Quality through inclusion?

Community-led healthcare delivery, training and advocacy related to sexual and reproductive health of lesbian, gay, bisexual and transgender people in South Africa

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List of abbreviations

ARV	Antiretroviral
DoH	Department of Health
LGBT	Lesbian, gay, bisexual and transgender
LGBTI	Lesbian, gay, bisexual, transgender and intersex
MSM	Men who have sex with men
NDoH	National Department of Health
NGO	Non-governmental organisation
PEP	Post-exposure prophylaxis
PrEP	Pre-exposure prophylaxis
SA	South Africa
SOGI	Sexual orientation and gender identity
SOGIE	Sexual orientation, gender identity and expression
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually Transmitted Infection
VCT	Voluntary Counselling and Testing
WSW	Women who have sex with women

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Introduction

Community participation in health, that is, involving individuals and groups in the work of creating accessible healthcare, is starting to be recognised as an important step toward equity in healthcare provision and healthcare policy making. Lesbian, gay, bisexual and transgender (LGBT) people, however, may be excluded from community participatory processes due to on-going hetero- and cisnormativity. Heteronormativity invisibilises and invalidates health concerns that are related to non-heteronormative sexual orientations and gender identities and expressions (SOGIE). At the same time, heteronormativity can result in prejudicial attitudes, or even violence, towards LGBT people and thus create a context in which LGBT people are more vulnerable to ill health. Recognising that not all people may have the same ability to contribute to community participation processes in health, this report seeks to examine how LGBT health concerns are included in healthcare provision, health advocacy and health policy-making through community-led initiatives.

The report takes LGBT non-governmental organisations (NGOs) as a proxy for wider LGBT communities and sees their work as representative of the ways in which community participation shapes healthcare provision for LGBT people. LGBT NGOs are uniquely placed, as they are part of the everyday experience of being LGBT in their respective areas, their staff are almost entirely people who identify as LGBT themselves, and they may share many of the lived experiences of their constituents. At the same time, NGOs, by nature of their expertise and networks, are also able to mobilise local people around health issues and convey information about health policy. Understanding how LGBT organisations shape healthcare provision, health advocacy and health policy-making gives us insight into the efficacy of community participation in healthcare in South Africa. Of course, community participation is as diverse as the idea of community itself, and we should not assume that all participation takes place through NGOs. Further, those that are grouped under the acronym LGBT are diverse in their identities, cultural and religious affiliations and socio-economic status, and we cannot assume that NGOs represent all the interests and needs of LGBT people, or even that they may be aligned with each other.

This research report evaluates the work of LGBT community organisation-driven approaches to participating in sexual and reproductive healthcare (SRH) provision, advocacy and policy in South Africa on three levels: (1) on the level of the constituents of the community organisation, the healthcare users who identify as LGBT; (2) on the level of the community organisations themselves, and (3) on the level of healthcare providers and health policy makers. Evaluating the knowledge of and attitudes towards community participation at the same time as the barriers to access to healthcare (which community participation and advocacy aims to reduce) allows us to triangulate our findings to examine the complexity of community participation in practice. At the same time, we analyse if, and how, the work of community organisations advocating for improved healthcare for LGBT populations is perceived by healthcare providers and government health officials, the stakeholders in the healthcare system who make and are governed by health policies.

The focus of this report is on two organisations: Triangle Project and OUT Well-Being. Although these two organisations are unique, in some ways they are also quite typical. The report speaks to the wider South African LGBT NGO context in general, and many of the services provided, strategies, gaps, challenges, policy and advocacy issues described in relation to OUT Well-Being and Triangle Project are in fact representative of the sector as a whole. We thus see OUT Well-Being and Triangle Project as two hubs of LGBT community participation in action. The aim of this report is not to compare the two organisations to each other. Rather, the point is to look at the effect of community participation, through the different perspectives of Triangle Project and OUT Well-being, in shaping access to SRH services for LGBT people in South Africa.

Although the focus of this report is on community participation, it necessarily raises other structural issues that have a bearing on the provision of healthcare for LGBT people in South Africa; chief among them the pervasive inequality in South African society in general, the structural challenges and inadequacies of the South African healthcare system, as well as the way that LGBT health is perceived at an international scale, and the way that funding is prioritised in relation to this. Within this context, LGBT community participation has the potential to enable access to existing SRH services, shape the rationalisation of resources, and advocate for the extension and provision of additional services.

It is often unclear what is meant by SRH services, particularly in relation to LGBT people. There is a pervasive conflation of SRH services with HIV-related care, largely because in the last few decades, HIV has been the most urgent sexual health concern. However, this has the potential to obscure other sexual health concerns, as well as the myriad of reproductive health concerns, including cancers of reproductive organs, pregnancy-related concerns, or gender-based violence. Further, global discourses around SRH have increasingly focused on agency and bodily autonomy, consent, the pursuit of pleasure, partnership and family life, child-having and rearing (Cornwall & Jolly, 2006).

These concerns are largely not seen as concerns of people in the global south, where sexuality is still largely construed as a problem and SRH care is either related to the prevention of pregnancy or limiting the transmission of HIV.

For our purposes, SRH then is the full and comprehensive list of services related to sexual and reproductive health. It includes (1) the prevention, diagnoses and treatment of sexually transmitted infections, including HIV; (2) family planning services, including fertility options; (3) pregnancy-related services; (4) prevention and early diagnosis of cancers of the reproductive system such as cervical cancer, breast cancer and prostate cancer; (5) prevention of gender-based violence and care for survivors; (6) comprehensive sexuality education (United Nations Population Fund, 2008). Although these definitions have largely been formulated, or are referred to, with cisgender heterosexual people in mind, all of the above areas of SRH provision are relevant to LGBT people. This list, however, excludes the additional SRH needs of gender diverse people. Thus, we explicitly add a final aspect of SRH that we include in this report: (7) healthcare services related to gender affirmation, such as psychosocial support that is affirming of sexual and gender diversity, as well as hormonal and surgical gender affirming treatment.

In addition, we also include mental health issues in this report. This is because the link between mental health and sexual and reproductive health is increasingly recognised, yet not adequately addressed (World Health Organization & Key Centre for Women's Health in Society, 2009). For example, people with depression may struggle with adherence to chronic treatment, including for HIV (Gonzalez, Batchelder, Psaros, & Safren, 2011), and other aspects of mental ill health, such as substance use, can impair sexual agency and decision-making. Further, SRH concerns such as gender-based violence can lead to mental health concerns. Given that LGBT people are more likely to experience mental health concerns due to their social context that devalues their SOGIE (Meyer, 2003), we think it is necessary to point to these wider connections in our report.

The structure of this report

Before we can detail the findings of our research it is necessary to unpack the existing state of knowledge on LGBT health, and on community participation, as well as to describe the South African context for LGBT-related health provision and community participation. Thus, the rest of this introduction consists of a literature review that does just this. Thereafter, we present the research findings in three parts.

Part 1 aims to 'set the scene' for the following parts, 2 and 3, and explain the context in which LGBT NGOs do their work. Part 1 draws on the findings of a survey questionnaire that 408 LGBT people answered about their health and wellbeing, their experiences in healthcare and their levels of confidence in interacting with public services. These survey findings are also contextualised by qualitative data from our interviews with NGO staff, healthcare providers and health policy makers.

