



Advancing sexual and reproductive health and rights (SRHR) of sexual
and gender minorities in Gert Sibande District, Mpumalanga: A rapid
ethnographic assessment

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Executive summary

The study reported on in this document builds on research conducted in the second year of the AIDS Foundation of South Africa (AFSA) three-year programme (2014-2017), *Making Sexual and Reproductive Rights Real*. The programme is intended to strengthen SRHR and community-based HIV/AIDS interventions, and to build the evidence base for effective regional responses. In line with recommendations for further research from earlier studies forming part of the AFSA three-year programme, (see Morison, Moolman & Reddy, 2015; Morison & Lynch, 2016a), this study examined (a) healthcare workers' perceptions and treatment of sexual and gender minorities; (b) the perceptions and experiences of LGBTI persons around accessing quality SRH services; (c) the range of LGBTI-specific SRH services required as part of quality SRHR; and (d) effective practices and lessons from organisations and public-private partnerships towards addressing LGBTI SRHR. The current study approached these research priorities with a deepened focus on a rural National Health Insurance (NHI) pilot area in the province of Mpumalanga, South Africa.

Aims of the study

1. Exploring the effects of systemic failures in the public healthcare system within an NHI pilot site, with particular a focus on the challenges and opportunities in providing SRH services to sexual and gender minorities.
2. Identifying effective practice and key advocacy priorities for ensuring SRHR of marginalised groups, delivered by NGO service providers and/or in partnership with public facilities, with a focus on LGBTI persons within the NHI pilot site

Research methodology

The research was conceptualised within a sexual and reproductive citizenship theoretical framework and made use of qualitative methodology to construct a detailed, nuanced situational analysis of sexual and reproductive health and rights. This methodology was also selected to enable the voices of LGBTI participants to be heard. A Rapid Ethnographic Assessment (REA) was conducted in selected healthcare facilities in Gert Sibande district, Mpumalanga – the identified NHI pilot area for this project. The rapid ethnography was focused on four different areas of data collection, allowing for triangulation of data, namely:

1. In-depth individual interviews with LGBTI healthcare users;
2. In-depth accounts of challenges and opportunities identified by healthcare workers;
3. Ethnographic observation of selected healthcare facilities;
4. Interviews with NGO service providers and other key informants across the country.

The transcribed interview material, field notes and observation schedules were analysed using thematic analysis.

Themes and key findings

1. Drivers of discrimination and denial of SRHR

'They believe it's a disgrace, a curse'

This theme identifies drivers of discrimination against sexual and gender minorities, and denial of their SRHR. A first factor informing denial of SRHR is *widespread stigma and heterosexism*, where healthcare workers form part of communities that remain largely patriarchal and

heterosexist (i.e. prejudiced against people who are not heterosexual or not gender-conforming in terms of socio-cultural appearance and behaviour norms). A second factor informing denial of SRHR is *unresponsive health systems*, characterised by pervasive heteronormativity in the design, management and provision of services, that functions as a deterrent for LGBTI persons seeking SRH care. Even in the absence of overt heterosexism, sexual and gender minorities report that healthcare services are not inclusive and are structured around heteronormative assumptions about gender and sexuality.

A third factor identified is that of prevention and redress of *violence as an unmet sexual- and reproductive health need*. Sexual violence and intimate partner violence cause significant health disparities for LGBTI persons, yet the findings show that this remains unacknowledged in public facilities' SRHR response, at times contributing to severe secondary victimisation and in some cases resulting in LGBTI persons discontinuing treatment. A fourth factor in denial of SRHR is that of *silences around transgender and sexual minority women's health*. The findings indicate that although transgender persons are included as a key population in the South African National Strategic Plan (NSP) on HIV, STIs and TB, they are not fully integrated into the HIV/AIDS response and experience a complete dearth of treatment for other healthcare needs. In relation to sexual health of lesbian and bisexual women, participants reflected on their need to test for HIV and access other SRH services, and spoke about the lack of sensitive, appropriate services for sexual minority women.

2. Desiring SRHR for sexual and gender minorities

'People wish to be free'

The findings under this theme indicate that there were instances, albeit not frequent, in which public healthcare workers and other community stakeholders expressed *solidarity with and support for the health rights of LGBTI persons*. This challenges notions of rural areas as entirely heterosexist and points to shifts towards greater support for sexual and gender minorities. It was possible to identify individual healthcare workers who were sympathetic to the SRHR needs of sexual and gender minorities and who spoke about strategies they employed to encourage marginalised persons to access care.

Further to this, LGBTI healthcare users recounted instances of *resistance to heterosexist treatment* at public healthcare facilities. However, LGBTI participants, particularly sexual minority women, often framed their claims to adequate SRHR in ways that were hypothetical – describing what they *would* consider to be ideal healthcare facilities, rather than reflecting on positive SRH care experiences. These reflections are important as they speak to a sense of entitlement to adequate care, although the findings indicate that such resistance remains limited to individualised responses by LGBTI persons and does not occur in the context of a broader movement towards advancing sexual and reproductive justice.

3. Crafting an agenda for universal access to SRHR

'It's about connecting our struggles'

A final theme concentrated on ways in which to connect different SRHR concerns towards a shared advocacy agenda. A 'key population' public health narrative was demonstrated to be a familiar framing of LGBTI HIV risk for organisations active in the Gert Sibande district,

particularly for HIV-focused organisations. This narrative holds traction among organisations but was, however, found to be limited to sexual health concerns of gay and bisexual men and other men who have sex with men (MSM), thus not translating into broader awareness of and responsiveness to sexual and gender diversity.

Public-private partnerships, specifically between public facilities and LGBTI-focused NGOs, were described as an appropriate way to support public facilities in addressing shortcomings related to LGBTI SRHR. A related challenge, however, is the *low capacity of NGOs to engage fully with sexual and gender diversity*, and especially the lack of LGBTI-dedicated NGO capacity in the district, and in rural provinces generally. Healthcare workers shared in this concern that although training related to marginalised groups has been offered at some facilities, this information has not been fully integrated into health systems and facilities remain reliant on NGO partners.

Key informants emphasised that NHI holds promise for increased affordability, availability and acceptability of healthcare services, but expressed concerns about the *lack of engagement with SRHR in NHI policy*, notably the absence of any reference in the policy document to sexual health. This translates into an absence of adequate SRHR indicators in the monitoring and evaluation framework of implementation of the NHI pilot in the Gert Sibande district.

Recommendations

Shifting community attitudes

1. LGBTI persons not only face discrimination and heterosexism in specific institutional spaces (such as healthcare facilities) but live in communities where homophobic and transphobic beliefs remain common. Community engagement, including with religious and traditional leaders, remains important in shifting attitudes.
2. Parallel to pervasive heteronormativity and heterosexism, it is possible to identify positive localised shifts in attitudes and behaviour of healthcare workers. Further in-depth research can assist in identifying and promoting the contributing factors towards such shifts.
3. Interventions can identify sympathetic healthcare workers who can champion more professional service provision for marginalised groups. Knowledge of these allies is passed on through social networks and word-of-mouth, and interventions can formalise channels for sharing this information, for example, by having persons or spaces identify as 'LGBTI friendly' or as allies.
4. A dual approach of providing specialised LGBTI-friendly services through NGO facilities, while concurrently strengthening public facilities to provide integrated care, remains necessary to ensure that pervasive heterosexism and heteronormativity do not pose access barriers to LGBTI persons.

Training and capacity building

1. Healthcare workers share negative beliefs about same-sex sexuality and perpetuate harmful attitudes towards sexual and gender minorities. Training with healthcare workers should include dismantling heteronormative assumptions and strengthening professional competency.

2. Training should also include the full range of sexual and gender diversity, to ensure that comprehensive SRHR of particularly marginalised groups such as sexual minority women and transgender and intersex persons are recognised.
3. Sexual violence and intimate partner violence experienced by sexual and gender minorities are currently not addressed in SRH service provision and need to be included as part of comprehensive SRHR for LGBTI persons.
4. Disaggregation of data by state institutions such as the police and justice system can assist with determining the extent of intimate partner violence and sexual violence perpetrated against LGBTI persons.
5. The care, treatment and support of sexual and gender minorities should be integrated into service provision at Thuthuzela Care Centres in particular, as the primary state response to sexual violence.
6. Continued education of LGBTI persons about their right to comprehensive SRHR remains important in order to foster a sense of entitlement to adequate treatment and care.
7. Civil society organisations that do not engage with LGBTI SRHR as their core mandate should be empowered through sexual and gender diversity training, in the form of knowledge exchanges that benefit organisations across sectors, so as to capacitate them to advance LGBTI SRHR.
8. Civil society should be supported in developing and applying appropriate indicators to monitor implementation of comprehensive LGBTI SRHR in the NHI pilot sites, in partnership with the Department of Health (DoH), in order for these indicators to be integrated into DoH quality control mechanisms.

Advocacy and movement building

1. There is a need to build solidarity among LGBTI persons to cross divides between sexual minority men and women, and challenge marginalisation of gender non-conforming and transgender persons within LGBTI spaces.
2. Complaints about rights violations lodged by LGBTI persons at healthcare facilities are not met with professional and prompt action. These individual acts of resistance to heterosexism should be connected with movements and organisations that can provide institutional authority and support (such as NGOs), in order to create greater impact and effect structural change. Complaints can be followed up through a coordinated civil society advocacy campaign in order to hold facilities to account.
3. The 'key population' narrative holds traction with civil society organisations and provides an entry point for advocating for LGBTI SRHR, but is limited to a focus on gay and bisexual men and other MSM; it needs to be expanded to include sexual minority women and transgender persons.
4. Applying an intersectional lens to SRHR can connect the struggles of different marginalised groups and foster solidarity and shared commitments to advocacy. Specific axes of identity to consider when applying an intersectional lens include race, class, rurality, gender identity and expression, sexuality, occupation (e.g. sex work), health status, and dis/ability, among others.
5. LGBTI-specific civil society organisations and networks in provinces and districts outside of urban centres – that tend to be relatively better resourced – should be strengthened. In particular, in the absence of relatively better funded NGOs, LGBTI-focused community-based organisations (CBOs) in rural provinces play an important

role in providing support to LGBTI persons and advocating in their communities; these organisations require funding support towards carrying out this work. Partnerships of mutual learning between established NGOs in urban centres and emerging CBOs in rural areas – aimed at sharing information and resources – can assist with this.

6. Related to the previous point, partnerships between local and national actors, to connect locally generated evidence with national-level advocacy, should be identified and nurtured.
7. Advocacy in relation to NHI should emphasise the need to expand the current focus on reproductive health to also include sexual health. This is in line with the South African NSP as well as regional SRHR commitments, such as the Maputo Plan of Action, to which the South African government is a signatory.
8. Advocacy towards the full realisation of SRHR can supplement rights-based approaches with the concept of reproductive justice, to highlight the inter-connection of reproductive and social justice concerns.

Section 1: Introducing the study

1.1. Introduction

Sexual and reproductive health rights (SRHR) play a fundamental role in the transformation of society, particularly for women. In this report, sexual and reproductive health (SRH) is understood broadly as encompassing people's comfort with their sexual and gender identities, and their agency regarding their sexual and reproductive lives, including engagement in sexual and procreative relationships (Klugman, Treger, Conco, & Moorman, 2011). Proceeding from a conceptual framework of sexual and reproductive citizenship (see Macleod & Vincent, 2014), these facets of SRHR are located contextually, with a view to understanding the ways that interpersonal and socio-cultural factors (such as violence, discrimination and coercion) impact upon people's rights and agency (Morison, 2013). Indeed, in South Africa, as in most other countries, persistent inequities act as barriers to people's ability to exercise their SRHR. These inequalities are rooted in social conditions of vulnerability (such as poverty, migration, and social exclusion); institutions (such as schools); and behaviours (such as sexual violence or coercion) (WHO, 2013).

In response to such challenges in the South African context, the AIDS Foundation of South Africa (AFSA) initiated a three-year programme (2014-2017), *Making Sexual and Reproductive Rights Real*. The overall programmatic aim is to advance the realisation of SRHR in South Africa. In particular the programme is intended to strengthen SRHR and community-based HIV/AIDS interventions, and to build the evidence base for effective regional responses. The programme is designed to deliver: (1) Strategic support for CBOs and national advocacy/policy actors engaged in effective HIV/AIDS and SRHR interventions; (2) demonstrable improvements in the realisation of SRHR in South Africa; and (3) a measureable contribution to the knowledge and evidence base on HIV/AIDS in the Southern African Development Community region.

This report speaks to these aims by providing evidence generated in a qualitative investigation, conducted in the second year of the project, of the state of SRH services in the Gert Sibande NHI pilot district in the province of Mpumalanga, South Africa, with a focus on SRH services provided to LGBTI persons and including those from other marginalised groups (e.g. sex workers, transgender people, LGBTI refugees, migrants and foreign nationals). Specifically, it explores the impact of systemic failures in the healthcare system on SRH access and service provision for marginalised groups in a rural area, including services for LGBTI survivors of sexual violence.

1.2. Background, aims and objectives

This study reported on in this document focused on SRH service delivery in the context of systemic failures in the public healthcare system within the NHI pilot site. The study built on research conducted in the first year of the programme. Specifically, it responded to recommendations for further research on: the perceptions and experiences of healthcare workers towards sexual and gender minorities; the perceptions and experiences of LGBTI persons around accessing quality SRH; the range of LGBTI-specific SRH services required as part of quality SRHR; and effective practices and lessons from organisations and public-private partnerships towards addressing LGBTI SRHR (Morison et al., 2015). The current report approaches these research priorities, with a deepened focus on a rural NHI pilot area.

The geographic focus of the study is novel and is a strategic advantage for AFSA implementation partners working towards the fulfilment of SRHR of LGBTI persons and other marginalised persons in rural areas. It contributes to a rich evidence base for advocacy. Further to this, focusing on an NHI pilot area allows for valuable information to be collected regarding the impact that NHI activities have in the area, as well as potential problems with future roll out, identified in the NHI pilot.

