 3: Buffalo City metro municipality)

An important insight reported by study participants was that despite the stigma and danger attached to being a sex worker, sex work also provided a space where transgender women feel affirmed as 'real' women. Despite the apparent vulnerabilities that transgender women who engage in sex work are exposed to, sex work also affords them opportunities to have positive experiences performing femininity:

> Selling sex is a complex issue for transgender women because it is also a space where transgender women can express their identities positively (Key informant 2: Cape Town)

Within sexual relationships with male romantic partners, transgender women want to be affirmed as women. In these relationships, transgender women are often insecure about negotiating for safe sex due to the fear of being rejected. At the same time, transgender women also experience pressure to play the subservient role, which is modeled on traditional heterosexual relationships.

> Trans women do not have as much say over their selection of partners and thus have riskier sex with riskier partners, which can expose them to HIV and STIs. When you tell people you're trans and what that means, they don't want you - they don't want anything to do with you. Let alone when we find someone who wants something to do with us, we're there. It doesn't matter if it's right or wrong. It's just – we're more willing to go with the wrong person because it's harder to find someone who will accept us for who we are (FGD participant: Buffalo City metro municipality)

Substance use

Transgender women in our study spoke of using illegal substances and excessive alcohol use. The reasons provided by transgender women for excessive alcohol use and other substances include survival, as a way of screening out rejection and stigma, to be able to operate as a sex worker, for partying, and as part of the lifestyle for sections of the trans community. Study participants spoke of the importance of these substances in allowing them to cope with the oppressive daily conditions they face, with groups sometimes forming around a substance of choice, allowing some communal connection. For transgender women who are homeless, using illicit drugs and drinking alcohol equates to surviving the cold and other dangers of living on the streets and as a coping mechanism against the rejection and stigma of society.

> Well, I know a few transgender women who have alcohol problems, and the sex worker community has also told me that drugs are used just so that they can push you through your day. The children that I have worked with have also smoked drugs and drank. I equate it to just trying to get through the pain. And you will find it often in people in violent relationships or abusive relationships or doing sex work. You try to dull the pain so that you will go to elicit substances (Key Informant 2: Gauteng)

Using substances is an important coping mechanism for dealing with the emotional trauma of stigma, including being socially rejected from one's family home. Other social realities add to the stigma and pressure and lead to choices that increase the risk of transmission and further social rejection, such as engaging in sex work for

survival purposes. Engaging in sex work and substance use places transgender women at higher risk of HIV and STI acquisition, as the capacity to negotiate safer sex is reduced. As this study participant reported below, these stresses accumulate and add to the need to cope by using substances.

> I would think stigma and rejection are very high. First, you are rejected at home. You are living a life you are uncomfortable with. Let's say this person ends up being a sex worker. So now you are depressed, you have anxiety, you are stressed. Another thing is that trans women don't take mental health seriously, leading them to substance and recreational drug abuse, which puts them at high risk of getting HIV and other sexual diseases (Key Informant 3: Buffalo City metropolitan municipality)

Transgender women's perception of HIV risk and vulnerability to TB

Qualitative interviews showed that transgender women are disproportionately affected by HIV and STIs. The almost universal perception was that most transgender women already have HIV or will contract the illness in the future. "You get HIV because there is no hope." This view carries the dangerous notions of the inevitability of infection and, more dangerously, that transgender women deserve to be infected. In such a context, arguments for prevention become more complicated. In this FGD, a participant recalled that:

> As transgender women, we know we will get HIV or some STI. It is life, and we must accept this. When we go out, guys want to sleep with us without a condom. They buy the drinks, so we go with them. Many of the sexual partners and clients don't want to use condoms, and it is just the way it is (FGD participant: Buffalo City metro)

In addition to the above, there is also the perception that most transgender women are sex workers or have engaged in sex work in their lifetime. Hence, because transgender women engage in sex work, they are more at risk of acquiring STIs, including HIV. Indeed, there is a perception that all transgender female sex workers are HIV positive, as is evident in the quotation below:

> I think there is a definite difference between a trans female sex worker and a trans female that is working or, I mean not that sex workers don't work, they work, but come in at 9:00 to 17:00 jobs. I can see a difference between the two and the difference in their lives. Most of them are underweight, and all of them are suffering from STIs and HIV…Ja [yes] and as I say, of the trans female sex workers that I see, there is not one that is not HIV positive… (Key Informant 3: Cape Town)

Transgender women are more vulnerable to TB and STIs through the same risks as HIV. The additional exposures to TB allude to the difficult living conditions experienced by trans sex workers as a result of this, contributing to a higher risk of exposure to infection, as mentioned by this key informant:

> If a trans woman is straight and likes men or is attracted to men, she would have a higher rate of HIV as opposed to a trans woman that was a lesbian, just because of the penetration in the anus. I would think that if you have HIV, then you are more vulnerable to TB and STIs. And like I told you about that whole penis thing, it is not part of me. I don't care about it you know, and with the whole strapping, I don't know, that you are maybe more prone to certain types of STIs. And remember the environment where I know trans sex workers live in East London. It is highly dense, so remember, with TB, it is also with any drop of saliva. So, you are more prone. And remember smoking, too. So, it is like a nightmare (Key Informant 2: Buffalo City metro)

PrEP a nd other prevention resources

Given the risks described above, awareness, accessibility, and uptake of pre-exposure prophylaxis (PrEP) is a critical bio-medical intervention for transgender women to reduce the risk of HIV acquisition.

> Sometimes, when it comes to the protection methods against HIV, I prefer PrEP to everything because PrEP does help. I have slept with a lot of clients, and I have been without a condom for the past months, but when I go to the clinic, I am still clean, and I am still negative. I still take PrEP every day. You take your PrEP, and if there is a way to prevent infection, then go for it and do it as a sex worker. But then, when you look at PrEP, it arrived on the scene when the damage had already been done. As a sex worker, to protect yourself and be on the safe side because

you can go and treat something like an STI (FGD participant: Gauteng)

PrEP is well-known among transgender women and is generally accepted as a vital tool in preventing HIV transmission among populations at higher risk. There was a common view that PrEP should be made more accessible and available to all transgender women, but at the time of the study, few healthcare facilities were able to offer PrEP. Moreover, there is also very little tailored information about HIV/STI prevention services targeting transgender women.

> And we must provide these services, whether it is for gay, straight, or trans people. But now, there are very few clinics that do give out PrEP services. Furthermore, you don't ever see any prevention material that targets trans women as no one cares about us (In-depth interview 6: Gauteng)

Although key informants felt the absolute need for PrEP to be available to transgender women, there were concerns regarding the sustainability of PrEP, with limitations on drug stocks and the reliance of most transgender women on public health services. Some participants called for PrEP to be seen as part of a larger-scale prevention intervention, including other tools for protection, such as lubrication and condoms.

> Number one, those are not provided for in the public space as they are now, yet it is one of the prevention tools they need. But my issue, and I believe it has been the issue that we have been grappling with in terms of asking about the sustainability of PrEP, is if it gets to be rolled out, you know, because you know the issues of drug stock-outs that we sometimes face in the province. So, if we want to take that angle of prep as a means of prevention, we will be able to sustain that because it is another risk to start and stop because it is not available. But there is just no doubt that it is needed, as well as lubes, as well as those condoms, like your finger condoms, that are relevant for transwomen (Key informant 5: Buffalo City metro)

Experiences of healthcare stigma

Study findings showed that transgender women may delay seeking testing and treatment for HIV and STIs due to prior or expected trans-phobia and insensitivity experienced by healthcare professionals. They reported experiencing discrimination as a judgment on their lifestyle, a reluctance to talk to or touch them, blaming transgender women for their health problems, and an unwillingness to provide or even speak about gender-affirming care.