Part 2 describes the various roles that the two LGBT NGOs play in facilitating access to SRH services for LGBT people. Drawing on the survey findings about health-seeking behaviour, as well as on interviews with NGO staff, healthcare providers and health policy makers, we show how LGBT NGOs provide direct health services, healthcare provider training, and are involved in health advocacy. Based on our interviews with healthcare providers and health policy makers, we show how this unique expertise places the two NGOs at the centre of healthcare for LGBT people as a resource that both healthcare providers and health policy makers depend on. Part 3 picks up key issues that emerge throughout the two previous parts and analyses them in more detail. Highlighting 'successes' and 'challenges' in the work of the two NGOs, it simultaneously analyses cross-cutting issues and discusses them against the wider context of healthcare provision and SOGIE-related rights in South Africa.

We then then make some concluding remarks, followed by a list of recommendations for various stakeholders involved in improving access to SRH and other health services for LGBT people in South Africa.

Literature Review and Context

Health disparities among LGBT populations

Over the past two decades research on lesbian, gay, bisexual and transgender (LGBT) health has highlighted substantial health disparities based on sexual orientation and gender identity. This research has largely focused on sexually transmitted infections, in particular HIV/AIDS. However, there is increasing attention on the wider negative health consequences of stigma, marginalisation, discrimination and violence among LGBT people (Bränström & Van Der Star, 2013; Graham et al., 2011; World Health Organization, 2013b).

A recent United Nations report observes that

> *"[i]n many cases, even the perception of homosexuality or transgender identity puts people at risk. Violations include – but are not limited to – killings, rape and physical attacks, torture, arbitrary detention, the denial of rights to assembly, expression and information, and discrimination in employment, health and education" (UN High Commissioner for Human Rights, 2015).*

One of the main challenges to improving the health and well-being of sexual and gender minority people, as highlighted in a report by the Executive Board Secretariat of the World Health Organization (World Health Organization, 2013, quoted in Muller & Hughes, 2016: 2), is the presence of "institutional prejudice, social stress, social exclusion (even within families) and anti-homosexual hatred and violence". The Institute of Medicine (a US non-profit, non-governmental organisation) has pointed out that people who identify as LGBT are at increased risk of harassment, victimisation, depression and suicide and have higher rates of smoking and alcohol use than their heterosexual counterparts, and that lesbian and bisexual women may also be at higher risk for obesity, cardiovascular disease and breast cancer (Graham et al., 2011). These findings comport with research that shows sexual orientation and gender identity as important social determinants of health (Logie, 2012; Pega & Veale, 2015), and underscore the link between the stigma, marginalisation, and discrimination experienced by LGBT people and health outcomes (Hatzenbuehler et al., 2014; Meyer, 2003). The reason for the disparities in health outcomes is that stigma (widespread disapproval held by many people in a society), prejudice, discrimination and structural stigma (social stigma that is institutionalised or made into law, such as laws that criminalise consensual same-sex behaviour), lead to stressful social environments for LGBT people (Meyer, 2003; Hendricks and Testa, 2012; Hatzenbuehler *et al.*, 2014). This is called *minority stress.*

Much of this work however is only about gay and other men who have sex with men and their exposure to HIV and other sexually transmitted infections. This is evidenced by a review of English language articles indexed by MEDLINE between 1980 and 2000 (Boehmer, 2002) and a review of research grants funded by the US National Institutes of Health (NIH) between 1989 and 2011 (Coulter, Kenst, Bowen, & Scout, 2014), which each found that there was a very low proportion of studies on LGBT health (as little as 0,1%), and of these only 37% and 14%, respectively, included information about lesbian or bisexual women. Boehmer (2002) also found that many articles addressed lesbians, bisexual women, and transgender persons together, despite known differences in their health risks and outcomes. While all share vulnerabilities due to social exclusion and stigmatisation, it is the difference between non-normative sexual orientation (lesbian or bisexual) and non-normative gender identity (transgender) that leads to significantly different health needs, for example access to dental dams for safer oral sex for lesbians, or gender affirming healthcare for transgender people (Feldman & Bockting, 2003).

Further, most of what is known about LGBT health is based on research from the global north, especially the USA, which gives us some insights, but does not address the nuances of LGBT health in under-resourced contexts, with varied socio-cultural factors. The report by the WHO (World Health Organization, 2013, quoted in Muller & Hughes, 2016: 2) makes the point that to "achieve a better understanding of the health needs of LGBT people, more data are needed on the demographics of these populations, particularly in low-income and middle-income countries". Our effort to evaluate the role of NGOs as key community participation actors in health policy and implementation is one step toward such an improved understanding of LGBT health in other contexts.

The African Commission on Human and People's Rights, in its resolution 275 and a recent report has emphasised the need to protect people on the continent against violence and other human rights violations on the basis on their real or imputed sexual orientation or gender identity (African Commission on Human and Peoples' Rights, 2014, 2016). This includes violations of the right to health, including physical and mental healthcare. Research from South Africa demonstrates the urgency of the need for protection, as LGBT people are significantly vulnerable to violence, sexual and mental health concerns , and yet experience discrimination at health facilities (Meer & Müller, 2017; Müller, 2017; Müller, Daskilewicz, & Southern and East African Research Collective for Health, 2019; Smith, 2015).

Sexual orientation, gender identity and access to healthcare

At an international level, treaties and provisions for the right to the highest attainable standard of health acknowledge the impact that social and economic discrimination have on access to and quality of healthcare. The International Covenant on Economic, Social and Cultural Rights (ICESCR), which South Africa has ratified, outlines the right to the highest attainable standard of health. ICESCR General Comment 14, which provides more detail how this 'highest attainable standard of health' is defined, outlines four main dimensions: availability of healthcare, accessibility of healthcare, acceptability of healthcare and quality of care (UN Economic and Social Council, 2000). Paragraph 12.b of this General Comment 14, which operationalizes the right to health, states that non-discrimination is a key dimension of accessibility to healthcare; and paragraph 18 explicitly lists sexual orientation in a list of grounds of discrimination and condemns "any discrimination in access to healthcare and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of [...] sexual orientation [...] which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health".

Previous research from South Africa shows that healthcare for LGBT people shows deficiencies in all four dimensions (Müller, 2017). An increasing body of academic literature highlights the various challenges that LGBT South Africans face when accessing healthcare. Although this is not exhaustive, these can be summarised as:

- *Prejudicial attitudes by healthcare staff,* rooted in societal homo- and transphobia. For example, studies show that LGBT people experience invasive or interrogatory questioning about their identities, and sexual lives, verbal harassment, ridicule and insults by healthcare staff due to their sexual orientation and/ or gender identity, and in some cases, are even denied access to services (Meer & Müller, 2017; Alexandra Müller, 2016; Smith, 2015).

- A *lack of knowledge among healthcare staff* about SOGIE-specific healthcare needs. For example, doctors and nurses often do not know how to take a sexual history using gender-neutral language, or do not know about the specific health risks associated with non-heteronormative sex (Meer & Müller, 2017). As a result, healthcare staff is not able to provide high quality services to LGBT people.