Specific objectives included:

- to explore the challenges and opportunities in providing SRH services to sexual and gender minorities;
- to identify effective practice and key advocacy priorities for ensuring SRHR of marginalized groups, especially LGBTI persons, delivered by NGO service providers and/or in partnership with public facilities within the NHI pilot site

The research objectives were addressed by conducting a rapid ethnographic assessment – drawing on narratives from LGBTI persons, healthcare workers and facility managers, CBOs and NGO service providers in the district. The methodology used is elaborated on in Section 3) In the remainder of this section we describe the context of the research study – in relation to the broader policy context of NHI and efforts to ensure universal access to SRHR, as well as in relation to the geographic context of the Gert Sibande district (see site description and map further below). We also define key concepts related to the sexual and reproductive justice lens that framed this investigation.

1.3. Context of the study

The National Health Insurance (NHI) initiative

The NHI scheme is an initiative by the South African Department of Health designed to address the deep inequalities of access to health services in the country. The scheme has a particular focus on rural and previously disadvantaged areas and the improvement of health outcomes for the most vulnerable in South Africa. The objective is to achieve universal health coverage through pooling funds and thereby providing access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socioeconomic status (DoH, 2015).

NHI AIMS

1. Improve access to quality health services for all, irrespective of employment
2. Pool risks and funds to achieve equity and social solidarity through the creation of a single fund
3. Procure services on behalf of the population and efficiently mobilise and control key financial resources
4. Strengthen the under-resourced and strained public sector so as to improve health systems performance

NHI was introduced in August 2011 and is being implemented in three phases over a period of 14 years, as summarised in table 1 below. Phase 1 has taken place over the last five years, and 2016 is its final year. This phase has included the strengthening of the service delivery platform and the overall improvement of quality in the public health sector. This phase also involves piloting key elements of NHI in selected districts, Gert Sibande being the selected district in Mpumalanga province. Activities in NHI pilots focus on key elements such as district health services, service delivery, strengthening of health systems and health financing. The pilots are

further assessing whether the health service package, primary health care (PHC) teams and strengthened referral systems will improve access to quality health services, particularly in rural and previously disadvantaged areas (DoH, 2015). This process is being monitored and evaluated against key indicators to determine the success of the implementation of the project and identify any challenges and required improvements. Despite some successes, progress remains well behind schedule. (See DoH, n.d., for more information on the NHI indicators for the Gert Sibande district pilot phase).

Phase I			<ul style="list-style-type: none"> Quality improvement strategies in public sector, including problems with infrastructure and availability of essential medicines;
(2012/2013	to		
2015/2016)			<ul style="list-style-type: none"> Piloting key elements of the National Health Insurance reforms in selected ten districts
Phase II			<ul style="list-style-type: none"> Continuation of activities initiated in Phase I;
(2016/2017	to		<ul style="list-style-type: none"> Mobilising additional revenue streams and generating additional revenue through taxation <ul style="list-style-type: none"> Establish an NHI fund Creation of a purchaser-provider split
2019/2020)			
Phase III			<ul style="list-style-type: none"> Continuing existing activities;
(2020/2021	to		<ul style="list-style-type: none"> Implementation of mandatory contributions;
2024/2025)			<ul style="list-style-type: none"> Initiation of contracting-out activities with identified accredited private providers

Table 1: NHI pilot phases

NHI, in transforming healthcare in South Africa, is intended to reduce inequities in access to and acceptability of healthcare, including SRH (Benetar, 2013; Shisana et al., 2013). In terms of the treatment of SRHR, the NHI White Paper has prioritised:

- a. the reduction of maternal mortality and the burden of disease borne by women, and
- b. maternal and reproductive health services.

This means they are ‘non-negotiable’ components of the health system, to be protected from under-funding (DoH, 2015). This is in response to high maternal mortality rates and the push from the international community to address gender inequalities (Chopra, Lawn, & Sanders, 2009; Mayosi et al., 2012).

While these priorities are certainly necessary and commendable, they do not address the narrow, woman-focused approach to SRHR within the health system, which limits services to a range of ‘ideal’ clients. The NHI White Paper does not engage with SRHR and in fact restricts the comprehensive package of health services to (women’s) *reproductive* health, not *sexual* and reproductive health (as listed on p. 26 of the NHI, DoH, 2015).

Thus, the current arrangement of NHI supports the existing SRHR care regime in South Africa, which is not oriented to meet the different needs of the diverse range of people who require these services, including “men, transgender people, people with disabilities, people living with HIV, adolescents and young people, women not of reproductive age, sex workers, or people with diverse sexual orientations, among others” (Klugman et al., 2011, p. 11). This has negative consequences for sexual and gender minorities in that the document assumes a heteronormative frame and marginalises vulnerable groups who access services not only or primarily for reproductive health but for reasons more directly related to sexual health. Other limitations of the NHI White Paper, as it relates to SRHR, include the negligible mention of

HIV/AIDS and lack of engagement with the NSP and other existing local and regional SRHR frameworks, such as the *National Adolescent SRHR Framework 2014-2019* and the regional Maputo Plan of Action on SRHR (Jones-Phillipson & Clayton, 2016; The African Union Commission, 2006).

Gert Sibande District, Mpumalanga, as an NHI pilot area

Gert Sibande is the largest of three districts in Mpumalanga, with a predominantly rural population of approximately 1,056,178. There is high youth unemployment and most households depend on social grants. The province experiences high levels of deprivation and allocated resources do not meet the population need (Massyn et al., 2014). The district incorporates Secunda, Ermelo and Piet Retief (Gert Sibande District Municipality, n.d.).



Figure 1: Map of Gert Sibande district, Mpumalanga

Gert Sibande district was selected as a pilot site based on its high prevalence of HIV/AIDS and poor health care facilities. In 2013 it was reported to have recorded the highest infection rate of HIV/AIDS in South Africa. There has been no significant change in HIV prevalence among the general population in Gert Sibande since 2002 (Gert Sibande District Municipality, n.d.).

A key concern in the district, in relation to health systems, is underspending on health budgets. Of all the NHI pilot sites, Gert Sibande has one of the lowest levels of primary healthcare expenditure per capita, at R709, followed only by OR Tambo district in the Eastern Cape (Massyn et al., 2014). Being in a rural province, the district struggles with staff shortages and availability of medicines and supplies. This poses significant problems for health outcomes, particularly in the face of a severe HIV/AIDS epidemic (DoH, 2012). Because of the demographic spatial arrangement of the province, there is a high number of trucking communities passing through the province which, along with the mining community, contribute to an active sex work industry.

The district fares poorly in terms of SRH when compared to the rest of the country and barriers to exercising SRH rights are reflected in the following problems:

- (i) increased rates of pregnancy-related mortality;

- (ii) low attendance at antenatal care services;
- (iii) lack of functional Termination of Pregnancy services;
- (iv) high teenage pregnancy rates;
- (v) poor access to, and use of contraception; and
- (vi) high HIV prevalence among vulnerable groups (e.g. sex workers; men who have sex with men; young women) (Morison & Janse van Vuuren, 2015).

These interlinked challenges are particularly expressed in high pregnancy-related mortality and high rates of teenage pregnancy (see Morison & Janse van Vuuren, 2015, for more information).

The work of CSOs in advocating for and enabling people to gain and maintain access to the relevant health care is indispensable particularly in rural and resource-poor contexts. In Mpumalanga province, two CSOs in particular – Section 27 and the Treatment Action Campaign (TAC) play active roles in advocating universal access to quality health services. Although their mandates are in promoting human rights (Section 27) and campaigning for HIV and AIDS treatment (TAC), they have widened their activities to include lobbying for SRHR, especially in marginalised and rural communities. In terms of the NHI process, there was little involvement of civil society in the piloting and planning process regarding the identification of important interventions that could strengthen local health care systems.

Aside from the presence of Section 27 and the TAC, there is a dearth of CSOs in Mpumalanga working on SRHR issues, especially in Gert Sibande. This is more so in relation to LGBTI-focused programmes. A recent situational analysis of LGBTI civil society in Mpumalanga found that the province is severely under-capacitated with no formal LGBTI NGOs, but with several smaller community-based groups that organise events such as LGBTI pride and other social events and activism (Hivos, n.d.) An exception is Project Boithato (and the associated Mpumalanga Men's Study). This project, jointly launched by the Anova Health Institute and the University of California, San Francisco (UCSF) was implemented in Gert Sibande from 2013-2015 and focused on creating awareness about MSM sexual health and increasing NGO capacity in the area. Project Boithato played a critical role in creating awareness of MSM issues and an environment where communities in the district would be more accepting and affirming of gay men. For instance, under the project, the area's first ever LGBTI Pride was held in Gert Sibande in 2014.

Although Project Boithato scored some success, it was only focused on MSM. There are very few CSOs focusing on sexual minority women. Overall, the situational analysis concludes that sexual minority women and transgender persons are particularly underrepresented in CBOs and civil society in the province (Hivos, n.d.).

1.3. Key terms and domains of the study

This work is conducted within a framework of critical sexual and reproductive citizenship. This theoretical framework is based on theorisation around the notion of citizenship, which, simply put, deals with who is eligible to be counted as a citizen and who is not. This determines who is included and who is excluded from the entitlements of citizenship (such as healthcare) as well as justice claims (such as the rights to health and non-discrimination). Sexual and reproductive citizenship theory emphasises the contextual location of people's sexual and reproductive rights

and the limitations on these. We outline key elements of this framework that guided this research, below.

Sexual and reproductive citizenship

A framework of critical sexual and reproductive citizenship, as outlined in Macleod and Vincent (2014, p. 13), draws on feminist, queer and disability theorists' re-conceptualisation of citizenship from an inclusive and process-based understanding, and serves to question the "patriarchal, heterosexist, and able-ist premises of citizenship", as theorised in traditional conceptualisations of citizen's rights. It understands marginalisation and discrimination as multi-dimensional and thus shaped by individual, social and structural factors that may work to prevent or perpetuate such rights violations. Further, such a framework regards sexual and reproductive citizenship as encompassing both *status* (belonging and the question of inclusion or exclusion from the rights of citizenship, including the right to full participation in society and sexual, reproductive and bodily integrity) and *practice* (the formal and informal politics that create and support of citizenship and sexual and reproductive citizenship) (Macleod & Vincent, 2014; Richardson, 2000a, 2000b).

Intersectionality

LGBTI persons are not a homogenous social grouping and, as alluded to in the literature review that follows, other axes of power (related to gender, race, age, class, refugee status, migrant status, for example) differentially shape LGBTI persons' SRH needs and experiences in health systems. A framework of critical sexual and reproductive citizenship attends to the multiple influences of these overlapping social identity positions, to make visible how these create inclusions and exclusions that impact in different ways on sexual and gender minorities. Rather than a particular method, intersectionality entails the "adoption of an intersectional way of thinking about the problem of sameness and difference and its relation to power" (Cho, Crenshaw, & McCall, 2013, p. 795). In this research, adopting such a lens will allow for questions to be posed around how exclusions (that are multiple and fluid) operate to create inequality and vulnerability and how these may be overcome. The normative frameworks that underpin these exclusions are highlighted as well as ways in which these frameworks may be challenged and new inclusion norms established (Macleod & Vincent, 2014).

Situated agency

Within a critical sexual and reproductive citizenship framework, individual decision-making is understood as located in the social (Macleod & Vincent, 2014). Citizenship can be understood as the expression of agency, contributing to recasting sexual and gender minorities as active participants, rather than reductively regarding them as victims of oppression, marginalisation, and violence. However, understood within the context of resources (such as enabling policies or health systems and a supportive broader community), situated agency stresses "the capacity for agency while recognising that it occurs within a social context that influences it" (Bevir & Richards, 2009, p. 9). Understanding that social and structural factors play a dominant role in delimiting what is possible in terms of the ability of LGBTI persons to practise their right to sexual and reproductive freedom, our research is particularly sensitive to the agency expressed by LGBTI persons, civil society advocates, health care workers, and others who are supportive of SRHR of sexual and gender minorities.

Section 2: An overview of existing literature and the national policy context

In this section we review existing literature to establish the current state of sexual and gender minorities' rights broadly, as well as research about the indirect and direct discrimination and barriers to the full realisation of health rights – including SRHR – for sexual and gender minorities. We then turn to a closer analysis of relevant policy and legislation documents that pertain to SRHR of sexual and gender minorities, to establish the extent to which sexual and gender diversity are responded to and fully integrated within the South African policy context. This provides a backdrop to the findings that we present in Section 4.

2.1. The national context of sexual and gender minorities' rights

“If one looks only at the black letter of the law, South Africa appears [to be] the most egalitarian society in the world.”

(Stacey & Meadow, 2009, p. 171)

Extensive *de jure* rights are guaranteed to persons from sexual and gender minority groups, most often referred to as lesbian, gay, bisexual, transgender or intersex (LGBTI¹) persons. The constitution prohibits discrimination on the basis of gender and sexual orientation and affords SRHR to LGBTI persons. There have also been significant shifts in the law to recognise the family rights of LGBTI persons. These progressive *de jure* rights set the country apart from other countries in Africa, where in some places simply being identified as LGBTI is a capital ‘offence’. Nevertheless, despite the progressive laws, the reality is that the country remains entrenched in heterosexism and homophobia (Distiller, 2013).

Animosity toward LGBTI persons is widespread. For example, the HSRC's annual South African Social Attitudes Survey showed that the majority (80%) of South Africans still express negative attitudes toward homosexuality (Roberts & Reddy, 2008). These negative attitudes often express themselves as ‘mundane heterosexism’, that is, subtle, not easily noticeable forms of discrimination, as well as in more overt ways. The widespread, daily verbal abuse and negative social attitudes are hardly recorded or reported (Nel & Judge, 2008). As a result of low reporting, as well as the failure to officially classify discrimination, assault, rape and killing of LGBTI people as hate crimes, the extent of this discrimination is unclear².

Despite high levels of heterosexist discrimination, South Africa is unique in the region because legal protections *are* afforded to those who speak out or campaign against rights violations. Nevertheless, prosecution rates remain low. For instance, of the 31 reported murders of lesbian

¹ While we use this acronym in this report, it is noted that it is not inclusive of all sexual identities and practices. Therefore, the term sexual and gender minorities is used more frequently. The latter term includes persons, who do not necessarily identify as homosexual but engage in ‘same-sex’ practices [e.g. men who have sex with men (MSM) or women who have sex with women (WSW)] as well as other local understandings of sexual identities and practices.