> When we go to the clinics, we get sworn at and discriminated against by people in the clinics who call us all sorts of names, and we get scared for our lives, so we do not go for treatment (FGD participant: Buffalo City metro)

> The nurses at the clinics we go to look down on us. They say: What kind of person do you want to be a woman? They laugh at us. When we go, if you have an STI, they will call all their friends to see. And when we go for ARVs, they say we deserve what we got (FGD participant: Buffalo City metro)

Transgender women experienced challenges with accessing hormonal and other gender-affirmative therapies due to limited resources and few healthcare workers being well-versed in providing treatment and care for transgender women. Very few healthcare staff at public healthcare facilities are knowledgeable about hormonal therapy for transgender women. The limited knowledge about transgender care and treatment often leads to stigma and discrimination experienced by transgender women. Experiences of healthcare stigma, as well as unavailability of gender-affirming care and treatment, led to some transgender women accessing hormonal therapy on the black market. Using hormonal treatment without the guidance of a medical professional could have a detrimental impact on the lives of transgender women.

> Unfortunately, there is a lot on the black market. Do you know what is nice about the procedure and the assessment? You understand they identify the correct dosage and treatment for you. Because they look at you, assess you, take your weight, and do a total medical history. On the black market, people purchase them, and there are a lot of side effects and challenges involved with that (Key informant 6: Buffalo City metro)

A few key informants were healthcare workers who spoke about the difficulty in obtaining resources for gender-affirming care and their isolation in delivering it. However, healthcare workers who participated in our study were optimistic

about the care they could provide. Their work does provide some direction for future health maintenance services for transgender women. Key informants interviewed spoke about the inclusion of peer navigation approaches as well as addressing not only the biomedical risks but also human rights violations that will assist with reaching transgender women.

Fostering resilience through support from family, friends, and peers

Despite experiencing violence, stigma, and discrimination, transgender women appeared to be resilient and accepting of themselves, "Yes. I am, out and proud". The excerpt below demonstrates resilience and an acceptance of oneself. To be in a position to recognize one's true worth and value in the face of societal problems is not defined by others' points of view. This journey of self-acceptance did not occur overnight. There were many criticisms of the participants' gender identity, which resulted in setbacks. And as much as transgender women experienced this, they could bounce back and reclaim their identity.

> Then I say to myself: this is who I am. This is who I am, so I don't worry what people say anymore (In-depth interview 8: Cape Town)

Social rejection from family and friends was not universal; some transgender women were socially supported in their transition by family members and friends, and this assisted in building resilience. Study participants, who had previously expressed concern about the lack of police protection when reporting violence, found solace in knowing that a family member would step in and offer support during instances of violence, such as sexual and physical violence. The excerpt below shows that family members, close relatives, and friends would unite to confront the perpetrator.

> I have a brother who loves me, and I will tell him, "You know what? That guy just did it to me." Then he will round up my cousins and my friends (In-depth interview 1: Buffalo City metro municipality)

By embracing, accepting, and offering a sense of belonging, family and friends play a significant role in supporting transgender women. In addition to social acceptance, offering more tangible social support (i.e. a stable place of residence) facilitates the integration and inclusion of transgender women within their communities. On the other hand, those who experience rejection from their families often find themselves homeless and are subjected to unhealthy circumstances as stipulated earlier:

> You know, where a trans female is accepted by her family or her friends, they tend to be living in a house. Some transgender females have family support structures. And then on the other side, you know, people that haven't been accepted by their family, who were kicked out when they were young, they've been on the streets for many years, they have ill health (Key Informant 3: Cape Town)

Peer support was established either formally or informally, where transgender women form close ties with each other in street communities or *via* formalized support groups that are led and maintained by transgender women themselves. As described above, the NGOs consulted in this study play a crucial role in developing resilience by providing places of acceptance and support.

Discussion

This paper sought to explore the structural, personal, and economic factors that make transgender women vulnerable to HIV infection in urban metros of South Africa. The tendency is to look simplistically at behavior and make judgments about risk and responsibility. Here, we argue that amongst a highly vulnerable group, such as transgender women, barriers and social constructions limit the agency and freedom of transgender women, making even protective behaviors difficult or, at times, impossible. These considerations are essential when framing HIV and STI risks for transgender women and are ultimately critical when developing interventions for HIV prevention and treatment services.

In the first instance, we found that social rejection and stigma are ubiquitous experiences for transgender women. Most of the transgender women in our study expressed experiencing

stigma and feelings of rejection from their families and communities. While some participants had positive encounters and a supportive family, the predominant experience was social exclusion and rejection. Homelessness impacted many of the transgender women who participated in our study. One of the main reasons that transgender women experience homelessness is a direct result of societal rejection, which includes parental and community rejection. A systematic review of prospective studies found that there is usually a breakdown in family relationships, especially when young individuals disclose their sexual orientation (McCarthy et al., 2022).