- *SOGIE-specific healthcare needs are not recognised in health policy and planning* and are therefore not available in public health facilities. For example, the South African Department of Health does not have treatment guidelines for gender-affirming care, and therefore access to care for transgender people wishing to undergo gender-affirming procedures is inconsistent at best, and impossible at worst (Spencer, Meer, & Müller, 2017).

These barriers are not altogether different from other contexts, however within the dilapidated South African healthcare system and the wider socio-economic marginalisation of those using it, these barriers may be more acute or difficult to overcome. This intersection of challenges based on SOGIE and challenges presented by the structural issues in South Africa are frequently raised in the findings of this report.

Including communities in health

'Community participation' in healthcare was introduced as a concept at the International Conference on Primary Healthcare in 1978. At the conference, delegates identified key tenets of primary healthcare and named 'individual and collective' participation in healthcare planning and implementation as a right (Declaration of Alma-Ata, 1978). Thus, community participation has been conceptualised as an empowerment tool through which local communities take responsibility for diagnosing and working to solve their own issues, including health(care)-related problems. This may mean anything from simply allowing community representatives to be party to the making of policy decisions, to a more thorough process of decentralisation and feedback where state policy-makers are more alert and responsive to the needs of communities, particularly marginalised and minority groups.

Available findings suggest that community participation has a positive impact on "intermediate" health outcomes, such as improving access to, and use of, health services (Bath & Wakerman, 2015). It is likely that these improvements shape individuals' health, allowing for treatment and prevention of illnesses to occur more quickly, but also through policy input, for healthcare to become more sensitive to the needs of different groups. A recent systematic review by Cyril and colleagues (2015) documents that community participation practices can successfully improve health for sexual minorities, among other 'disadvantaged' groups. It is not definitive which elements of community participation are most beneficial, though use of community healthcare workers and emphasis on "collaboration, partnerships, and empowerment" appeared to be linked to positive outcomes (Cyril, Smith, Possamai-Inesedy, & Renzaho, 2015). As with the wider literature on LGBT health, recent published work on sexual and gender minorities' participation in health focuses on the HIV/AIDS epidemic (Bauermeister et al., 2017; Chang Pico, Kohler, Hoffmann, & Mungala, 2017; Molyneux et al., 2016).

As community participation is understood, organic self-motivated participation originating from inside the community is the ideal. However, some point out that community participation may require facilitation or prompting by experts or intermediaries from outside (Morgan, 2001). In this regard LGBT NGOs, such as Triangle Project and OUT Well-being, play an interesting role with regards to community participation, holding both insider and outsider status. On the one hand, these organisations are deeply intertwined, and constitutive of the communities which they serve – LGBT people in their respective cities. On the other hand, by virtue of their professionalised roles, their particular educations or expertise, and their mandate to intervene in healthcare provision, NGO staff members are different from the average LGBT person that might use their services. This insider-outsider status thus puts NGOs in an advantageous position for participating in healthcare policy making and implementation as they have a good view of both the local level and the needs of the community, and of the government policy terrain.

In addition, whilst proponents of community participation encourage early and frequent participation of sexual minorities, including the more marginal or least visible, they are wary of the risks that community members may face due to the visibility of participating, and possible resulting increased stigma, discrimination or threats to safety (Molyneux et al., 2016). However, NGOs are already visible as actors in the LGBT and policy spheres, ameliorating this risk to some extent (although there is evidence that NGO workers do still experience hostility based on the visibility that their work creates – see, for example, Meer & Müller 2018), and aiding the inclusion of more marginalised individuals or groups through consultative processes that may still conceal those who do not wish to become more visible.

Much of the research on community participation is about its role in achieving specific project goals, such as in the case of a project from the USA by Bauermeister and colleagues (2017) on the prevention of HIV/STIs with young gay and bisexual men, men who have sex with men (MSM), and transgender women. In our case however, the research was focused on LGBT community participation in the broader sphere of healthcare policy and healthcare provision. This raises a larger set of issues. Community participation in this wider context is more varied and on multiple levels and rubs up against the more general challenges of the struggling South African healthcare system. Whilst the underlying reason for the exclusion of LGBT health concerns is the same – heteronormativity and the resulting invisibility of sexual and gender minorities – the ways in which community participation addresses this are very varied: from alternative healthcare provision, to community-led education and training for healthcare providers, to participation in state policy and accountability processes.

Finally, some have cautioned against an overemphasis of evaluating participation as a specific input or output, arguing that participation must be understood as a process, not a product, and that it should be incorporated into all activities at different stages (Morgan, 2001; Oakley, Bichmann, & Rifkin, 1999). Further, beyond the positive impacts on health, participation has been shown to have other benefits for communities, such as promoting community building and ensuring community members' needs are met effectively in their local, cultural, social context (Cyril et al., 2015; Sule, 2005).

Thus, we purposefully did not collect quantitative data about the role of NGOs, or about specific projects that NGOs work on. This is not a technical impact assessment. Instead we combined quantitative data about the lived experiences of LGBT people and qualitative data from key informants in LGBT healthcare to analyse the role of community participation of the two LGBT NGOs in access to sexual and reproductive healthcare for LGBT people.

Community participation by LGBT organisations in South Africa

The work of LGBT organisations and COC to date

In South Africa, partner organisations of COC Netherlands have worked with healthcare providers and health sector stakeholders in various ways to improve healthcare services for LGBT populations. These engagements range from providing training for specific healthcare personnel in the public sector, to engaging the Department of Health in health policy evaluation, to providing specific services themselves. Together with COC Netherlands, some partner organisations have also participated in high-level stakeholder meetings to raise awareness about, and knowledge on SOGIE-specific health issues with national health policy makers. Some of these efforts have been documented in individual case studies in the "Lessons Learned" series produced by COC (for example, *OUT's Peer Education Programme for MSM / LGBT's in Tshwane, Pretoria* (issue 27) documents the process of building an outreach programme to take HIV prevention services into communities). To date however, there has been little research on the impact this kind of training, education and advocacy on health policy and service provision. This research report evaluates the role of two local LGBT organisations in influencing healthcare service provision and health policy in South Africa, their success and challenges. In order to better understand the empirical findings from our research relating to how NGOs intervene in and influence policy development, implementation and healthcare provision, we need to first explain the South African law and policy framework, the healthcare system, as well as the context in which community participation efforts take place.

Law and policy related to SRH for LGBT people in South Africa

The South African Constitution guarantees the right to protection from discrimination based on, amongst others, sex, gender and sexual orientation (Bill of Rights, Section 9 (3) and (4))[1]. This has been interpreted to include protection based on gender identity. The Constitution also guarantees access to healthcare, including sexual and reproductive healthcare (Bill of Rights, Section 27(a))[2]. In addition, the National Adolescent Sexual and Reproductive Health and Rights Framework Strategy 2014 – 2019, developed by the Department of Social Development (DSD, 2015) affirms the right to sexual and reproductive health services for all adolescents, including adolescents who identify as LGBT.