² Research findings released by the Hate Crimes Working Group (HCWG) in February 2013 showed that among a sample of 394 victims of hate crimes, equal proportions (49%) cited their nationality or sexual orientation as the reason for the attack. The HCWG has developed a monitoring form that will assist in documenting the nature of and motivation for hate crimes.

women between 1998 and 2007 only one conviction was made³. In addition, political, traditional and religious leaders also sometimes display and promote heterosexist sentiments or fail to condemn attacks on LGBTI people. It is therefore imperative that the rights of sexual and gender minorities are safeguarded. Advocacy remains critical to ensure appropriate policy measures, effective programming and resource allocation in this area. For instance, the national task team set up in May 2011 to address hate crimes against LGBTI people, was formed only after sustained lobbying by civil society, led by LGBTI activists. This provides an important rationale for supporting civil society work in South Africa and forming regional partnerships.

2.2. Discrimination, marginalisation and SRHR

Both indirect and direct prejudice act as significant barriers to LGBTI persons' access to SRH services, as well as the quality of care they receive, and whether their SRH needs are ultimately met (DoH, 2011; Klugman et al., 2011). Both forms of discrimination are discussed below, where we review findings of research conducted on these topics.

Indirect discrimination – the heterosexual bias of health systems

Indirect discrimination is manifest in the lack of attention given to the SRH needs of LGBTI persons, both as individuals and couples. The public healthcare system, particularly with regard to SRH, is structured in heteronormative ways that render LGBTI persons invisible (DoH, 2011; Klugman et al., 2011; Muller, 2013, 2014). This is evident, for example, in the heterosexual bias of health policies, so that contraceptive services are framed within reproductive healthcare and focused on heterosexual family planning and pregnancy (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; Muller, 2013). As a result, health services in general have largely been oriented toward heterosexual people and their needs (Rispel, Metcalf, Cloete, Moorman, & Reddy, 2011). Representatives from civil society argue that the near absence of national guidance in public health facilities severely cripples the care sexual and gender non-conforming persons receive in relation to specific health concerns (Muller, 2014). For instance, Rispel and colleagues maintain that “current policies and public health programmes are largely unresponsive to the needs of MSM [Men who have Sex with Men]” (Rispel et al., 2011, p. S138). Another example is that of infectious disease education, including around HIV and other sexually transmitted infections. Researchers have noted that the hetero-centric nature of guidelines means that health workers do not pay adequate attention to the necessary messages of prevention and treatment when dealing with LGBTI persons (Muller, 2013, 2014; Rispel et al., 2011). As a result, inadequate information about HIV prevention is provided and an already marginalised group of people is potentially placed at greater risk (Muller, 2013). The invisibility of LGBTI persons means that their health care needs are ignored or misrecognised, and, ultimately, their constitutionally guaranteed rights are unprotected.

Another crucial issue that arises due to the heterosexual bias of the health system is the lack of training regarding the basic issues that are critical for providing adequate care to sexual and gender minorities. For instance, LGBTI persons who experience sexual assault or rape often experience secondary victimisation as they access health and psycho-social support services within the public health care system. Those who approach health facilities report a ‘one-size-

³ Report of the Special Rapporteur on violence against women, its causes and consequences, communications to and from governments, A/HRC/4/34/Add.1, March 19, 2007. Cited in Mieses (2009).

fits-all' approach to counselling, treatment and protection that is based on an assumption of heterosexuality by SRH service providers (Polders & Welsh, 2004). Researchers have therefore pointed to the need for medical training curricula to challenge heteronormative assumptions and attend to sexual and gender diversity, as well as for health prevention and promotion messages to be inclusive of sexual and gender minorities. Inadequate training means that health workers lack relevant information, understanding, and knowledge to provide suitable care to people from sexual and gender minority groups. In addition, they are not required to reflect on their own beliefs and attitudes toward sexual and gender minorities, or how to manage these (Muller, 2014). This is important, because discriminatory social attitudes and practices have been identified as a significant obstacle to obtaining SRH services for this group of people (Rispel et al., 2011; Smith, 2015).

Direct discrimination – treatment in communities and health facilities

Direct discrimination occurs in the healthcare system in the form of negative attitudes and intolerance of sexual or gender non-conformity. Several South African studies in the public health sector report on this (e.g., Lane, Mogale, Struthers, McIntyre, & Kegeles, 2008; Lane et al., 2014; Muller, 2013, 2014; Muller & McGregor, 2013; Reddy, Sandfort, & Rispel, 2009; Rispel et al., 2011; Smith, 2015). Health workers have been reported to engage in discriminatory practices such as lack of care towards LGBTI persons (Muller, 2014). For example, in a study in Johannesburg, patients who identified as lesbian reported being ridiculed and subjected to religious judgment. They were refused pyjamas, prohibited from sleeping in wards with other female patients, and their HIV status was disclosed without their consent (GNP+ & NAPWA, 2012).

In the study conducted in year one of the AFSA programme, LGBTI participants also recounted negative experiences in the public health system, especially in relation to SRH services. Health workers were reported to discriminate against LGBTI persons in various ways, including rude and unprofessional behaviour. They often embarrassed or humiliated participants by being insensitive and tactless, and disregarding patients' privacy, because of their sexual identity. In addition to this poor treatment, participants described medical personnel as gatekeepers to services, preventing access for LGBTI persons. Some refused to provide treatment, prayed for patients, provided expired medication, or refused to admit patients overnight. The individual attitudes that undermine service delivery were seen as linked to underlying institutional cultures that support these, as well as wider community attitudes; hence there are intersections between structural issues and local-level discrimination (Morison et al., 2015).

Such experiences of stigma, discrimination, and negative health worker attitudes affect health service utilisation by people from this marginalised group (Rispel et al., 2011). For instance, the participants in the study by Rispel and colleagues (2011) "were reluctant to use public sector healthcare services and to disclose their sexual orientation to health workers because of past negative experiences" (p. S147). Muller (2013) also argues that discriminatory behaviour by healthcare workers exacerbates feelings of social isolation and exclusion that many LGBTI persons already experience.

LGBTI persons' experiences of heterosexism are also mediated by racial and class-based positions (Graziano, 2004). Poorer and Black LGBTI people generally encounter more extreme

forms of discrimination, such as violence, rape and murder, while White and wealthier LGBTI people usually encounter less direct prejudice or are able to avoid spaces where they are likely to experience discrimination. This is relevant to the current study in terms of accessing SRH care through public or private providers. The private sphere may offer LGBTI persons greater privacy, control, and accountability for wrong doings, yet the reality is that the majority of South Africans, as well as migrants, cannot access these services.

Many LGBTI people therefore turn to NGOs to gain access to SRH services, including OUT LGBT well-being; Durban Lesbian and Gay Community and Health Centre; Gay and Lesbian Network (GLN); Triangle Project; Health4Men; and Sex Workers Education and Advocacy Taskforce (SWEAT). Such NGOs have attempted to address the gap in the public sector by providing support, guidance, advocacy and lobbying services, and establishing support groups for those living with HIV (GNP+ & NAPWA, 2012). In earlier research conducted as part of the AFSA programme of activities, participants highlighted these organisations as models for the public sector (Morison et al., 2015). Given the distrust and fear that many sexual and gender non-conforming people have of public health facilities, such NGOs were identified as a potential resource that could be used in addressing LGBTI persons' unmet SRHR needs. A need for further research on LGBTI-specific SRH services was identified in terms of effective practices and lessons from these organisations, as well as the ways that these can be connected with public health services. These could involve: outreach programmes that take cognisance of the needs of LGBTI persons (e.g., around contraception); mobile clinics, such as those used by Anova Institute and SWEAT, are an example of such an intervention; working with appropriately trained Community Health Workers to reach LGBTI persons who are unwilling or unable to attend facilities; as well as possible partnerships between state facilities and 'gay friendly' clinics (Morison et al., 2015).

The current research picks up on two recommendations of the earlier study, viz., the need for further research on (a) the perceptions and experiences of healthcare workers towards LGBTI persons, and (b) NGO-provided LGBTI-specific SRH services, specifically documenting effective practices and lessons, and the ways that these can be connected with public health services. In the sections that follow we discuss South African policy and legislative context in more detail, in relation to SRHR of sexual and gender minorities.

2.3. Critical overview of SRHR and LGBTI rights in policy and legislation

As part of post-apartheid efforts to redress inequality, a number of laws, policies and guidelines have been developed to support delivery of comprehensive quality SRH services. This legal framework largely responds to five key areas:

1. fertility management;
2. cancers of the reproductive system;
3. sexual- and gender-based violence;
4. patient autonomy and consent; and
5. the Batho Pele Principles and Patient Rights Charter (Muller & Mout, 2014).

However, despite some recognition of sexual and gender diversity in these documents, and notably the constitution as mentioned earlier, the extent to which the health needs of LGBTI persons are met remains uncertain. The section below reviews key SRHR policy documents to

assess the extent to which sexual and gender diversity are responded to and fully integrated within the policy context, and ultimately service provision.

Key policy shifts in support of LGBTI SRHR

Opportunities enabled by the National Strategic Plan (NSP) 2012-2016

The *National Strategic Plan (NSP) on HIV, STIs and TB, 2012-2016*, as a key document guiding prevention and treatment of HIV/AIDS and other STIs, includes gay and bisexual men and other men who have sex with men (MSM) as a key population in the response to HIV/AIDS (SANAC, 2011). Key populations include groups “who lack access to services, and for whom the risk of HIV infection and TB infection is also driven by inadequate protection of human rights, and by prejudice” (SANAC, 2011, p. 25). The inclusion of MSM as a key population translates into policy directives to ensure provision of appropriate targeted HIV prevention and treatment services, and capturing of data to systematically monitor and evaluate HIV prevalence and delivery of services (SANAC, 2011). Transgender persons and sex workers are similarly included in the NSP; in the case of sex workers this provides targeted services to a group otherwise criminalised in the South African legal system (Scorgie et al., 2013).

South African National Sex Worker HIV Plan 2016-2019

People who engage in sex work are marginalised in ways that overlap with the discrimination and stigma that LGBTI persons experience, often centred on moralising narratives that sanction certain types of sexual activity and prohibit others (Scorgie et al., 2013). Further to this, many sex workers identify as LGBTI, and for this reason are a relevant group in efforts to advance the SRHR of LGBTI persons. The *South African National Sex Worker HIV Plan* was launched at the beginning of 2016 and targets, amongst others, key areas of HIV infection and gender-based violence (SANAC, 2016).

The Alteration of Sex Description and Sex Status Act 49 (2003)

The *Alteration of Sex Description and Sex Status Act 49* provides for “the alteration of the sex description of certain individuals in certain circumstances”, with such changes officially recognised on birth certificates and identity documents (RSA, 2004, p. 2). The passing of this Act paved the way for improved healthcare for transgender persons; however, limited resources mean that patient needs, particularly in rural areas, remain largely unmet. The availability of gender-affirming hormonal treatment and surgery is critical and withholding transition-related care has detrimental consequences for the mental health of transgender persons (Nkoana & Nduna, 2012). It is, however, important to note that not all transgender persons wish to access gender-affirming treatments and Act 49 provides for alteration of one’s gender without surgical transition (Stevens, 2012).

National Adolescent SRHR Framework 2014-2019

South Africa, with its youthful population, has several policy documents and government machinery aimed at responding to challenges faced by the youth. LGBTI youth, however, remain absent in policy. The *National Adolescent SRHR Framework 2014-2019* provides the first explicit recognition of the need to include LGBTI youth in government responses to SRHR. Adolescent and youth SRHR overall is typically overlooked. The development of the Framework was prompted by recognition of vulnerability of adolescents and youth, and the document notes that LGBTI youth, along with other underserved groups, including HIV-positive youth, young

persons engaged in sex work, and those living with a disability, should be included in rolling out the Framework. Currently, however, the inclusion of these groups remains tokenistic. Nowhere in the five key priorities identified in the Framework, nor in the adolescent SRHR monitoring and evaluation indicators listed, is there any content related to sexual and gender diversity (see DSD, 2015, p. 30-32; p. 35-36). While clearly limited, the inclusion of LGBTI youth as a vulnerable group in the Framework does offer opportunities for advocacy to align implementation with this broad policy goal.

Draft Policy Framework on Combating Hate Crimes, Hate Speech and Unfair Discrimination

There is widespread acknowledgement of the vulnerability of LGBTI persons to sexual- and gender-based violence (SGBV), both in relation to sexual violence motivated by homophobic prejudice, such as in cases of targeted rape and related sexual offences against lesbian and bisexual women, as well as in cases where the person's gender expression or sexual orientation is not considered relevant to the motive for the crime (Human Rights Watch, 2011). Further to this, LGBTI persons who experience SGBV are frequently subjected to secondary victimisation and institutionalised discrimination when engaging with health systems (Sandfort, Frazer, Matebeni, Reddy, Southey-Swartz, & Southern African Lesbian and Bisexual Women Research Team, 2015). Current SGBV legislation, such as the Sexual Offences and Related Matters Amendment Act 32 (DoJ&CD, 2007), does not include substantive content towards mitigating secondary victimisation related to sexual orientation and/or gender identity. However, the *Draft Policy Framework on Hate Crimes* explicitly includes hate crimes against LGBTI persons within the scope of the policy aims (DoJ&CD, 2013). Further to this, pending hate crimes legislation provides an opportunity for improved policy responses to LGBTI-related sexual violence, should clear directives toward training of healthcare workers in relevant skills and competencies be included (Lee, Lynch, & Clayton, 2013).

Policy limitations and gaps

The policies and legislation discussed above are meant to be translated into an implementation model that links different SRH services. Indeed, the South African government framework—*Sexual and Reproductive Health and Rights: Fulfilling our Commitments – 2011- 2021 and beyond* – includes as a guiding principle for the full realisation of SRHR the integration of services, so that “all services are available to all clients at the time that they access them” (DoH, 2011, p. 13). The reality, however, is that different SRH services are separated. For instance, “health services related to HIV are provided in a largely vertical fashion”, with the consequence that family planning, HIV/STI testing and treatment, and PMTCT services are not sufficiently integrated (Ramkissoon, Searle, Burns, & Beksinska, 2010, p. 38). Muller and MacGregor (2013) note that there is “little integration between services addressing GBV and broader SRHR programmes” (p. 10). This has negative implications for all health care users, but can particularly affect LGBTI persons who risk being viewed through a narrow focus on HIV/STI testing and treatment, especially in the case of MSM and sex workers. Such an approach does not consider other SRH needs that LGBTI persons might have.