Secondly, despite the social and legal protections for transgender women brought on by Section of the South African Constitution, other legal policies and frameworks remain a human rights barrier to effective HIV programming for this group, which bears the highest burden of HIV in the country (Chimatira et al., 2022). For instance, the Provisions of the Sexual Offenses and Related Matters Amendment Act of 2007 criminalize clients who engage in sex work, make illegal prostitution, brothel keeping, solicitation, indecent exposure, and knowingly living from the proceeds of sex work (Criminal Law (Sexual Offences & Related Matters) Amendment Act, 2007). According to the Drugs and Drug Trafficking Act of 1992, using, carrying, and dealing with narcotic substances is illegal (Drugs & drug trafficking Act 140 of 1992 and Government Gazette, 1992). Magistrates default to sentencing drug users to prison terms (The Global Fund, 2018). Criminal records increase the stigmatization and marginalization of persons who inject drugs once released (Clinton & Pollini, 2021).

Moreover, qualitative data highlighted how transgender women did not receive protection from structures such as police services. During arrests, widespread harassment and abuse of power by the police were experienced by transgender women in our study. There are mitigating reasons why a rape or sexual assault is not reported to authorities by homeless transgender women, as stigma and discrimination are already embedded in those who are supposed to protect the vulnerable (McCarthy et al., 2022). Study participants reported that due to the misconceptions that police had about transgender women, they preferred not to report the case or confide in them for their safety and protection.

Unprotected sex frequently takes place under the influence of alcohol or illicit substance use. However, the findings indicate that for transgender women, homelessness often leads to using illegal drugs and alcohol to survive the cold and other risks of living on the streets and coping with society's rejection and shame. Using substances as a coping method leads to decisions that enhance the risk of transmission and put transgender women at a higher risk of HIV and STI acquisition. High rates of unprotected sex among transgender women carry an increased risk of HIV and STI transmission. However, stigma and discrimination experiences often lead to low self-esteem and disempowerment, which makes it more challenging for transgender women to insist on condom use (Bockting et al., 2005). Feldman et al. (2014) articulate that transgender women may be more submissive to male sexual desires both as part of enacting the female gender role and of accessing male partners (Feldman et al., 2014). Therefore, as confidence in one's gender identity increases, the ongoing process of affirming womanhood through sexual interaction with straight men may become less encompassing (Feldman et al., 2014). Other social factors make transgender women more likely to engage in high-risk sex. In many settings, the insertive sexual partner controls condom use, so many transgender women who have sex with men are unable to bring about the issue of condom use (Feldman et al., 2014). For these reasons, many transgender women believe that at some stage, they will inevitably acquire HIV or an STI.

In addition to experiencing stigma that often manifested first in the household, in communities, at school, and with potential romantic partners, stigmatization faced when accessing HIV and STI care and treatment appears also to be persistent in the lives of transgender women. Healthcare stigma as experienced by transgender women has been well documented globally (Barrington et al., 2016; Deye et al., 2015) and in South Africa (de Villiers et al., 2020; Luvuno et al., 2017, 2019; Spencer et al., 2017). In reducing the stigma experiences of transgender women

when accessing healthcare, it is helpful for public health workers to be trained on the needs of key populations and the importance of respectful services. The Department of Health is rolling out (with the President's Emergency Plan for AIDS Relief) key population sensitization training and establishing key population-friendly facilities. This, albeit a slow process, is a step toward achieving equitable healthcare access.

Study participants are aware and knowledgeable about PrEP but also discussed obstacles to accessing PrEP services. Poteat et al. (2020) emphasize that South Africa is poised to scale up PrEP services and provide prevention resources for transgender women (Poteat et al., 2020). Dedicated transgender clinics provide comprehensive care, including PrEP, preventative commodities, and treatment for transgender women. Another helpful approach is to partner with transgender women influencers or trans advocates in designing and implementing PrEP programs. Transgender women have identified critical issues that the health industry must address to increase PrEP uptake amongst transgender women. These include addressing contextual factors related to HIV in this community, creating more inclusive messaging and imagery, having ongoing conversations about PrEP with patients, and community mobilization. However, transgender women faced various obstacles due to marginalization, according to study participants.