Healthcare provision for specific health concerns is outlined in health policy documents, also called 'strategic plans'. From these health policies, specific clinical guidelines are developed to guide healthcare providers in decisions relating to the treatment of specific health concerns. These 'treatment guidelines' outline the criteria for a diagnosis, the criteria for starting a specific treatment, as well as the detailed plan for which medication to use.

At the moment of writing this report, only HIV-related health policy makes special mention of sexual orientation or gender identity by referring to two 'at-risk' groups: men who have sex with men (MSM) and transgender people. The Department of Health's National Strategic Plan on HIV, STIs and TB (2017-2022) identifies MSM and transgender people as so-called 'key populations'[3]. This recognises MSM and transgender people's unique risks for HIV transmission and requires that all interventions include a component targeted at MSM and transgender people. The Department's Operational Guidelines for HIV, STIs and TB programmes for key populations in South Africa (DoH, 2012) outline the key social and economic vulnerabilities of MSM and transgender people.

At the time of writing this report, neither health policy nor treatment guidelines exist for gender affirming care for gender diverse people.

The Health Professions Act 56 of 1974[4] which outlines the roles and responsibilities of healthcare professionals, states that practitioners must always act in the best interests of the patient, respect patients' choices and dignity, and maintain the highest standards of personal conduct and integrity (section 27A). The Health Professions Council of South Africa (HPCSA)'s core ethical values and guidelines for good practice elaborate on these obligations and emphasise that health professionals need to ensure that 'their personal beliefs do not prejudice their patients' healthcare'[5]. Gender and sexual orientation are specifically cited as issues around which personal beliefs could negatively shape the treatment of the patient (section 5.1.5), and it can be assumed that this includes gender identity.

The South African healthcare system

Because of South Africa's history of racial segregation, the healthcare system is very unequal. The contemporary system is actually three parallel systems: one public, financed through tax, government subsidy and service user fees; one private, financed through service user fees, paid either out of pocket or through private medical insurance schemes[6]; and a vast heterogeneous system of indigenous healing practices, financed out of pocket and not covered by health insurance. About 40 million people (84% of South Africans) rely on care in the public sector (Mayosi & Benatar, 2014), while only 16% of people, largely middle-class, regularly use the more expensive private sector through private health insurance. Up to 25% of people without private insurance pay out of pocket for private sector care, if and when they can afford it, and patients

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[1] Department of Justice and Constitutional Development. The South African Constitution, 1996. Pretoria: Department of Justice and Constitutional Development, 1996 [http://www.justice.gov.za/legislation/constitution/constitution.htm]

[2] Department of Justice and Constitutional Development. The South African Constitution, 1996. Pretoria: Department of Justice and Constitutional Development, 1996 [http://www.justice.gov.za/legislation/constitution/constitution.htm]

[3] SA National Department of Health. National Strategic Plan on HIV, STIs and TB (2012-2016).
Available online at http://www.sanac.org.za/nsp/the-national-strategic-plan

[4] Republic of South Africa. The Health Professions Act 56 of 1974. Cape Town: Government Gazette, 2006

[5] Health Professions Council of South Africa. General Ethical Guidelines for the Health Care Professions. Pretoria: HPCSA, 2008

[6] While the private sector is primarily financed through private membership in medical aid schemes, it is also indirectly cross-subsidized by the public sector. The public sector, unlike the private sector, trains healthcare providers. Further, medical aid benefits are tax-deductible for members of medical aid schemes.

who run out of funds for private care return to the public system. The disparities in resource allocation between the two parallel systems are wide. The public system services the large majority of South Africans, but employs only about 30% of doctors in the country, whilst the private system employs the remaining 70%, and 95% of all medical specialists (Breier, 2008). The public health system is in a state of crisis, overwhelmed by a quadruple burden of disease – HIV/AIDS and TB, maternal and child mortality, high levels of violence and injuries, and a growing burden of non-communicable diseases – higher than in most countries of comparable economic profile (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009), and undermined by staff shortage, lack of infrastructure and resources, mismanagement and neglect (Coovadia et al., 2009; Von Holdt & Murphy, 2007).

The cost of care for healthcare users in the public sector is determined by income (the threshold for free care is at a monthly income of R4000 or EUR250). Private health insurance is costly, and usually offered as benefit for white-collar employment positions. The disparities between the public and private healthcare system are evident in the annual per capita health expenditure, estimated to be ten times higher in the private sector than the public sector (EUR1300 versus EUR130) (Coovadia et al., 2009).

South Africa follows a primary healthcare approach. In the public system, resources are focused at primary care level with an emphasis on health promotion and prevention[7], facilities are largely nurse-based, and the package of care encompasses infectious disease management including HIV testing and treatment, sexual and reproductive health services and management of chronic conditions.

In 2011, the National Department of Health proposed a large-scale reform of health systems financing, National Health Insurance[8] (NHI), intended to decrease the disparities between the public and private health sectors, so that all South Africans could have universal health coverage. NHI would be a mandatory public health insurance scheme, under which the public could access a range of free specified health services[9]. Individuals could choose to take out additional private health insurance. According to the draft 'White Paper' (Department of Health, 2015), the minimum package of care would be available to all South African citizens and legal permanent residents and would follow established South African treatment guidelines. The process of legislative consultation for NHI is still ongoing, and it is unclear whether it will be passed and when it might come into effect.

Indigenous healing practices encompass 'health practices, approaches, knowledge, and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, to treat, diagnose and prevent illnesses and, maintain well-being' (WHO, 2003). In South Africa there are currently more than 200,000 'traditional' healers, and it is estimated that between 1% and 11% of South Africans regularly use indigenous healing practices (Nxumalo et al, 2011; DoH, 2003). These healers are regulated by the Traditional Health Practitioners Act10. However, because of the extensive, remote and informal nature of indigenous healing practices, regulation is not very thorough.

Due to the inequality of the current trifurcated system, access to healthcare[11] is dependent on a number of factors. Wealthier people pay for the services that they want in the private system and seem to experience relatively few barriers, including based on sexual orientation or gender identity. In the public system, not all facilities are equally capable and resourced, with urban centres doing better. However, there are also differences from province to province and, considering the location of each of the two NGOs addressed in this study, the Western Cape Department of Health seems to fair better than that of Gauteng. Unsurprisingly then, evidence suggests that the level and quality of care that LGBT people, especially transgender people, can access is often determined by geographical location and socio-economic status (Husakouskaya 2013a, Husakouskaya 2013b; Klein 2013). Furthermore, recent evidence points to crucial disparities in access to healthcare due to a lack of implementation of the existing constitutional and legislative framework. For example, reports of health service discrimination based on sexual orientation (Lane et al., 2008; Rispel et al., 2011), or gender identity (Newman-Valentine & Duma, 2014; Theron, 2014; Husakouskaya, 2013a; Stevens, 2012) highlight that healthcare providers' attitudes often influence the quality of their service provision to marginalised and vulnerable groups.

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[7] National Health Act of 2003.

[8] Policy Paper for National Health Insurance. National Department of Health, 2011.
Available online at http://www.gov.za/sites/www.gov.za/files/nationalhealthinsurance_2.pdf.