When more closely considering the extent to which the policy context responds to sexual and gender diversity, in general, with the exception of gay and bisexual men and other MSM in the NSP, there is only token inclusion of LGBTI persons, with particular marginalisation of lesbian and bisexual women and transgender persons. We expand on this below.

Exclusion of lesbian and bisexual women and other WSW

Health interventions focused on women's SRHR predominantly cohere around fertility management and neonatal/maternal health. These services are framed around assumptions of heterosexuality and are typically delivered through contact made at the point of pregnancy or childbearing, when women are provided with access to HIV/STI testing and screening or treatment of reproductive cancers (Muller & MacGregor, 2013). The implication of this is that women who do not engage in reproductive heterosex and/or do not present for fertility-related or maternal health services are not linked to HIV/STI testing and screening services.

A widespread belief that lesbian and bisexual women and other WSW carry little or no risk of HIV infection has resulted in a lack of HIV indicators and targeted services for this group, despite their vulnerability in relation to violence against women generally and targeted sexual violence against gender nonconforming women in particular, contributing to their increased HIV risk (Lynch & Clayton, 2014; Matebeni, Vasu, Sandfort, & Southey-Swartz, 2013). The *NSP 2007-2011* included LB women as a vulnerable group in relation to HIV, but limited advocacy by civil society as well as within the SANAC Women's Sector and LGBTI Sector resulted in the complete omission of this group from the *NSP 2012-2016*, despite growing evidence of this group's vulnerability (Cloete, Sanger, & Simbayi, 2011; Daly, 2015; Sandfort, Baumann, Matebeni, Reddy, & Southey-Swartz, 2013).

Lack of recognition of comprehensive SRHR of transgender persons

Transgender persons – while enjoying improved recognition of HIV risk due to inclusion in the NSP key populations – have diverse SRHR needs not attended to in current policy. Comprehensive transgender-related healthcare is currently only available at one public facility (Groote Schuur Hospital in Cape Town), with severe restrictions in resources resulting in waiting periods of up to 20 years for surgical care (Wilson, Marais, De Villiers, Addinall, Campbell, & The Transgender Unit, 2014). Rural- and financially insecure transgender persons are particularly disadvantaged in accessing care (Wilson et al., 2014). The current policy framework does not attend to trans-specific health needs since it operates on assumptions of normative male/female bodies.

2.4. Implications of the gaps and restrictions in current SRHR policy

Some of the consequences of the limitations in current SRHR policy for LGBTI persons are listed below:

- The focus on key populations of MSM and sex workers has clear benefits to these groups, but also some unintended consequences. It masks the exclusion of other vulnerable groups in that an MSM focus in policy is taken as comprehensive inclusion of sexual and gender diversity. For instance, when healthcare workers are trained in sexual and gender diversity it is done in accordance with policy directives and the emphasis is placed on MSM-related health, with the particular health needs of LB women and transdiverse persons not being addressed.
- The NSP inclusion of MSM, sex workers and transgender persons – albeit mainly referring to male-to-female transgender persons with little recognition of female-to-male transgender persons or masculine presenting queer women – does not translate into recognition in SRHR policies beyond prevention and treatment of HIV/AIDS and STIs. Aspects such as

reproductive decision-making, fertility management and other SRHR-related concerns of groups included as key populations remain unaddressed in South African SRHR policies.

- At the level of national and global reporting of the AIDS response, LGBTI persons are largely invisible since policy directives require only MSM data to be disaggregated in HIV statistics.
- Token inclusion of LGBTI persons in most SRHR policy documents, with no substantive engagement with this group in frameworks, guidelines and regulations, means that there is no guarantee that these groups will be included in programming. For instance, LGBTI adolescents remain vulnerable with no substantive policy recognition beyond their mention in the *National Adolescent SRHR Framework 2014-2019*.

Section 3: Research methodology

3.1. A rapid ethnographic assessment of LGBTI SRHR in the Gert Sibande district

The research entailed a Rapid Ethnographic Assessment (REA) of healthcare facilities in Gert Sibande district, Mpumalanga, foregrounding the narratives of LGBTI participants in constructing a situational analysis of SRHR at this site. REA is a form of ethnography with a shorter period of immersion in the field. REA includes a range of different data collection methods, contributing to an integrated assessment of policies, systems, services and experiences of service users, related to SRH-service provision for LGBTI persons. Data collection is guided by 'insider' insights (Trotter, Needle, Goosby, Bates, & Singer, 2001). This method allows researchers to obtain locally relevant data quickly and systematically inform programme development, policy design, and advocacy (IPPF et al., 2009; Needle et al., 2003; Wilson, 2009).

The rapid ethnography was focused on four different areas of data collection, allowing for triangulation of data obtained from the different sources and contexts:

1. We conducted in-depth individual interviews with LGBTI persons in Mpumalanga, to gain an understanding of the experiences and perceptions attached to accessing public or private health care facilities, with a focus on SRH services.
2. We obtained in-depth accounts of the challenges and opportunities that healthcare workers in Mpumalanga identified in relation to the impact of systemic failures, particularly as it relates to SRH access and service provision for marginalised groups. Individual interviews were conducted with selected healthcare workers and managers from three different facilities that fall within the Gert Sibande NHI pilot district.
3. Ethnographic observation schedules were completed at these three selected sites to contribute to the situational analysis of the Gert Sibande district.
4. Finally, we interviewed NGO service providers and other key informants across the country, involved in SRHR advocacy and/or direct service provision, aimed at identifying effective practices and key advocacy priorities for ensuring SRHR of LGBTI persons and other marginalised groups. This provides valuable formative data for advocacy strategies of implementing partners and can feed into regional learning.

3.2. Sampling and recruitment

Healthcare workers and facility managers from three sites in the Gert Sibande district were invited to participate in the research. These sites comprised an urban clinic, an urban hospital and a rural clinic. LGBTI persons who are healthcare service users in Mpumalanga were also invited to participate in individual interviews. Participants were identified through existing LGBTI networks (civil society organisations active in the province) as well as implementation partners (TAC and Section 27). Key informants were selected based on their active involvement in the following fields:

- a) LGBTI-focused NGOs providing direct psycho-social and sexual health services and those that can provide input regarding particularly marginalised groups
- b) Organisations involved in service provision to survivors of sexual violence and other key informants dealing with SRHR advocacy in Mpumalanga and further afield.

3.3. Semi-structured individual interviews

Pilot interviews were conducted around Nelspruit prior to the commencement of the actual study; this was done in order to refine the individual interview guides (attached as appendix B). Thereafter, in-depth, semi-structured interviews were conducted with the selected participants. These were conducted in English, Sepedi, SiSwati, Afrikaans, or Xitsonga, depending on the participants' preference, and transcribed and translated into English for analysis. The approximate numbers and sites for the interviews are summarised in Table 2 below.

KEY SITES		#
Public healthcare facilities (Gert Sibande district)	Urban clinic interviews (facility manager, clinic-based healthcare worker, community-based healthcare worker) and site observation	3
	Urban hospital interviews (facility manager, clinic-based healthcare worker, community-based healthcare worker) and site observation	3
	Rural clinic (facility manager, clinic-based healthcare worker, community-based healthcare worker)	3
	4. Thuthuzela Care Centre interview (focused on responding to sexual violence - facility manager) and site observation	1
NGO / CBO organisations and facilities (Gert Sibande district)	Local HIV-focused NGO interview	1
	Local youth-focused NGO 1 interview	1
	Local youth-focused NGO 2 interview	1
	Local GBV and HIV focused NGO interview	1
	Local MSM-focused NGO interview	1
	Local LGBTI-focused CBO interview	1
	Local women's rights focused NGO interview	1
	Local MSM-focused service provider interview	1
LGBTI healthcare users (Gert Sibande district)	Interviews with LGBTI persons self-identifying as lesbian, gay and bisexual	10
Key informants in LGBTI / SRHR sector across country	Nationally active LGBTI organisation interview	1
	SANAC LGBTI sector representative interview	1
	Nationally active MSM-focused organisation interview	1
	Nationally active sex work-focused organisation interview	1
	SRHR research specialist interview	1
Totals		33

Table 2: Summary of sampling and qualitative data collection

3.4. Direct observation of healthcare facilities

The final component of the rapid ethnographic assessment relied on direct observation, aimed at obtaining focused, contextual understandings of the settings in which SRH services are provided. The observation was of the physical environment of the three selected public healthcare facilities in Gert Sibande district, in relation to accessibility and quality of care. The information was captured in field notes and observation schedules completed by researchers (the schedule, adapted from Horstman, Cleland, Douthwaite, Ambegaokar, & Salway, 2002; Collumbien, Busza, Cleland, & Campbell, 2012; Swartz et al., 2014, is attached as appendix C). Photographs of aspects of the physical sites – i.e. educational material in facilities, infrastructure, and the immediate areas surrounding facilities – were also taken in order to contextualise the data for analysis purposes (thus, not for publications so as to maintain confidentiality). Broadly, the areas attended to as part of direct observation included:

- a) General conditions of facilities;
- b) Structural constraints or resources influencing capacity of facilities to deliver SRH services
- c) Inclusive 'climate' in facilities, e.g. availability of information and education materials, that are inclusive of sexual and gender diversity;
- d) Description of other barriers or resources in accessing care, e.g. transport routes and means used by patients to travel to and from facilities.

3.5. Data analysis

The transcribed interview material, field notes and observation schedules were analysed using thematic analysis. The process of coding and analysis was guided by Braun and Clarke's (2012) approach to thematic analysis, which comprises six phases, namely: (i) familiarisation with the data set through repeated readings; (ii) initial code generation; (iii) construction of preliminary themes; (iv) refinement of themes through comparison with coded extracts and the entire dataset; (v) naming and defining themes; and (vi) generating the narrative report of the findings. We approached the analysis from a deductive, critical, and constructionist standpoint (Braun & Clarke, 2012). After coding and classifying the data according to themes, we interpreted the resulting thematic structures using theoretical and analytical concepts drawn from our conceptual framework of critical sexual and reproductive citizenship.

3.6. Ethical considerations

The research process was conducted according to standard ethical guidelines for research with human subjects. These include special attention to communicating the aims of the study, the rights of people participating in the research, obtaining informed consent and ensuring confidentiality. All instruments, consent forms and ethical considerations were reviewed by the HSRC *Research Ethics Committee*. The research instruments were shared with the funder (AFSA) for feedback.

Section 4: Research findings

The findings of the study indicate that structural and individual factors shape health service utilisation and health-seeking behaviours, confirming prior research (Rispel et al., 2011). This study adds to the growing body of evidence that documents the ways that heterosexism shapes the health system. At the interpersonal level, stigma and heterosexist attitudes are common, acting as a deterrent to seeking or continuing to use public SHR services. Stigma and heterosexism also create less direct barriers at a broader systemic level because health systems are not welcoming of or responsive to the particular needs that sexual and gender minorities might have. This section addresses the issues of interpersonal prejudice – which most often manifest in health workers' interactions with patients – as well as systemic barriers, particularly with regard to sexual violence and the SRH of minority women.

4.1. “They believe it’s a disgrace, a curse”: Drivers of discrimination and denial of SRHR

Widespread stigma and heterosexism as barriers to access

The World Health Organisation (2013) asserts that access to healthcare should be viewed broadly as including not only availability, physical accessibility and economic accessibility (affordability), but also non-discrimination and information accessibility. The current study indicates that these latter dimensions prevent LGBTI persons from utilising services and hence from getting the healthcare that they are entitled to, and often desperately need.

Participants reported negative and judgmental healthcare worker attitudes towards LGBTI patients and discrimination in healthcare settings. Healthcare workers form part of communities that remain largely patriarchal and heterosexist (i.e., prejudiced against people who are not heterosexual), reflecting these broader societal beliefs in the care that they provide inside clinic spaces. In the excerpt below, participants describe the perceptions about same-sex sexuality that remain prominent in rural areas, particularly where religious and traditional leaders hold sway:

R⁴: [Traditional leaders] don’t accept it [same-sex sexuality] at all because they believe it is a disgrace, a curse.

(Zuko, gay healthcare user)

R: The churches as a stakeholder are very influential to start with, they are very crucial stakeholders in our community. Because if a church believes in something, if for example one pastor has taught a congregation of 500 people to believe in something, then that’s 500 people from the community. The challenge here is that most churches don’t accept this type of group [LGBTI persons].

(Local NGO)

It was reported that healthcare workers at times embarrassed and/or were insensitive in their treatment and interactions with LGBTI persons:

R: People complain a lot about the services they get from the clinic that is in town; others say when they go to the hospital or clinic in the location the workers there will embarrass them by discussing their sexuality with each other or in front of other patients.

(David, bisexual male healthcare user)

⁴ R = respondent; I = interviewer

One healthcare worker openly expressed feelings of prejudice against LGBTI persons seeking services:

I: What is the institutional support, or any form of support, for providing quality services to lesbians, gay men, bisexual persons, transgender persons and so on? Are there any training programmes or any formal or informal support [for staff in this facility]?

R: For lesbians and gays?

I: Yes, does your institution support them so that they can get quality services?

R: There are no systems in place to support those people, because of our religious values, I am less interested in helping those people.

I: So there are no systems in place to help them regarding their health, due to religious values?

R: Yes, religious values, and apart from religion, most of us disapprove although the government does grant them [rights], but personally I don't want to assist those people.

(Healthcare worker, clinic)

Staff members talk negatively about sexual and gender minority groups. They seem to be very negative and not accommodating towards LGBTI persons.

(Observation schedule for healthcare facility – hospital)

As these comments illustrate, public healthcare facilities are at times unfriendly, unsupportive, restrictive and discriminatory. Rispel and colleagues (2011) also identified heteronormative health services; unsympathetic/insufficiently trained healthcare providers; stigma and discrimination as major structural barriers to service utilisation and health-seeking behaviour among MSM. Similarly, Muller (2014) discussed the attitudes of healthcare workers in relation to persons with non-normative sexual identities and noted that discrimination and harsh, judgmental attitudes were common among healthcare workers.

The quote above from the healthcare worker is unusual in its frankness but is indicative of broader widespread heterosexism within the country, which allows officials and service providers to ignore the constitutional rights of LGBTI persons, as well as a lack of accountability for this heterosexist behaviour. The comment also suggests the dissonance between official rhetoric (e.g. in policy documents such as the NSP) and actual practices.