Transgender South Africans encounter many socioeconomic challenges that put them at greater risk of ill-health. Unemployment is a crucial determinant not only for HIV risk but for poor quality of life. For those individuals who are socially marginalized, such as transgender women, economic exclusions have a severe impact on not only access to HIV care and treatment but also the overall quality of life. Our study findings showed that as a result of social and economic marginalization, transgender women are often prone to other issues, including stigma, discrimination, violence, and increased vulnerabilities to STI/HIV and TB acquisition. Social determinants of health, including housing and unemployment, can deter transgender women from accessing care. This is quite revealing of the syndemic conditions of transgender women in South Africa and shows intersections of race, trans identifications, and socioeconomic status as factors disadvantaging this population.

Despite this, the resilience of transgender women is reflected in their ability to find strength in adversity and seek out support systems. Moreover, we found that transgender women form close ties and relationships with each other to build community resilience and often function as alternative kinship structures for those disowned by their families (Scheibe et al., 2018). By supporting trans identifications and establishing a solid support system, family and friends of transgender women redefine their relationships and work toward fostering a more inclusive society for a marginalized community. These supportive individuals play a significant role as a protective barrier for transgender women, shielding them from harm and the potential consequences of societal exclusion and victimization that emerge when they openly express their gender identity. Consequently, transgender women establish a stable atmosphere conducive to overcoming challenges and fostering internal fortitude.

Study limitations

The study findings should be interpreted considering its potential methodological limitations. Due to the research design, findings will only allow tentative generalizations. Purposive sampling of transgender women was limited to urban areas in this rapid qualitative assessment. Transgender women were mainly recruited through organizations and service providers working with transgender women. Hence, the method of sampling led to the selective inclusion of transgender women who have established networks and ties with service providers for transgender women in the Western Cape Province, the Johannesburg metropolitan area in the Gauteng province, and the Buffalo City metro located in the Eastern Cape province of South Africa. The study findings apply only to the sample of transgender women participating in the rapid qualitative assessment. Hence, the results do not represent all transgender women living in South Africa. Finally, a

significant limitation of our qualitative study is that we did not collect important socio-demographic information from study participants.

Conclusion

Although South Africa guarantees constitutional protection for people of all sexual orientations, these data demonstrate that the lived realities of transgender women are complex and that personal, social, and structural factors contribute immensely to making transgender women vulnerable to HIV. The reality of prevention or using healthier practices is considerably more complicated than at first appearance. There is an ease in blaming those infected for their predicament that underlies a deeper level of stigma and false righteousness that must be acknowledged and confronted when addressing risk in vulnerable and marginalized communities. Community-derived policies are required to decrease stigma and discrimination, but more critical is community education about transgender persons as it is the beliefs about transgender women that lead to discrimination, and legislative change has limitations. Organizations of and those supporting transgender women do need more support. These will be key to developing a positive identity among transgender women and promoting resilience.

In addressing the specific HIV prevention and treatment needs of transgender women in South Africa, multi-level interventions are required that address risk at interpersonal, biological, structural, and community levels. High-impact biomedical interventions (ARV and PrEP), as mentioned by Poteat et al. (2020), should be made more accessible to transgender women in South Africa. Additionally, mental health interventions to manage depression, low self-esteem, and excessive consumption of illicit drugs and alcohol are also critical support to be considered. They should be made available to transgender women in South Africa. Considerations of the legal and policy framework in which sex work happens in South Africa must be examined. Successful interventions should address stigma and victimization and draw upon the resilience of transgender women. Peer-driven interventions may empower and motivate personal responsibility to use high-impact HIV prevention and treatment services.

Transgender women are disproportionately impacted by barriers preventing them from accessing vital HIV care. These obstacles are interconnected and hinder progress at every stage of the care continuum. Removing barriers is not only essential, but we should also ensure that transgender women receive equitable and gender-affirming healthcare to create a healthcare system that is inclusive and respectful of the healthcare needs of transgender women.

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