[9] The package is proposed to include: Preventive, community outreach and promotion services, Reproductive health services, Maternal health services, Paediatric and child health services, HIV and AIDS and Tuberculosis services, Health counselling and testing services, Chronic disease management services, Optometry services, Speech and Hearing services, Mental health services including substance abuse, Oral health services, Emergency medical services, Prescription medicines, Rehabilitation care, Palliative services, Diagnostic radiology and pathology services

[10] Traditional Health Practitioners Act 22 of 2007.

[11] The four dimensions of access to care encompass availability, accessibility and acceptability of health services, as well as quality of care, according to UN General Comment 14, based on the International Covenant on Economics, Social and Cultural Rights, which contains the Right to Health.

Community participation in health in South Africa

Community participation in health is one of the tenets of the South African National Health Act (2003), but it remains unclear how such participation should happen, and who has the capacity to be involved.

The Act has established the statutory body of health committees to institutionalise community participation in “various aspects of the planning and provision of health services”[12]. Health committees comprise of the head of the health facility, one or more local councillor(s), and one or more members of the community that is served by the facility. Research documents the benefits of community participation through health committees. In a recent study, Glattstein-Young (2010) concluded that some health committees in the greater Cape Town area were able to improve health service delivery. She suggests that even in resource-poor settings with minimal support, community participation had a positive impact on the right to health. One example of this was a health committee that was successfully involved in ensuring that a day clinic changed into a 24-hour-facility. However, a number of studies suggest that health committees in South Africa are not functioning optimally (Padarath and Friedman, 2008, Glattstein-Young, 2010, Haricharan 2011). In this context, NGOs have played important roles in improving access to healthcare. Perhaps the best-known case is that of the Treatment Action Campaign, who successfully took the South African Department of Health to court to force it to provide antiretroviral treatment to prevent the mother-to-child-transmission of HIV.

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[12] South African National Department of Health (1997). White Paper on Transformation of the Health System, pp. 5-6.

Methodology

Community-based research

Our project applied a community-based participatory research (CBPR) approach, which actively involves community members and academic researchers as partners in all steps of the research process (Israel, Schulz, Parker, & Becker, 1998). The research project was conducted in partnership between the Gender Health and Justice Research Unit (GHJRU) at the University of Cape Town (UCT) and two civil society organisations: Triangle Project and OUT Well-Being (from hereon called 'partner organisations'). Central to our approach was that all research partners should have shared decision-making power about the research design, implementation and dissemination. The project team consisted of three GHJRU researchers, the research and advocacy officer of Triangle Project and the project manager of OUT Well-Being. All major decisions about design, implementation and dissemination were discussed within and decided upon by the project team.

Study design

Rooted in the principles of community-based research methodologies, this project used a mixed-methods approach incorporating both quantitative and qualitative methodology to evaluate how, to what extent, and with what outcome the partner organisations' work on LGBT people's access to sexual and reproductive health and rights (SRHR) are able to influence healthcare service provision, health policy and advocacy in South Africa. Based on the research objectives, literature review and an initial discussion among the project team, the GHJRU researchers drafted a survey instrument as well as an interview guide. For the questions on confidence levels in public service use, we adapted an existing tool (World Health Organization, 2013a). The overall project team met to review the survey instrument and interview guide and amended them as necessary.

The project team met to plan the project and decide on each team member's role. It was determined that quantitative data would be collected by partner organisations. Based on the data collection instruments and input from partner organisations, GHJRU researchers designed a training manual, in order to guide and standardise the collection of quantitative data. A small group of designated fieldworkers from partner organisations were trained on the research process, research ethics and data collection, and familiarised with the training manual, in order to collect quantitative data through their organisations in two provinces: the Western Cape and Gauteng.

Prior to formal quantitative data collection, a pilot of five questionnaires was completed with eligible participants at Triangle Project. The goals of the pilot were to assess whether questionnaire language was easily understood and interpreted correctly, as well as to identify questions that were missing or needed to be altered. As the pilot was successful and no issues were raised about the questionnaire, no revisions to the questionnaire were made.

The project team decided that researchers from the GHJRU would be responsible for collecting qualitative data through in-depth interviews with healthcare providers and partner organisations' representatives. The GHJRU researchers were responsible for analysing all data, quantitative and qualitative.

Our quantitative data is meant to elucidate the context in which NGOs do their work – based on the lived experiences of the LGBT constituents of organisations, and their health-seeking behaviour and healthcare needs. These data provide the background for our qualitative data, which is based on interviews with NGO staff and various healthcare providers and government stakeholders. Through these interviews, the role of NGOs in providing SRH services to LGBT South Africans and in facilitating access to mainstream SRH services becomes clear, against the backdrop of the dysfunctional South African public health system and pervasive homo- and transphobia.

Data collection

Survey data collection

Two fieldworkers from Triangle Project, in the Western Cape, and two fieldworkers from OUT Well-Being, in Gauteng, collected data in their respective provinces. Each fieldworker aimed to survey approximately 100 participants through a combination of purposive cross-sectional community venue-based sampling, combined with snowball sampling, where initial respondents referred suggested further respondents. The fieldworkers provided information about the study and asked each participant if they consented to participate. Only if eligible participants consented, including by signing an informed consent form, was the questionnaire completed. To be eligible to participate, one needed to be age 18 or older and to self-identify as lesbian, gay, bisexual, transgender, intersex, or any other sexual orientation or gender identity except heterosexual and cisgender. In total, 408 surveys were analysed. Twenty-eight percent of participants completed the questionnaire with the help of a fieldworker (fieldworkers administered). The rest of the participants completed the questionnaires by themselves (self-administered).

Of the 408 survey participants, slightly more than half of the participants were women (53%)—42% were cisgender women and 11% were transgender women (see Figure 1). 44% percent were cisgender men and 2% were transgender men. Participants' ages ranged from 18 to 63 years (M = 26.6, SD = 7.1). More detailed information about the sample is included at the beginning of the next part of this report (Findings Part 1).

In-depth interview data collection

Taking the questionnaire findings and the purpose of the study into account, it was determined that in-depth interviews with knowledgeable people in the field of LGBT health and policy (key informants) would support and supplement the quantitative data. The project team identified the issues and knowledge gaps that could be addressed by speaking to key informants, and GHJRU researchers then developed a semi-structured qualitative interview guideline for in-depth key informant interviews. Based on the project team's experience and networks, a list of suitable individuals to be approached for interviews were compiled (strategic sampling), including the representatives of partner organisations, healthcare providers and health policy makers. Initial interview participants were asked to recommended anyone else who might be useful for us to contact (snowball sampling).

In total, we interviewed 19 key informants. Nine worked at LGBT community organisations in various roles. This included directors and researchers of organisations (who could provide a broader view of structural issues and concerns), employees who provided sensitization training to healthcare providers, and employees who provided direct healthcare and support to LGBT individuals. Further, we interviewed four healthcare providers who currently provide services to LGBT people, and six policy makers who are involved in health policy. For the latter two groups, we decided to interview people who had, in some form or other, existing knowledge on SOGIE-related health issues, or had interacted with LGBT organisations in the past, so that we could get more information about how such relationships and knowledge transfers came about. We re-interviewed two key informants during the process of data analysis, because we had additional questions that came out of their initial interviews.