Respondents reported that some healthcare workers allowed their judgmental attitudes to interfere with service provision, as indicated in the extract below, where Lindiwe, a lesbian woman, shares the response she received from nursing staff after she was raped:

I: How was the treatment from nurses and doctors?

R: It was okay. I was treated by a male doctor. He performed all [the] tests and they came back negative. The nurses that were counselling me are the ones that were rude, saying nasty things such as 'This happened to you because you are acting like a man while you are a woman'. So I stopped going for counselling.

(Lindiwe, lesbian healthcare user)

Such judgmental and uncaring behaviour amounts to secondary victimisation. The targeted homophobic rape of black lesbian women has increasingly received media and research attention (Human Rights Watch, 2011; Mkhize, Bennett, Reddy, & Moletsane, 2010). Yet,

increased awareness of hate crimes and violence against sexual minority women does not necessarily translate into sensitive SRH care, treatment and support from healthcare workers.

In order to avoid secondary victimisation, many lesbian women withdraw from the public health system and often from the criminal justice system as well. Some LGBTI patients also terminate HIV treatment as a result of experiences of prejudice within the public health system. As one key informant explains, LGBTI persons 'default' from treatment based on fear of stigma, discrimination and homophobic behaviour:

I: What role does stigma play in people's access to sexual and reproductive health services?

R: The result of stigma is defaulters, do you know what defaulters is?

I: No, but you can explain?

R: Defaulters is when a patient, whatever illness that he/she has got, needs to take treatment according to the instructions but unfortunately the patient does not take it.

I: Okay.

(Local NGO)

A similar finding was reported in the year-one study of the AFSA programme (Morison et al., 2015). The findings confirm research in South Africa (e.g. Graziano, 2004; Muller, 2013; Padmanabhanunni & Edwards, 2013; Rispel et al., 2011) and the Southern African region (e.g. McIntyre, 2010; Onyango-Ouma, Birungi, & Geibel, 2005; Onyango-Ouma, Birungi, & Geibel, 2009) that has shown that sexual minorities are often reluctant to use public healthcare services or to disclose their sexual orientation to health workers.

Unresponsive health systems

For services to be accessible, they must be both available and acceptable to patients in terms of their cultural, gender, life-cycle and other requirements (WHO, 2013). Our findings suggest that this is not the case for LGBTI persons in Gert Sibande. In addition to obvious discrimination by service providers, pervasive heteronormativity also functions as a deterrent for LGBTI persons seeking SRH care. Care is sometimes limited because healthcare workers do not have knowledge on policies/legislation on SRHR and their specific roles and responsibilities (Rispel et al., 2011). Even more concerning: sexual and gender minorities report reluctance, even fear, to use healthcare services, because the services are structured around prejudiced assumptions about gender and sexuality. This is illustrated by Mbulelo's account of his experience in trying to access VCT services as a bisexual patient:

R: I remember there was this other time I was dating this other guy and because we were staying far from each other and we didn't trust one other, we decided to go to the hospital together and test [for HIV]. When we got to the hospital they started asking us a lot of questions, for example 'are you sure you want to come in together?' 'Are you friends?' 'What are you?'

(Mbulelo, male bisexual healthcare user)

Previous research in urban facilities similarly reports on unresponsive health systems that assume universal heterosexuality (Rispel et al., 2011). Smith (2015), in her research with sexual minority women in Cape Town, noted that "participants were highly aware of environmental and behavioural cues that indicated the heteronormativity of healthcare space. For example, sexual health information being presented with heteronormative language, providers exclusively asking about opposite-sex partners, and a lack of lesbian, gay, bisexual

and transgender visibility on brochures and posters were thought of as presenting an image of healthcare facilities as unwelcoming” (p. 185).

As a result of these negative perceptions, often reinforced by experience, some LGBTI persons seek alternative healthcare facilities, such as clinics in other districts that are perceived as more welcoming or where they are not known by the community, often travelling further to access care. The majority of gay and bisexual men and other MSM in the study indicated that in the absence of adequate care, they accessed services at NGO facilities. In the absence of NGO services, people would have to pay for services. In Gert Sibande alternative facilities are not widely available, mostly limited to Ermelo. In addition, what services there are usually cater for men. Notably, sexual minority women in the study did not know of any such LGBTI-focused facilities that cater to lesbian women’s sexual health. The participant below describes how, prior to the availability of an alternative facility (*ANOVA Health4Men*), he would buy condoms and lubricants at a private facility:

R: Before ANOVA I was in the closet, so I used to buy lubrication and condoms.

I: You were not comfortable with going to the public facilities?

R: Yes, I wasn’t comfortable at all.

I: What is the problem, why are you not comfortable? Besides the fact that you were in the closet

R: I know a lot of people and people around here talk a lot

(Mbulelo, male bisexual healthcare user)

User perceptions of healthcare as inaccessible remain important, especially in light of the fact that even people who are severely financially insecure opt for private sector facilities. “This results in greater resources flowing to private facilities, thus worsening the public sector” (Harris et al., 2011, p. S119). It also places an unnecessary burden on already marginalised persons and runs counter to NHI objectives of making services accessible without placing an unaffordable burden on any particular individuals and improving health outcomes for the most vulnerable in South Africa (Harris et al., 2011). Ultimately, discriminatory structuring of services negatively impacts policy attempts, such as the NHI White Paper, to undo the uneven distribution of healthcare resources.

Support for survivors of violence as an unmet SRH need

A major gap in service provision was noted in this study with regard to responses to sexual violence. This may be part of a wider policy gap in which violence and reproductive health are often dealt with separately, despite the wealth of evidence indicating their strong inter-linkage (Watts & Mayhew, 2004; Klugman et al., 2011). Sexual violence and intimate partner violence can cause significant health disparities for LGBTI persons, yet remain unacknowledged in public facilities’ general SRHR response. The findings indicate that specialised knowledge is restricted to those who work with victims of sexual violence. The problem with this was highlighted by a health worker at the *Thuthuzela Care Centre*.

R: [Talking about training needs regarding LGBTI persons] Yes, but if training can happen then we have to accommodate the OPD (Out Patient Department) staff members and the casualty staff members where people normally report to (after hours when the centre itself is closed) because that’s where victims or patients go to first, before they call us.

I: So what you are saying is that it’s not just you at the centre that has to be more sensitive or attuned to LGBTI experiences?

R: No, because there should be police because others report at the police station and others report especially at the casualty where they are OPD and others come for follow ups at the OPD, so I think this training should be broad.

I: Just like you have said that if you are on 24 hour call it means they have to go to casualty first.

R: Yes, they should go to casualty first then casualty will call the one that is on standby. So you see that they also need to get more information?

I: Yes, specialised?

R: Yes.

(Healthcare worker, Thuthuzela Care Centre)

Thuthuzela Care Centres, which operate in public hospitals in communities with a high incidence of rape, have become known as models of good practice in dealing with sexual violence. However, as the health worker points out, knowledge regarding the SRH needs of sexual minorities needs to extend beyond these pockets of excellence and become incorporated system-wide. This is especially important in early identification and helping to limit the consequences and decrease the likelihood of further victimisation, given that reproductive health service providers play an important role in helping to identify and support victims of intimate partner violence who often avoid seeking help from the police (Watts & Mayhew, 2004).

What training is provided on intimate partner violence and sexual violence is often framed through a heterosexual lens that simplistically positions women as victims and men as perpetrators (Lee et al., 2013). This dominant heterosexual narrative often renders intimate partner violence and sexual violence invisible in same-sex relationships and makes it difficult for men to access care, treatment, and support. While this affects men of all sexual orientations, men who identify as other than heterosexual are especially vulnerable to discriminatory attitudes. The excerpts below illustrate the marginalisation of gay men as survivors of sexual assault.

R: I once heard of someone who went into a police station to report a matter on assault and then police started asking him "so why didn't you hit him back because you are also a man?"

(David, bisexual male healthcare user)

R: I think what it [the corrective rape narrative] has done is also completely alienate gay men, for example. So I remember speaking to a gay man who went to a clinic ... after he was raped and was told flat-out 'but men can't get raped and we can't help you here'. [I: No...] But it's the same problem, right? It's an incredibly narrow, heteronormative understanding of what sexual violence is and who can perpetrate it against whom.

(SRHR researcher)

These extracts illustrate how preconceived ideas about gender, specifically of 'what it means to be a man', act as a barrier to men's help-seeking in cases of rape and sexual assault. Silence and invisibility are encouraged by the interlinkage of the taboos of male rape and homosexuality, which threaten dominant notions of masculinity (Gear, 2007). Such responses "legitimise coerced and violent relationships ... while at the same time undermining and demonizing other patterns of (homo)sexual interaction that are consensual and non-violent. ... [H]urt men are erased, desire is disqualified and violence endorsed" (Gear, 2007, p. 224).

Silences around transgender and sexual minority women's health

In the data the term 'LGBTI' was often used to refer to gay men only; further to this, participants generally focused their discussions on health concerns of gay, bisexual men and other MSM with little reference to transgender persons or sexual minority women. This is part of a broader trend in which "SRHR for women who have sex with women, lesbian women, transgender women, or women who are sex workers, are rarely addressed" (Muller & Macgregor, 2013, p. 19). Participants reflected on the need to test for HIV and access other SRH services, and as mentioned earlier, spoke about the lack of sensitive, appropriate services for sexual minority women. This is illustrated by the following account in which a lesbian respondent reflects on her experience of visiting public health care facilities.

R: I wasn't that comfortable [at the clinic], because everybody was giving me a funny look. And the way we walked in, it was clear that this person and I, we are in a relationship. So they gave us a funny look. And the elders were making comments, like saying "what you guys are doing is not OK". They said a whole lot of things, so I didn't mind them because they are elders and responding wouldn't be OK, because they're elders... I am a bit scared [to go to the clinic], but as an individual you need to know your status, as there are a lot of things that I do with my girlfriend, we do other things whilst having fun at the clubs, so we need to know our status and where you stand.

(Noluthando, lesbian healthcare user)

This finding supports evidence from the research conducted in Kwa-Zulu Natal and Gauteng in the first year of the AFSA programme, in which lesbian women emphasised healthcare workers' discrimination based on their perceived ideas of sexual behaviour. This resulted in some lesbian women leaving the clinic and receiving medication from friends rather than going back to the clinic (Morison et al., 2015). Other research has reported similar prejudice in healthcare facilities. For example, GNP+ and NAPWA (2012) identify lesbian women as receiving particular discriminatory treatment "where patients who identified as lesbian were refused pyjamas and their HIV status was disclosed". Often sexual minority women face double discrimination, based on their sexual identity as well as their sero status (Muller & Macgregor, 2012). Sometimes when testing for and accessing treatment for HIV, they encounter suspicion by healthcare workers who believe that lesbian women cannot contract HIV (Morison et al., 2015).

Another group whose SRH needs were found to be neglected was transgender persons. This population may have a number of unique SRH needs, including gender-affirming hormone therapies or other transition-related services, as well as competent care for other trans-specific health needs – amongst others "cross gendered hormone treatment and possible interaction with ARVs and other medicine are not known; [p]rostate cancer in post-operative trans women and cervical cancer with trans men are often ignored because of pre-conceived notions of transgender bodies" (Aids Accountability, 2011, p. 12). In addition to these needs, transgender persons may be more likely to engage in transactional sex due to discrimination in the formal economy and are also more susceptible to HIV infection, violence, victimisation, and suicide (Greifinger, Batchelor, & Fair, 2013; Stevens, 2012). Yet, transgender persons' health needs often go unmet due to, on the one hand, a lack of knowledge and understanding, and on the other, prejudices against gender-nonconformity (Muller, 2013).

Service provider education around transgender issues is a key concern in improving SRH service access and retention of transgender patients (Greifinger et al., 2013). Healthcare

workers often do not understand the meaning of the terms ‘transgender’ or ‘intersex’ and are ignorant of associated healthcare needs. In addition to this, transgender patients are often actively discriminated against in healthcare settings. For example, North American research indicates transgender women are less likely to receive ARVs than all other people living with HIV (Greifinger et al., 2013). In South Africa, evidence suggests that “health services are discriminatory and health workers provide sub-standard care to transgender persons” (Stevens, 2012, pp. 22–23). While transgender persons are included as a key population in the NSP, transgender health issues are not fully integrated into the HIV/AIDS response and are lacking in relation to other healthcare needs (Nkoana & Nduna, 2012; Wilson et al., 2014). Very often within public health care systems, transgender individuals are ridiculed and scolded for not behaving according to the appearance of a conventional heteronormative gendered identity. These acts and gestures on the part of healthcare workers reinforce conservative and heterosexist notions of identities and limit access to health care and treatment for transgender and intersex persons. In short, treatment and medications that can be provided are just not made available, as described in the extract below:

R: And then there's trans-specific care which at primary care level will be to know how to administer hormones, know which hormones to administer, know where to refer for anything else, be able to give a rough mental health assessment and sort of identify if there are any big issues. And I mean primary care providers can provide hormones, they do it all the time; they give woman hormones for contraception. There's nothing different, you monitor it the same way. You give them tablets; they're available at the pharmacy, so people take it whether or not you've prescribed.

I: But at least there's an opportunity to screen and monitor?

R: Exactly. And I mean of course surgical gender affirming care needs to happen at tertiary level, but I think a lot of the rest can be managed at primary care level.

(SRHR researcher)

In addition to invisibility within health systems, transgender persons are also often marginalised within the LGBTI sector, with some sexual minority men in the study expressing transphobic views and othering of gender non-conforming persons:

R: Thing is I am still scared of... you know those bottoms, the cross dressers, because I feel they are too 'out there' and they just draw too much attention. Even when I date I don't date guys like that, I date a guy that looks like a guy.... They scare me, and even if I date, I would never date a bottom like that.

(Sibusiso, gay healthcare user)

Prejudice from other sexual minority persons means that it is difficult for transgender persons to mobilise around SRH concerns, as other sexual minorities might, and also to access safe spaces of support and solidarity.

4.2. “People wish to be free”: Desiring SRHR for sexual and gender minorities

Solidarity and support for LGBTI SRHR

The analysis shows that, while not frequent, there were instances in which public healthcare workers and other community stakeholders expressed support for the health rights of LGBTI persons. This challenges notions of rural areas as entirely heterosexist and points to shifts that are occurring towards greater support for sexual and gender minorities. The excerpts below

capture instances where healthcare workers and local NGOs advocated for the rights and belonging of LGBTI persons:

I: What do you think the role of NGOs can be in improving SRH service delivery to LGBTI persons and other marginalised groups?