Table 1: Table of participants

Type of organisation	**Number of participants**
Partner organisations	**9**
Triangle Project	*4*
OUT Well-Being	*5*
Health policy makers	**6**
Healthcare provider	**4**

Data analyses

In this project, all partners agreed at the inception meeting that the GHJRU would lead analysis and the write-up of the findings, and that Triangle Project and OUT Well-Being would be involved through reviewing the preliminary findings and providing input on study outputs.

Survey data analysis

The GHJRU team members entered all survey data into an online database called REDCap, an electronic data management system by Vanderbilt University, and then cleaned and analysed it with the statistical analysis software Stata15. We ran descriptive statistics and when necessary, we used chi squared tests and logistic regression models to assess associations*w*between variables.

Qualitative data analysis

The recordings from the key informant interviews were transcribed. The GHJRU researchers used Nvivo12 software to code the transcripts. We initially created a coding map based on the research protocol and the interview guideline in order to categorise the data. The initial coding map had four main themes, but on close reading of the data, other themes emerged, and codes were added as these came up. After reviewing the coded text segments, the project team explored the interrelation between the topics that emerged from the data, based on which we wrote the result section.

Research approval and regulatory compliance

The study was approved by the University of Cape Town's Faculty of Health Sciences Human Research Ethics Committee (reference number: HREC/195/2018). This research complies with the Declaration of Helsinki (2013) and the Department of Health: Ethics in Health Research: Principles, Structures and Processes (2004). All survey data was collected anonymously. To preserve the anonymity of key informants, we have assigned pseudonyms, and use these throughout the report.

Findings Part 1: Lived realities/setting the scene

Part 1 of our report presents quantitative findings from a survey with people who identify as LGBT, as well as qualitative data from interviews with key informants. These data illustrate LGBT people's experiences in accessing healthcare. It is the context in which LGBT NGOs operate and support or facilitate access to healthcare for LGBT people.

Participant demographic and characteristics

About half of the 408 people who answered the questionnaire were from Gauteng (51%) and the other half was from the Western Cape (49%). Most participants were from urban areas (48%), followed by peri-urban (39%) and rural (11%) areas. A large majority of participants were South African (92%), and the rest were from Zimbabwe and Mozambique. Participants ranged in age between 18 and 63, with a mean age of 27 years old. Most people identified as Black (75%), followed by coloured (21%) and white (3%).

More than half of people said that they were in a relationship but not married (57%), more than a third said they were not in a relationship (37%) and only 6% said that they were married or living with someone as married.

In order to ascertain participants' income, we asked 'How much money have you received in the past month? (including money for work that you have done (including sex work), stipends, grants, etc.)'. About half (48%) of respondents had received less than R1,000 per month. This was followed by 14% with between R1,001 – R2,500, 15% between R2,501 – 5,000, 11% between R5,001 – R10,000, 8% between R10,001 – R20,000, and only 4% earning more than R20,000 per month. This means that almost half of our participants (48%) lived below the poverty line (Statistics South Africa, 2019).

Forty-two percent of participants identified as cisgender women, 44% as cisgender men, 11% as transgender women and 1% as transgender men (see Figure 1). In terms of sexual orientation, one third of participants identified as lesbian (31%), with a further 3% identifying as 'woman who has sex with women'. Another third (35%) of the sample identified as gay, with another 12% identifying as 'man who has sex with men'. Bisexual people made up 17%, and 1% identified as straight (see Figure 2).

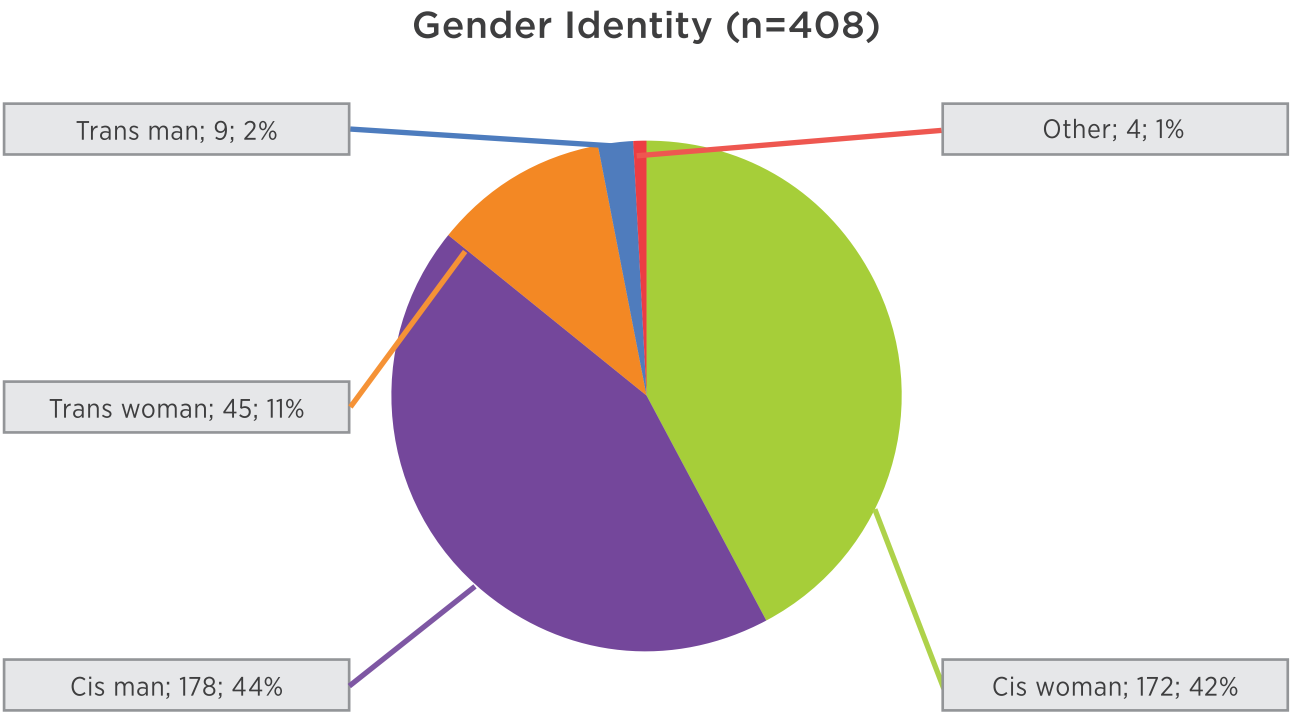

Figure 1: Participants' gender identities

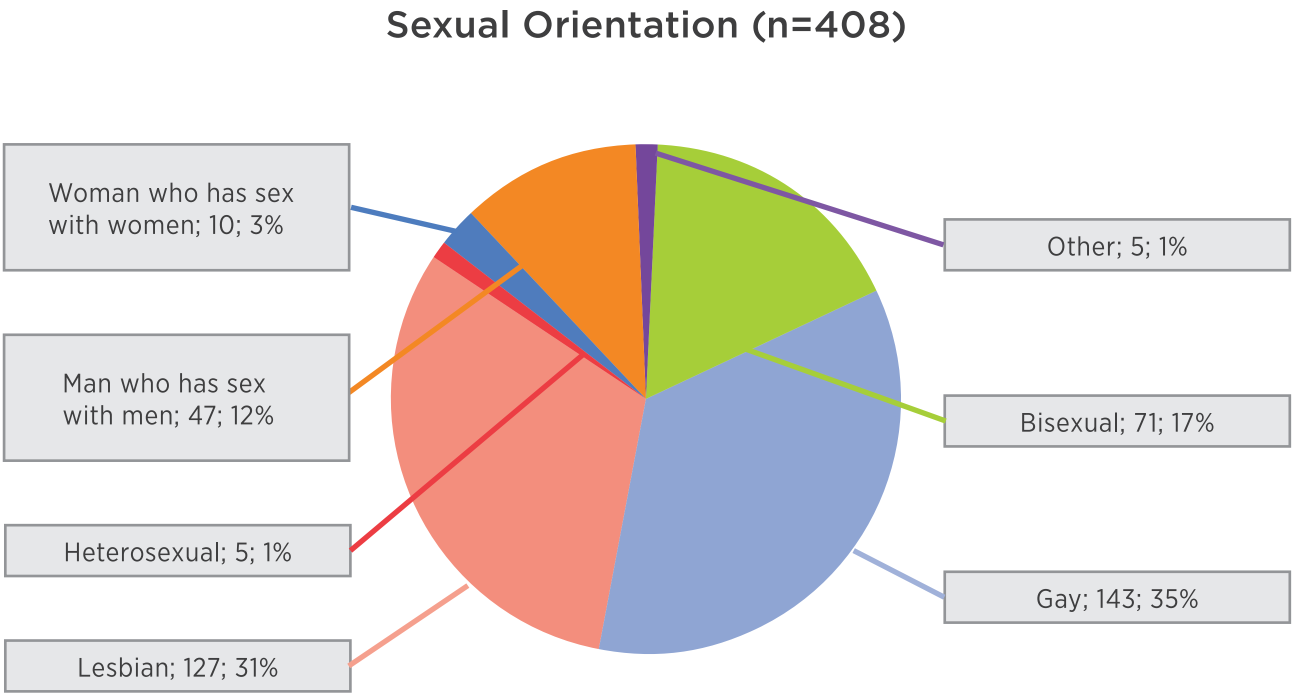

Figure 2: Participants' sexual orientations

Participant health status and health-seeking behaviour

About half of the LGBT people who answered our survey said they regularly interacted with the healthcare system. Over one third (37%) said they go for regular health check-ups, such as blood pressure checks and cancer screenings. Another 14% had a chronic health concern, which meant that they needed to access healthcare regularly. Three percent of participants had been pregnant in the previous year.

More than nine out of ten knew their HIV status (92%). About one fifth (18%) disclosed that they were living with HIV. It is quite likely that even more participants were living with HIV, because another quarter (25%) preferred not to disclose their status.

Almost three quarters of participants (70%) used public healthcare facilities as their usual source of healthcare. This is less than among the general South African population, where about 84% of people use public health facilities. About one in four LGBT people who answered our survey went to private healthcare facilities or GPs for healthcare (25%), and similarly, one in four also said that pharmacies were a usual source of care for them (27%). One in five people (21%) went to an NGO for healthcare. In the year prior to answering our survey, most people had gone to a healthcare facility more than once, but less than five times (41%), followed by people who had gone only once (29%).

By far the most common sexual and reproductive health service that survey respondents had sought in the previous year was healthcare related to HIV: 58% had gone for voluntary HIV counselling and testing (VCT), 53% had collected condoms, and 43% had collected lubricant. 14% had gone to receive screening or treatment for another sexually transmitted infection. By comparison, less than one in ten (7%) had gone to a healthcare facility for reproductive health concerns, such as cervical cancer or prostate cancer screening, to access hormonal contraception (8%), to test for pregnancy (5%) or for antenatal care (2%). 3% had sought pre-exposure prophylaxis for HIV (PrEP), and 1% had gone to get post-exposure prophylaxis (PEP). 8% had sought healthcare for mental health concerns.

When we asked people about the last time they had gone to seek healthcare (whether at a public facility, in private care, or at an NGO), one in eight (12%) said that they did not receive all the healthcare that they needed. The reasons for this ranged from homo-, trans- and xenophobic healthcare provider attitudes (experienced by 9 respondents), to stock-outs of medication, condoms or lubricant (experienced by 11 respondents) to healthcare providers refusing to provide LGBT specific care, for example anal exams (experienced by 7 respondents).

At their last healthcare visit, one in six survey respondents (18%) had delayed seeking healthcare because they were afraid of sexual orientation or gender identity-related discrimination. Less than half (47%) said that their healthcare provider knew their sexual orientation or gender identity at that visit. Respondents' concerns about SOGIE-related discrimination seem justified by their previous experiences at healthcare facilities: one in five (20%) said that a healthcare provider had treated them worse because of their sexual orientation, gender identity or sexual behaviour; one in ten (11%) were refused treatment because of their SOGIE or sexual behaviour; one in six (15%) felt that they were made to wait longer because of their SOGIE or sexual behaviour; one in five (22%) said that healthcare providers had disclosed their SOGIE or sexual behaviour to others without their consent; one in four (24%) said that a healthcare provider had spoken ill of them, or gossiped about them because of their SOGIE or sexual behaviour; and one in four (25%) said that healthcare providers had spoken to them about morality or religion in response to their SOGIE or sexual behaviour. Perhaps not surprisingly, then, only one in four respondents (24%) thought that LGBT people were treated as fairly as everyone else at healthcare facilities.

These findings confirm the findings of a recent study in South Africa, which show that 44% of LGBT participants had tried to hide their health concern related to their sexual orientation or gender identity from a healthcare provider and 22% of participants had been denied healthcare because of their sexual orientation or gender identity (Alex Müller et al., 2019).

Confidence in seeking healthcare services

Evidence about men who have sex with men (MSM) suggests that disclosure one's SOGIE to healthcare providers, having a high sense of self-worth, and utilizing condom negotiation scripts may be linked to improved condom use (Brown et al., 2016; Siegler et al., 2014). Whilst there is no comparable evidence about LGBT confidence in negotiation of condom use, we did enquire about this amongst our sample, to gain some insight about how empowered participants felt to insist on safer sex. When asked "How confident are you in your ability to use a barrier method with someone you have sex with, even if they get angry" and "even if they try to convince you to not use one?", almost half (49% and 46%) of participants responded that they were "very confident". About one third (36%) of participants answered that they were "sometimes confident" in both cases. About 14% were "not confident" if their partner got angry, and about 17% were not confident if their partner tried to convince them not to use a barrier method (for detailed findings, see Table 2).