R: My request is [that] the challenges of this target group [LGBTI persons] must be addressed because they are being discriminated against in the communities.

(Local NGO)

I: It would be to teach the community on how to handle them [LGBTI persons] and how not to discriminate against them because the community often discriminates against them.

(Healthcare worker, clinic)

I: Who do you think should be responsible to help with issues in the health system?

R: Our community is very difficult; they can attack them or even rape the lesbians because they want to check their sex. The community should be more respectful of other people's preferences

(Healthcare facility manager)

In Ermelo, the presence of an MSM-focused intervention and research project (Project Boithato) was highlighted as contributing to greater awareness of sexual diversity in relation to same-sex practising men:

R: Here in Ermelo there is Project Boithato and it has a lot of projects, it worked a lot with ANOVA helping the community with dialogues, and so people started to become more understanding.

(Zuko, gay healthcare user)

Individual healthcare workers who are sympathetic to the SRHR needs of sexual and gender minorities spoke about strategies they employ to encourage marginalised persons to access care, such as making it known that they are available to offer non-judgemental care. The excerpts below describe how small changes are occurring where healthcare workers are attempting to provide adequate care for LGBTI persons:

I: So do you think they feel comfortable to come here for help?

R: You mean gays and lesbians?

I: Yes LGBTI people.

R: People in general are comfortable but gays and prostitutes don't come. I have developed a strategy where I have allocated myself; if someone is gay or [a] prostitute they should know that I am the focal nurse for them, they don't have to stand in long queues or don't even have to be seen anywhere in the clinic, they just have to come straight to me and they know that I am their focal person

(Healthcare worker, clinic).

I: So how did they treat you at the clinic on that day?

R: It was better because I was helped by someone I know, I know the nurse that helped me. She's my friend's mom.

I: Did you know that she worked there?

R: Yes, I went to her, because I am used to her a lot.

I: So you went straight to her.

R: Ya, I got there and asked for her

I: So if you go to the clinic next time and you look for that nurse and you don't find her, what are you going to do?

R: I will try to ask for another nurse, but if she is also going to treat me badly with a similar attitude that they usually have, I will go back home and find a date when she will be available, then come back on that day, because she is okay.

(Noluthando, lesbian healthcare user)

Healthcare workers who are willing to act as a 'focal person' or champion for sexual and gender minorities may be a useful entry point for interventions in public health settings.

LGBTI persons' resistance to prejudice and entitlement to care

LGBTI persons in the study expressed instances of resistance to heterosexist treatment at public healthcare facilities. For LGBTI participants, particularly sexual minority women, their claims to adequate SRHR were often framed in ways that were hypothetical – through describing what they would consider to be ideal healthcare facilities, rather than reflecting on positive SRH care experiences they have had. These reflections are, however, important as they speak to a sense of entitlement to adequate care that can be harnessed for advocacy:

R: I really wish there was a place where lesbians only could get help.

I: When you think about that place, how would it look like?

R: I suppose it would be fine if the people who worked there were straight, but as long as they don't discriminate, or we could just have strictly gay and lesbian doctors and nurses.

I: So health workers should also be lesbians and gays?

R: Yes.

I: And you think that is going to help?

R: Yes, I think so.

(Lindiwe, lesbian healthcare user)

Lindiwe's wish for caregivers who also identify as gay and lesbian suggests a desire to minimise the sense of otherness that patients from sexual minority groups often experience in public facilities, as well as a wish for empathic health workers who can relate to patients' needs and concerns.

Lindiwe also described her resistance to the heterosexist treatment she received following a sexual assault – referred to earlier in the findings - where nursing staff blamed her for the assault and she subsequently lodged a complaint with the facility:

I: What did nurses say to you?

R: That we [lesbians] are acting like men while we are women.

I: And what did you say?

R: I explained that it's not that I am acting like a man when I'm woman, I also don't like to be treated the way I'm treated, but this is the way I am and I cannot change it. And I also told her that it doesn't mean people have the right to treat me like that and she ended up saying "no I am not saying that they are right but you also have to think for yourself". So I just ended up leaving.

(Lindiwe, lesbian healthcare user)

Lindiwe's account illustrates an attempt to explain one's identity and to assert one's rights (not to be "treated like that"). Expressions of entitlement to equal treatment and comprehensive

SRHR often took the form of a human rights narrative, with LGBTI participants articulating their claims in relation to appeals to “equal rights”:

R: Everyone has their rights. I believe it is about rights; there are people who wish to be free.

(David, bisexual male healthcare user)

R: LGBTI persons are human being just like straight people, and as much as straight people have rights, the same rights applies to the LGBTI as well, people mustn't be discriminated against on the basis of their sexual orientation and preferences. We live in a democratic country and we are all free to live the lives we are comfortable with.

(Vusi, gay healthcare user)

Previous research with sexual and gender minorities accessing SRH services points to an increased sense of entitlement to professional and non-judgemental care among those accessing private care. This is related to public services being free and people feeling less able to assert their right to adequate care, as well as having limited possibilities to seek out alternative service providers (Smith, 2015). LGBTI persons accessing public facilities “may have less cultural, economic and social capital due to their intersecting identities and experiences with marginalisation, thus placing them in more vulnerable positions in regards to negotiating health systems” (Smith, 2015, p. 189). These factors influence the ability to resist heterosexist treatment. Our findings indicate that there are instances in which sexual and gender minorities who are negatively positioned along lines of race, class, and rurality resist and challenge poor treatment. However, such resistance remains limited to individualised responses by LGBTI persons and does not occur in the context of a broader movement towards advancing sexual and reproductive justice. Other responses reported involved diminishing sexual difference or presenting oneself in ways that appear more ‘acceptable’ within heteronormative spaces; for example, downplaying or avoiding disclosure of one’s sexual identity. Faced with prejudice in public facilities, participants also turned to the internet for information and support. As Vusi, a gay healthcare user, explained “the Internet is very informative and less judgmental and you will access all the information you need freely”. This was particularly appealing to participants who did not feel comfortable forming part of LGBTI social spaces and did not want to access services at an LGBTI-focused facility.

4.3. “It’s about connecting our struggles”: Crafting an agenda for universal access to SRHR

Expanding the ‘key population’ narrative

The ‘key population’ public health narrative was a familiar framing of LGBTI HIV risk for organisations active in Gert Sibande district, particularly for HIV-focused organisations. This narrative holds traction among organisations who are able to identify MSM as an at-risk group in the HIV epidemic, requiring targeted interventions:

R: In terms of addressing HIV and AIDS we need to focus on key populations e.g. one key population [is] truck drivers because they work far away from their families and they are tempted to have multiple sexual partners. The reason they fall under key populations is because they are far from services, they are far from information. So lesbians and gays also we have identified as a key population I believe the [LGBTI] key population is not addressed and it needs to be addressed.

(Local HIV-focused NGO)

This narrative was found to limit awareness to HIV/AIDS risk, related to gay and bisexual men and other MSM, and did not necessarily translate into broader awareness of and responsiveness to sexual- and gender diversity. However, it does potentially provide an entry point for LGBTI-related work and further advocacy can build on the sensitisation brought about by this focus. In this manner, the 'key population' narrative can be expanded to include the full range of sexual and gender diversity that healthcare providers will engage with when providing care, including sexual minority women and transgender persons:

I: But what are the persuasive arguments for LGBTI SRH to be included [in government responses]?

R: So you could say that we know that gay men, and men who have sex with men, actually have a much higher HIV prevalence than the general population. Yet, if you don't provide specialised services or services that cater to them, you won't be providing any services. And you can make the public health argument that both epidemics are interlinked, we're not speaking about an isolated group ... [You can extend it] to cervical cancer screenings – that we already know they are not as available as they should be but we also know that lesbians usually don't access them for a couple of reasons. One, they don't know they should. Two, they're worried about what the health care provider will say. Three, they might have experienced homophobia at some point so they don't go. And then they present 10 years down the line with cervical cancer and they need to either get an operation or it's too late and they die. So I think you can make a really strong cost argument even, you can make a preventative care argument. It's about making sure that screening is done across the board. You can make an argument that at least in the NSP trans people are mentioned, and MSM are mentioned, so you can refer back to those guidelines.

(SRHR researcher)

A further recommendation towards expanding the key population narrative was to apply an intersectional lens to SRHR and connect the struggles of different marginalised groups:

R: The problem we find as well is that people see the key population as an isolated group, so there are people who inject drugs as one population, MSM is another population, sex workers are another population, but when in fact there are a lot of kind of inter-linking issues that all the populations face. There should be more of a kind of intersectional approach.... Social justice issues and equality, patriarchy, all these things which a very complex mixture of things.

(Sex work-focused NGO)

It is important to find practical and accessible ways of highlighting the how various social signifiers (like race, socio-economic status and so forth) interact and overlap. This allows the possibility of identifying common struggles across groups (e.g., HIV-related stigma or violence) rather than seeing groups as distinct and homogenous.

Strengthening civil society capacity to partner with public facilities

Public-private partnerships, specifically between public facilities and LGBTI-focused NGOs, were described as an appropriate way to support public facilities in addressing shortcomings related to LGBTI SRHR. The ways in which this is done would need to be carefully thought through due to the different interests of the private and public sectors. Another concern in this regard is the low capacity of NGOs to engage fully with sexual and gender diversity, and especially the lack of LGBTI-dedicated NGO capacity, as exemplified in the Gert Sibande district, and seen in rural provinces generally. An HIV-focused NGO shared this concern, stating "it is just a challenge because we don't have that [LGBTI-specific] organisation in our area, the [LGBTI]

organisation I was telling you about is about 110km away from us". While MSM-focused organisations are relatively more available compared to organisations that include sexual minority women and transgender health concerns, the available MSM structures were still described as not meeting the demand.

In addition to this, advocacy capacity of LGBTI organisations was described as low:

R: There is nowhere near sufficient advocacy capacity; few LGBTI organisations have a dedicated sort of advocacy person... Where our organisation made submissions last year, we made a lot of different policy submissions [and] we are quite often the only LGBTI organisation making those submissions. So when it comes to having the kind of policy capacity to sit down and draft a comprehensive LGBTI response to something like the National Health Insurance Plan, that is severely lacking

(LGBTI-focused NGO active at local and national level)

Participants described the kind of civil society advocacy efforts that can impact health systems in a meaningful manner as requiring long-term, sustained activity that is aimed at transforming government systems, to avoid state facilities simply 'outsourcing' functions such as LGBTI SRHR without adequately reshaping what are essentially heteronormative health services:

R: I think in an ideal world, with a sustainable idea, you don't want to continue to provide separate services. Ideally you want integrated and inclusive services that are non-judgemental, non-discriminatory, non-homophobic enough for everybody to go to. With the understanding that in order to get there, for a while you might want different services, but we also know how separate services don't speak to each other and you don't want somebody having to go to the LGBTI sexual health clinic and then come back on another day to go to this clinic. So the idea of really integrating services is really important. To almost mainstream LGBTI sexual health, because we also don't want to let the Department of Health get away with parcelling out LGBTI health. They are supposed to provide these services and they have to make a plan. And I think it's very easy to say 'oh that's great because we will always have ANOVA to provide MSM services'.

(SRHR researcher)

Healthcare workers shared in this concern that although training related to marginalised groups such as gay and bisexual men and other MSM has been offered at some facilities (by civil society partners), this information has not been fully integrated into health systems and facilities remain reliant on NGO partners. For example, in the excerpt below a healthcare worker explains that an MSM-focused NGO provides their facility with lubricated condoms for MSM, but if the NGO does not actively distribute the condoms through events that engage MSM, the condoms are not accessed at the facility:

R: But because they [MSM] don't come here, so the condoms just sit. So we don't give them [out] a lot because they are still used to going to the NGO because they have their days, sessions and programmes there and they share information.

(Healthcare worker, clinic)

Organisations such as TAC were identified as appropriate partners to advance LGBTI SRHR – based on the depth of their human rights work – but the need to familiarise such organisations that do not engage with LGBTI issues as their core mandate was often reiterated:

R: So I think ideally if TAC would take LGBTI SRHR on this would be perfect, right? Because it goes out of the special niche towards a much broader based movement or advocacy approach. I think the danger with that is that you have to make sure that people get it right and know what they are talking about, and don't exoticise or reproduce stereotypes in the process of trying to do really good. But I think that is a matter of training people within the existing organizations really well.

I: On gender and sexuality?

R: On gender and sexuality and pretty much everything that health care providers would need to be trained on, right? On what gender is, and what sexuality is, how it develops and what the issues are, what the health disparities are and what can be done about it. So you would almost need competency training for people within the more mainstream organizations.

(SRHR researcher)

Inserting comprehensive SRHR into NHI

Key informants emphasised that NHI holds promise for increased affordability, availability, and acceptability of healthcare services, but expressed concerns about the lack of engagement with SRHR in NHI policy, notably the absence of any reference in the policy document to sexual health. This has negative consequences for gender equality broadly and sexual and gender minorities specifically, in that the document (1) structures care along heteronormative lines in that the implied focus is on the management of heterosexual fertility, and (2) marginalises vulnerable groups who access health services not for pregnancy/fertility-related reasons but for reasons more directly related to their sexual wellbeing:

R: I mean, there's reproductive health but there's no sexual health [in the NHI White Paper]. So my worry is that by calling it reproductive health you're excluding anybody who doesn't want to reproduce. And what does that mean for queer people who need other sexual health services? I mean for everybody, but specifically for queer people who can't even use the excuse of reproductive health services to access sexual health services.

(SRHR researcher)

This translates into an absence of adequate SRHR indicators in the monitoring and evaluation framework of implementation of NHI in the Gert Sibande district. Participants emphasised the importance of local monitoring of comprehensive SRHR indicators, particularly as these are not currently captured in the NHI monitoring and evaluation mechanisms in order to hold health systems accountable. (For the NHI pilot phase 1, these mechanisms are limited to reporting on infrastructure and human resource capacity improvements, with no mention of indicators assessing SRHR access and quality for marginalised groups.)

Well-functioning local AIDS councils (LAC) and district AIDS councils (DAC) were singled out as important spaces in which to build synergistic and supportive relationships between civil society partners and the Department of Health, for optimising service provision as well as for monitoring progress in relation to SRHR indicators:

R: I think the best platform to even create that kind of a relationship [of best practice in public-private partnerships] is through the local AIDS council. It's very important. And your district AIDS council, because that is where you tend to meet the organisations that are operating in the district, including your DoH which is the main stakeholder. And it is the correct platform to talk such things [through] and to even create that rapport as to what you are dealing with. And we tend to see where are you lacking as a district, and try to cover that. Because what I don't do, department of health does, or what ANOVA doesn't do, the department should do. So if we work in collaboration

then we can have all services in one place. For example, I give my services to the MSM only to find that MSM is not circumcised, then there is DoH that can take care of that, you know. If MSM is positive, then DoH can initiate that patient into treatment. It becomes easy when there is that link between the organisations.

(Local MSM-focused NGO service provider)

The findings further demonstrate the value of using locally generated evidence to inform national-level advocacy to influence, for example, healthcare curricula and discipline-specific accountability structures (such as the Health Professions Council of South Africa or nursing-specific regulatory authorities). This was suggested to take place through partnerships between local and national civil society actors. In the excerpt below a participant links local evidence of inadequate LGBTI SRHR knowledge among healthcare workers, to national advocacy to influence training curricula:

R: You train in-service nurses for a very long time, but you don't impact on what is being included in the curriculum, what is being offered as continuous professional development courses for them, what the requirements are for them to perform well. I mean, if suddenly the Nursing Council says one of your core competencies has to be that you know how to deal with LGBTI people, that's going to change a lot! Because then suddenly nurses are forced to learn it, how to deal with it. Or if there's a very clear case of a nurse being expelled from the Nursing Council because she was really homophobic – that sets an important precedent. But that you only get if you start tackling it at the top.

(SRHR researcher)

Section 5: Discussion and recommendations

5.1. Discussion

Our findings resonate with previous research conducted in other, mainly urban, geographic regions (Morison et al., 2015; Rispel et al., 2011; Smith, 2015). This confirms that discrimination against sexual and gender minorities is not limited to particular facilities or geographic contexts but is widespread in the healthcare system. Furthermore, the research builds on prior studies by including not only MSM but also sexual minority women, as well as a focus on the experiences of rural LGBTI persons. Only one previous study has explored health care access of sexual minority women and was limited to urban areas (Smith, 2015). The geographic focus of the study is a strategic advantage for AFSA implementation partners working towards the fulfilment of SRHR of LGBTI persons and other marginalised persons in rural areas and contributes to a rich evidence base for advocacy. In this final discussion we relate the findings to three key areas relevant to SRHR in the context of implementation of NHI, that of (i) access barriers to SRHR, (ii) capacity to advance LGBTI SRHR in the NHI pilot, and (iii) supplementing a rights-based approach to SRHR with the concept of reproductive justice.

Availability and acceptability of SRH services as access barriers

Access barriers relate not only to *affordability* of services, but also *availability* and *acceptability*—the latter encompassing “reasons for provider choice, user satisfaction and health system perceptions, including reasons for delayed care”, amongst other factors (Harris et al. 2011, S104). The findings point to severe shortcomings in availability of SRHR services for sexual and gender minorities in public facilities – particularly a lack of LGBTI-specific SRHR information; trans-specific services such as gender affirming healthcare; appropriate barrier methods such as dental dams and lubricated condoms; and sensitive services for LGBTI survivors of sexual violence.

Acceptability of SRH services for LGBTI persons was also found to be very low. Sexual and gender minorities in this research report access barriers of discriminatory attitudes and treatment, contributing to delayed care-seeking and emphasising the importance of “understanding how frontline staff shape acceptability of health care” (Harris et al., 2011, p. S118). In addition to actual experiences of discrimination, our findings highlight the importance of *anticipated* heterosexism as a factor shaping healthcare access. In research by Harris et al. (2011, p. S115) “anticipated disrespectful treatment” was identified as one of several key factors contributing to delayed care-seeking, considerably so for persons accessing care from public facilities. Smith (2015) similarly found that sexual minority women, regardless of whether they have experienced heterosexist treatment at healthcare facilities or not, anticipated such treatment. “Acceptability of health care is socially ingrained, and shaped by the media, and experiences of family and friends” (Harris et al., 2011, p. S118). This might be particularly true for persons occupying stigmatised identities and anticipate discriminatory responses, and “policy makers therefore need to challenge negative perceptions and stereotypes, while simultaneously addressing legitimate concerns about the quality of care on offer” (Harris et al., 2011, p. S118).

For NHI to respond to access barriers for marginalised groups, the availability and acceptability of services should be improved. In quantitative research conducted as part of the AFSA-funded programme of activities, it was found that SRHR services in the district are “accepting of (and

acceptable to) a very narrow range of people: married, heterosexual women, of childbearing age” (Morison & Lynch, 2016a, p. 34). Phase 1 of the NHI pilot is primarily focused on strengthening resources in health systems; the qualitative findings in this report support previous findings that availability of LGBTI-friendly services, such as appropriate barrier methods and knowledgeable healthcare workers, is currently not included in the NHI pilot.

Low civil society and state capacity to advance LGBTI SRHR

The NHI initiative operates on the assumption that where skills and expertise are not available in state health facilities, these can be procured by the state from private facilities. The findings confirm that much of the LGBTI SRHR expertise in the country is located in the NGO sector, not in public or in private for-profit facilities. Problematic, however, is that NGO capacity is weak with continual funding challenges and limited presence in rural areas in particular. In Gert Sibande district, for instance, LGBTI-focused civil society is largely limited to MSM-related service provision. Public-private partnerships, specifically between public facilities and LGBTI-focused NGOs, can be beneficial but are not currently a reality, especially so in rural provinces. Where NGO partners support state facilities in LGBTI SRH service provision, these efforts often remain separate to mainstream services resulting in untransformed state facilities. This is a common risk in public-private partnerships in support of universal access to healthcare, in that states may increasingly abdicate responsibility for specialised services resulting in the benefits of public-private partnerships becoming “restricted to islands of excellence in seas of underprovision” (Buse & Waxman, 2001, p. 750). Further to this, the findings indicate that current efforts in SRH service provision in the Gert Sibande pilot district do not include indicators focused on SRHR, resulting in a lack of monitoring and evaluation of LGBTI SRHR in the piloting of NHI.

If LGBTI SRHR is to be fully taken up in NHI, it will be necessary to expand the focus in current policy on reproductive health to include sexual health. Further to this, when sexual health is indeed included in implementation, it is important to expand the narrow focus on HIV/AIDS in key populations – often limited to MSM and less frequently, transgender persons – to offer comprehensive SRHR to the full spectrum of sexually and gender diverse persons.

Infusing the language of justice into SRHR

Finally, the data also indicate that there is support for sexual minorities within public healthcare facilities, although usually limited to particular spaces or individual caregivers who are willing to act as allies to sexual and gender minorities. Likewise, resistance to prejudice in the health system was limited to individual challenges and usually framed within the language of rights. Such approaches are promoted by the dominant framing of SRH solely within a rights-based public health perspective, a framing echoed in the NHI White Paper (DoH, 2015). The findings suggest that there is space to introduce a discourse of justice in order to balance the individualising tendency of the rights-based approach. The rights-based approach tends to emphasise the notions of individual choice, autonomous decision-making, protecting the freedoms of particular groups, and rights along a single axis of difference (Morison & Lynch, 2016b). Yet, as the data in this study show, possessing SRH rights does not necessarily translate into the ability to exercise these, as several inter-related factors at both the individual and social level work together as barriers to SRHR (Morison, 2013).

The concept of reproductive justice expands the rights-based frame to include these interwoven social barriers. “This concept illuminates the real-life connections between SRH and interrelated socioeconomic and political issues, like poverty, access to care and insurance, gender-based/intimate partner violence, and stigma” (Morison, 2013, p. 2). Advocacy towards the full realisation of SRHR can supplement rights-based approaches with the concept of reproductive justice, to highlight the inter-connection of reproductive and social justice concerns.

We take these and other recommendations up in the section that follows.

5.2. Recommendations

Shifting community attitudes

1. LGBTI persons not only face discrimination and heterosexism in specific institutional spaces (such as healthcare facilities) but live in communities where homophobic and transphobic beliefs remain common. Community engagement, including with religious and traditional leaders, remains important in shifting attitudes.
2. Parallel to pervasive heteronormativity and heterosexism, it is possible to identify positive localised shifts in attitudes and behaviour of healthcare workers. Further in-depth research can assist in identifying and promoting the contributing factors towards such shifts.
3. Interventions can identify sympathetic healthcare workers who can champion more professional service provision for marginalised groups. Knowledge of these allies is passed on through social networks and word-of-mouth, and interventions can formalise channels for sharing this information, for example, by having persons or spaces identify as ‘LGBTI friendly’ or as allies.
4. A dual approach of providing specialised LGBTI-friendly services through NGO facilities, while concurrently strengthening public facilities to provide integrated care, remains necessary to ensure that pervasive heterosexism and heteronormativity do not pose access barriers to LGBTI persons.

Training and capacity building

1. Healthcare workers share negative beliefs about same-sex sexuality and perpetuate harmful attitudes towards sexual and gender minorities. Training with healthcare workers should include dismantling heteronormative assumptions and strengthening professional competency.
2. Training should also include the full range of sexual and gender diversity, to ensure that comprehensive SRHR of particularly marginalised groups such as sexual minority women and transgender and intersex persons are recognised.
3. Sexual violence and intimate partner violence experienced by sexual and gender minorities are currently not addressed in SRH service provision and need to be included as part of comprehensive SRHR for LGBTI persons.
4. Disaggregation of data by state institutions such as the police and justice system can assist with determining the extent of intimate partner violence and sexual violence perpetrated against LGBTI persons.

5. The care, treatment and support of sexual and gender minorities should be integrated into service provision at Thuthuzela Care Centres in particular, as the primary state response to sexual violence.
6. Continued education of LGBTI persons about their right to comprehensive SRHR remains important in order to foster a sense of entitlement to adequate treatment and care.
7. Civil society organisations that do not engage with LGBTI SRHR as their core mandate should be empowered through sexual and gender diversity training, in the form of knowledge exchanges that benefit organisations across sectors, so as to capacitate them to advance LGBTI SRHR.
8. Civil society should be supported in developing and applying appropriate indicators to monitor implementation of comprehensive LGBTI SRHR in the NHI pilot sites, in partnership with the Department of Health (DoH), in order for these indicators to be integrated into DoH quality control mechanisms.

Advocacy and movement building

1. There is a need to build solidarity among LGBTI persons to cross divides between sexual minority men and women, and challenge marginalisation of gender non-conforming and transgender persons within LGBTI spaces.
2. Complaints about rights violations lodged by LGBTI persons at healthcare facilities are not met with professional and prompt action. These individual acts of resistance to heterosexism should be connected with movements and organisations that can provide institutional authority and support (such as NGOs), in order to create greater impact and effect structural change. Complaints can be followed up through a coordinated civil society advocacy campaign in order to hold facilities to account.
3. The 'key population' narrative holds traction with civil society organisations and provides an entry point for advocating for LGBTI SRHR, but is limited to a focus on gay and bisexual men and other MSM; it needs to be expanded to include sexual minority women and transgender persons.
4. Applying an intersectional lens to SRHR can connect the struggles of different marginalised groups and foster solidarity and shared commitments to advocacy. Specific axes of identity to consider when applying an intersectional lens include race, class, rurality, gender identity and expression, sexuality, occupation (e.g. sex work), health status, and dis/ability, among others.
5. LGBTI-specific civil society organisations and networks in provinces and districts outside of urban centres – that tend to be relatively better resourced – should be strengthened. In particular, in the absence of relatively better funded NGOs, LGBTI-focused community-based organisations (CBOs) in rural provinces play an important role in providing support to LGBTI persons and advocating in their communities; these organisations require funding support towards carrying out this work. Partnerships of mutual learning between established NGOs in urban centres and emerging CBOs in rural areas – aimed at sharing information and resources – can assist with this.
6. Related to the previous point, partnerships between local and national actors, to connect locally generated evidence with national-level advocacy, should be identified and nurtured.
7. Advocacy in relation to NHI should emphasise the need to expand the current focus on reproductive health to also include sexual health. This is in line with the South African

NSP as well as regional SRHR commitments, such as the Maputo Plan of Action on SRHR, to which the South African government is a signatory.

8. Advocacy towards the full realisation of SRHR can supplement rights-based approaches with the concept of reproductive justice, to highlight the inter-connection of reproductive and social justice concerns.

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Appendix A: Glossary, acronyms and abbreviations⁵

CBO: Community-based organisation

DoH: Department of Health

DoJ&CD: Department of Justice and Constitutional Development

DSD: Department of Social Development

Heteronormativity: The system of regulatory norms and practices that emerges within heterosexual communities and that serves a normative function.

Heterosexism: A system of beliefs that privileges heterosexuality and discriminates against other sexual orientations. It assumes that heterosexuality is the only normal or natural option for human relationships, and posits that all other sexual relationships are either subordinate to or perversions of heterosexual relationships. In everyday life, this manifests as the assumption that everyone is heterosexual until proven otherwise.

Intimate partner violence (IPV): A pattern of abusive and threatening behaviours acted by one partner in an intimate relationship on another. This may include physical, emotional, economic and sexual abuse as well as intimidation, isolation and coercion, and can occur in the partnerships of heterosexual or LGBTI persons.

Key populations: Key populations are vulnerable groups in the HIV epidemic “who lack access to services, and for whom the risk of HIV infection and TB infection is also driven by inadequate protection of human rights, and by prejudice” (SANAC, 2011, p. 25). These groups include men who have sex with men (MSM), transgender people, sex workers, injecting drug users, prison populations and specific migrant groups.

LGBTI: Lesbian, gay, bisexual, transgender, intersex

MSM and WSW: ‘Men who have sex with men’ (MSM), and ‘Women who have sex with women’ (WSW) are socially constructed research categories coined in recognition of the fact that sexual behaviour does not necessarily translate into sexual identity; i.e. someone who has sex with a person of their same gender may or may not identify as heterosexual, bisexual or gay or lesbian – or may not identify with any sexual orientation at all. In public health research, these research categories are increasingly used to study sexual and reproductive health and rights among diverse persons who engage in same-gender sexual activity regardless of self-identification. ‘WSW’ and ‘MSM’ therefore refer to a behavioural dimension of analysis, while ‘lesbian’, ‘gay’, ‘bisexual’ or ‘heterosexual’ refer to self-aware social identities (Young & Meyer, 2005).

NGO: Non-government organisation

NHI: National Health Insurance

⁵ Based on Lynch and Clayton (2014); Meer (2014) and Victor, Nel, Lynch and Mbatha (2014).

NSP: National Strategic Plan (on HIV, STIs and TB, 2012-2016)

SANAC: South African National Aids Council

SRHR: Sexual and reproductive health and rights

Transgender and transdiverse: Terms for people who have a gender identity, and often a gender expression, that is different to the sex they were assigned at birth by default of their primary sexual characteristics. These broad terms encompass people who are androgynous, and those who defy what society tells them is appropriate for their gender. Gender identity and sexual orientation are two separate concepts; transgender people can be heterosexual, bisexual, lesbian, gay, or may not identify with any sexual orientation at all.

WHO: World Health Organisation

Appendix B: Semi-structured individual guides

Interview guide for NGO healthcare workers / facility managers

A. Background

1. Can you start by telling me a bit about your organisation and the role that you play?
 - a. How long have you worked in this sector?
2. Can you tell me about your organisations aims and values? Who do you serve?
3. Can you tell me what services you offer here or programmes that you run?
 - a. Can you tell me about any Sexual and Reproductive Health (SRH) services you offer (if a direct services organisation, such as Thuthuzela) / or any advocacy work or other programmes you run (if not a direct services organisation)
 - b. Do you think there are any other services or programmes that should/should not be offered? Why?

B. Access to and quality of services

1. How long have you worked at this facility and what has your experience working here been like?
2. How does your facility compare to public health facilities?
 - o Probe: accessibility and quality of care?
3. Can you tell me about any challenges with regard to service delivery, especially sexual and reproductive health services, within the health system
 - o Probe: access and quality
 - o What role does stigma or other social issues play in people's access to SRH services?
4. How accessible would you say this facility is?
 - o Are there any people who struggle to access these services and why?
 - o Probe around: cost, travelling distance, operating hours, waiting times

C. Availability of specialised services

1. Can you tell me a bit more about your Sexual and Reproductive Health services?
 - o Are there any particular kinds of services that you don't feel comfortable offering? Why?
2. Who accesses these services and what services mostly do they come for?
 - o Are there any people who should come for help or information with sexual and reproductive issues who don't?
 - o Are there any people who do come for help or information with sexual and reproductive issues who should not?
3. How comfortable do you think your clients feel to come here for help or information with sexual and reproductive health?
4. [*If not already answered*] Tell me about any LGBTI-specific SRH services that you have (nature and range of services).
 - o Do you have services for LGBTI survivors of sexual violence? Tell me more about those?
5. Are there any challenges in providing specialised services?
 - o Any gaps or areas requiring attention?
6. Is there anything that you would improve or change about Sexual and Reproductive Health (SRH) services in public sector 'mainstream' facilities?

7. Do you think that your organisation has any lessons or expertise that it could offer public health facilities?
8. Do you think there are ways for NGOs to connect with public health services (e.g. best practice of relationship with a public health facility)?
 - In what ways?
 - Do you think this is a real possibility?
 - Would you/government be open to this?

D. SRHR advocacy by marginalised groups

1. At an organisational level, what are the advocacy priorities for advancing LGBTI and other marginalised persons' SRHR?
2. And best-practice strategies?
 - a. What have you found is successful in getting government on board with (MSM health / transhealth, etc.)? Why is this approach successful?
 - b. Probe for human rights arguments, legal arguments (e.g. the inclusion of key populations in the NSP), "science" arguments
3. What are the challenges in ensuring effective advocacy, including issues such as NGO capacity (also exploring the role of structures such as SANAC, Network on Violence Against Women, etc.)?
4. What are the limits or barriers to advocacy strategies?
5. What are the main points of influence in ensuring quality service provision to marginalised groups? (e.g. policy & legislation, training of facility managers, nursing staff, community healthcare workers)
6. What are some of the potential organisations / networks through which joint advocacy/politics of solidarity can take place?

Interview guide for other SRHR stakeholders

A. Background

1. Can you start by telling me a bit about your organisation and the role that you play?
 - a. How long have you worked in this sector?
2. Can you tell me about your organisation's aims and values? Who do you serve?
3. Can you tell me what services you offer here or programmes that you run?
 - a. Can you tell me about any Sexual and Reproductive Health (SRH) services you offer (if a direct services organisation, such as Thuthuzela) / or any advocacy work or other programmes you run (if not a direct services organisation)
 - b. Do you think there are any other services or programmes that should/should not be offered? Why?

B. Access to and quality of services

1. How long have you worked at this organisation and what has your experience working here been like?
2. How does your organisation compare to public health facilities?
 - Probe: accessibility and quality of services? (e.g. information services)

3. When you think of public health facilities, can you tell me about any challenges with regard to service delivery, especially sexual and reproductive health services, within the health system
 - Probe: access and quality
 - What role does stigma or other social issues play in people's access to SRH services?
4. How accessible would you say this facility is?
 - Are there any people who struggle to access your organisation's work and why?
 - Probe around: cost, travelling distance, operating hours, waiting times

C. Availability of specialised services

1. Can you tell me a bit more about your Sexual and Reproductive Health programmes / advocacy?
 - Are there any particular kinds of services that you don't feel comfortable offering? Why?
2. Who accesses these services and what services mostly do they come for?
 - Are there any people who should come for help or information with sexual and reproductive issues who don't?
 - Are there any people who do come for help or information with sexual and reproductive issues who should not?
3. How comfortable do you think your clients feel to come here for help or information with sexual and reproductive health?
4. [*If not already answered*] Tell me about any LGBTI-specific programmes and/or advocacy work that you do.
5. Are there any challenges in ensuring that your programmes and/or advocacy work include LGBTI persons?
 - Any gaps or areas requiring attention?
6. Is there anything that you would improve or change about Sexual and Reproductive Health (SRH) services in public sector 'mainstream' facilities?
7. Do you think that your organisation has any lessons or expertise that it could offer public health facilities?
8. Do you think there are ways for NGOs to connect with public health services (e.g. best practice of relationship with a public health facility)?
 - In what ways?
 - Do you think this is a real possibility?
 - Would you/government be open to this?

D. SRHR advocacy by marginalised groups

1. At an organisational level, what are the advocacy priorities for advancing LGBTI and other marginalised persons' SRHR?
2. And best-practice strategies?
 - a. What have you found is successful in getting government on board with vulnerable groups (women's health; MSM health; transhealth, etc.)? Why is this approach successful?
 - b. Probe for human rights arguments, legal arguments (e.g. the inclusion of key populations in the NSP), "science" arguments

3. What are the challenges in ensuring effective advocacy, including issues such as NGO capacity (also exploring the role of structures such as SANAC, Network on Violence Against Women, etc.)?
4. What are the limits or barriers to advocacy strategies?
5. What are the main points of influence in ensuring quality service provision to marginalised groups? (e.g. policy & legislation, training of facility managers, nursing staff, community healthcare workers)
6. What are some of the potential organisations / networks through which joint advocacy/politics of solidarity can take place?

LGBTI participant individual interview guide

1. Can you start by telling me a bit about yourself?
2. Is there a place in your community where people can go for help or information with sexual and reproductive health [i.e. relationships, sex, contraception, sexually transmitted infections, HIV/AIDS, etc.]?
 - *Can you tell me what it is like?*
 - *Are these services LGBTI-friendly? Do you feel comfortable accessing them as an LGBTI person? Why / why not?*
3. In your opinion, are these services that people need?
 - Why/why not?
 - Probe for perceptions regarding entitlement to SRHR broadly and healthcare services specifically
4. Where do you go for help or information with sexual and reproductive health?
 - Why did you choose that place?
 - What is that place like?
5. What have your experiences been, in general, as an LGBTI person going for help or information with sexual and reproductive health [i.e. relationships, sex, contraception, sexually transmitted infections, HIV/AIDS, etc.]?
 - *Probe for staff attitudes, treatment, and privacy ability to disclose sexual orientation, comfort*
 - *Can you tell me about your last visit to a public healthcare facility? What was the experience like? (Was it positive / negative, and why?)*
 - i. *Probe for subtle and overt indications of positive / negative treatment (e.g. rude comments by a security guard or someone in the waiting room, or just a sense of feeling out of place, or not)*
 - ii. *Probe for issues around access (whether services are available at all, easy/difficult to access) and quality (the appropriateness of and satisfaction with services)*
6. Is there ever or has there ever been a time that you have not gone to help or information with sexual and reproductive health when you needed it?
 - *Can you tell me a bit about that?*
7. Are there any things that stop you from going to a health facility for help or information with sexual and reproductive health?
8. Can you tell me about any LGBTI-specific SRH services that you know of?
 - *How easy or difficult is it for you to access these services?*
 - *What is the quality of care like?*

- *Are there any things that you would change or improve about these services?*
- 9. Can you tell me about any services for survivors of sexual violence that you know of?
 - *Would you say that these services are sensitive to LGBTI persons, or not? Why would you say so?*
 - *Are these services easy to access, or not? Can you tell me why you would say so?*
- 10. Can you tell me your thoughts on services that are offered in the government facilities compared to those run by NGOs or private?
 - *Where do you feel most comfortable and why?*
- 11. Can you tell me what the ideal space would look like, for you, to get help or information with sexual and reproductive health?
- 12. Have you ever been involved in community mobilisation / advocacy (protests, marches, workshops, etc.) around healthcare rights?
 - *Can you tell me more about that? Why/not? Would you be?*
 - *If yes, what kind of issues were being raised by the organisation / protest / meeting?*
 - *Do you feel that it is important for LGBTI persons to speak out about issues that concern them? Why? Is it easy / difficult to do so?*

Appendix C: Direct observation schedule

Date:	_____	
Observer / Fieldworker:	_____	
Name of facility:	_____	
Observation number:	_____	(If more than one observation a day)
Tracking number:	_____	

GENERAL INSTRUCTIONS

- Please complete the table above before you start your observation session.
- Introduce yourself (your name and the organisation you are from) to the SRH provider.
- Say what you are doing there, how you will spend time at the facility.
- Ensure that you speak to and observe a range of service providers and clients.
- Take photographs of observations if appropriate (posters, art, access problems, etc.), or other aspects / images you feel are relevant towards the observation.
 - o Include a short clear description of the photograph, and explanation for including it
 - o If there are persons in the scene, ask them if they mind if you take a photograph
- After the observation session:
 - o Clarify ambiguous observations after the observation session is over, and amend misunderstood observations.
 - o Write up your field notes carefully and thoroughly but not always in the presence of participants.

FACILITY OBSERVATION

General conditions of facility

1. Basic descriptive information:

- What kind of health services (including the range of SRH services) can be accessed at this facility?
 - o Enquire about LGBTI-specific services and availability of barrier methods other than condoms (e.g. female condoms, dental dams) and lubricant
- How many service users are at the facility at any given time during your observation?
 - o Note if this changes according to the time of day, or due to other factors
 - o Note the number of service users generally attended to in a day, and during which hours
- What is the age, racial, class, language and gender makeup of clients present at the facility during your observation?
 - o Note if this observation is based on your impression, or if based on information received, please note the source (e.g. the facility manager, security personnel)

2. Geographic location:

- Where is the facility located?
- What other services are in the area where the facility is located? (e.g. police station, magistrate's court, other healthcare services)

- What other SHR services (if any) are there in the area?
- What is the main industry or sources of employment in the area?

3. Structural constraints or resources influencing capacity of the facility to deliver SRH services:

- How many healthcare providers and other staff members are at the facility?
 - o Description of the different healthcare providers and staff roles
 - o What is the healthcare provider: service user ratio?
 - o Is there enough space for the service to be rendered?
 - o Is the administration conducted efficiently? Is the facility organised or not? What evidence is there?
 - o Is there security staff and if yes, what role to they play? (e.g. do they offer security services only, or do they interact with service users, provide information on where to access different services, or even function as gatekeepers?)
- How would you describe the facility itself?
 - o Is there running water and electricity in the facility?
 - o Are there restrooms for service users and what is their condition? How are the restrooms marked (e.g. by gender, or gender neutral?)
 - o What is the size of the facility?
 - o Is there sufficient space and seating in the waiting area?
 - o Where in the facility are SRH services rendered (e.g. in a specific section of the facility and if so, what is it like and how is the space designated to service users?)

4. The 'climate' of the facility

- Information, education and communication (IEC) materials, other visual displays
 - o Does the imagery on display, or used in IEC material, display sexual and gender diversity or are they restricted to depicting heterosexual people?
 - o Is there any IEC material specific to sexual and gender minority groups, or visual indications of being LGBTI-friendly, at this facility?
 - o Is there religious imagery or content on display, or used in information and education material?
- Interpersonal interactions
 - o (How) do staff members talk about sexual and gender minority groups? (positive, negative, neutral, mixed)
 - o (How) do staff members talk about SRH? (with implied heteronormativity, or with specific reference to sexual and gender minorities as well)
 - o What are relationships between client and providers like?
 - o What is the atmosphere in the facility like? Supportive, one of respect?
 - o Is there always at least one staff member present inside the clinic waiting area?
 - o Do the staff members seem supportive of each other?

5. Description of other barriers or resources in accessing care

- Socio-economic influences: Are clients generally hungry when they make use of the facility? Do they have sufficient income (and from which sources) to ensure basic needs are met? Other indicators of poverty – descriptions of service users' homes?
- How do service users travel to the facility?
 - o Distance and means?

- Can sexual and gender minority groups comfortably use the same means of transport (or do they experience / fear verbal or physical harassment when travelling to and from the facility?)

6. Broader community

- Are people working, employed? If they are unemployed what are they doing?
- What do young people in the community do to relax or have fun? What do adults and older people do?
- Is there a sense of community, neighbourliness?
- To what extent do community members experience or fear crime?
- What are some of the other concerns or challenges this community faces?
- How do people in the community talk about sexual and gender minority groups? (positive, negative, neutral, mixed)
- Are there any people who openly identify as part of a sexual and gender minority group?
- Are there reports of violence in the community against sexual and gender minority groups?

7. Other observations:

- Any other comments?
- Relevant photographs including descriptions / explanations