About two in five participants (42%) said that they were very confident about going to a government clinic or General Practitioner (GP) for STI services (even if health workers knew their sexual orientation and/or gender identity), 37% said that they were sometimes confident and 21% said that they were not confident. It is not surprising that more than half of the sample was not always confident given that poor treatment at healthcare facilities is well documented in the literature, and that questions around sexual orientation, gender identity and sexual behaviour are likely to come in consultations about sexually transmitted infections. A Namibian study found that MSM respondents were reluctant to utilise testing services for fear of discrimination (Stephenson, Hast, Finneran, & Sineath, 2014), and a study in eSwatini found that stigma and dual discrimination (being both MSM and HIV-positive) led to delayed entry into care (Kennedy et al., 2013). In South Africa, too, evidence shows that about 1 in 10 gay men and lesbian women delayed seeking treatment at clinics as a result of fearing discrimination, while others are refused services altogether (Alexandra Müller, 2014), and that up to 60% of transgender individuals in South Africa report negative experiences in state clinics (Stevens, 2012b).

When asked how confident they were in seeking STI services even if treated badly by healthcare workers, the percentage of respondents who felt very confident dropped to only 22%, and the percentage of those who were not confident rose to 40%. They were similarly (un) confident about going to a government clinic or GP for HIV counselling and testing if healthcare workers treated them badly, with only 20% feeling very confident, 35% sometimes confident and 44% not confident. This again comports with the literature, as a study of MSM in Malawi, Namibia, and Botswana found that there was a strong relationship between discrimination and the fear of seeking out health services (Fay et al., 2011; Jacques, 2014).

Table 2: Confidence levels in barriers methods and seeking services, by organisation

Level of confidence in using barrier methods.
How confident are you in your ability to use a barrier method with someone you have sex with, even if they get angry?
How confident are you in your ability to use a barrier method with someone you have sex with, even if they try to convince you to not use one?
How confident are you in your ability to use a barrier method with each client, even if you have been using alcohol or drugs?
Level of confidence in seeking STI services (not including HIV)
How confident are you about going to a government clinic or GP for STI services, even if health workers know your sexual orientation and/or gender identity?
How confident are you about going to a government clinic or GP for STI services, even if health workers treat you badly?
How confident are you about going to a government clinic or GP for STI services, even if health workers don't provide the specific service you need (e.g. no anal exam, no medication)?
Level of confidence in seeking HIV counselling and testing
How confident are you about going to a government clinic or GP for HIV counselling and testing, even if health workers know your sexual orientation and/or gender identity?
How confident are you about going to a government clinic or GP for HIV counselling and testing, even if health workers treat you badly?
How confident are you about going to a government clinic or GP for HIV counselling and testing, even if health workers will not keep your visit confidential?
Level of confidence in seeking treatment for any chronic condition such as TB, HIV, cancer, etc.
How confident are you about going to t a government clinic or GP for treatment, even if health workers know your sexual orientation and/or gender identity?
How confident are you about going to a government clinic or GP for treatment, even if health workers treat you badly?
How confident are you about going to a government clinic or GP for treatment, even if health workers record your name and address as part of registration?
How confident are you about going to a health facility for PrEP (pre-exposure prophylaxis for HIV)?
How confident are you about giving advice to other LGBT people, or speaking your opinion in front of a large group of people?

	Overall sample (n=408)			Triangle project (n=198)			OUT well-being (n=210)		
	Very confident	Sometimes confident	Not confident	Very confident	Sometimes confident	Not confident	Very confident	Sometimes confident	Not confident
	49 %	36 %	14 %	52 %	26 %	19 %	46 %	44 %	10 %
	46 %	35 %	17 %	47 %	31 %	18 %	44 %	39 %	17 %
	39 %	31 %	28 %	36 %	25 %	36 %	42 %	37 %	21 %
	42 %	37 %	21 %	47 %	25 %	26 %	37 %	47 %	16 %
	22 %	37 %	40 %	22 %	29 %	47 %	21 %	45 %	33 %
	16 %	38 %	44 %	18 %	28 %	49 %	15 %	47 %	39 %
	40 %	41 %	18%	44 %	31 %	23 %	36 %	51 %	14 %
	20 %	35 %	44 %	21 %	26 %	51 %	20 %	43 %	38 %
	19 %	32 %	48 %	19 %	26 %	54 %	18 %	39 %	43 %
	36 %	44 %	20 %	38 %	36 %	24 %	33 %	51 %	16 %
	19 %	35 %	45 %	19 %	25 %	54 %	19 %	44 %	37 %
	35 %	41 %	23 %	39 %	32%	28 %	32 %	50 %	19 %
	27 %	35 %	20 %	33 %	29 %	19 %	21 %	41 %	20 %
	51 %	35 %	12 %	61 %	25 %	10 %	41 %	44 %	14 %

Participants expressed even less confidence when services where not tailored to their health needs and health workers didn't provide the specific service that they required (e.g. no anal exam, no medication), with only 16% saying that they would be very confident, 38% being sometimes confident and 44% feeling not confident. This suggests that participants might see the provision of specific services as an indicator of how welcoming or accepting health services are to LGBT people in general. This was also raised in the interviews with key informants. For example, on participant noted: "we know that people from key populations prefer to go to a clinic where they know that it's a specialised service specifically catering for their needs" (Tim, interview 05).

When it came to HIV counselling and testing, 40% said they were very confident, 41% sometimes confident, and 18% not confident going to a government clinic or GP for counselling and testing if health workers knew their SOGIE or sexual behaviour. This changed to 19%, 32% and 48% respectively if health workers were not keeping their visit confidential. About one in four respondents (27%) was very confident in going to a health facility for PrEP (pre-exposure prophylaxis for HIV). One in three said they were sometimes confident (35%).

When seeking chronic treatment at government health services, 36% felt very confident, 44% were sometimes confident, and 20% were not confident if health workers knew their SOGIE or sexual behaviour. This did not change much if health workers recorded names and addresses as part of registration (35% very confident, 41% sometimes confident, 23% not confident). However, this shifted to only 19% very confident, 35% sometimes confident and 46% not confident if health workers treated them badly. This again underscores the impact that healthcare provider attitudes have on the health-seeking behaviour of LGBT people.

It is encouraging to see that on the whole, four in five (81%) participants answered that they felt they can access health services when they need them. However, this also means that one in five (18%) do not feel that they can access health services.

Access to healthcare

Key informants provided a good overview of what LGBT peoples' access to healthcare looks like, including for those in our sample. One participant from an LGBT organisation, described access to healthcare holistically as

> *the ability to be able to access all forms of sexual and reproductive health that people have, so being able to access barrier methods that make sense to you, the ability to present at a hospital that has a fertility clinic to explore pregnancy, to be able to present at a clinic and request abortion services and to have the right to health services, sexual health services that are not prejudiced and discriminatory, and gender affirming care (Sarah, interview 03).*

However, due to a range of issues, currently access to care is much patchier and more limited for people who identify as LGBT. The issues raised by key informants include a general lack of capacity and SOGIE-related knowledge in the South African public health system, limited access to gender affirming care for gender minority people, and a lack of sexual and gender minority friendly services for LBQ women, transmen and other people with uteruses.

Structural issues in the public health system

The South African public health system is extremely overburdened and in many instances is struggling to provide competent care for the general population. It is unsurprising then that LGBT patients are often also affected by larger structural issues, such as long waiting times and stock outs (interview 01), poorly distributed services, as well as more LGBT specific barriers to access.

It is a well-known problem that healthcare professionals in the public sector in South Africa often do not have the time, capacity or inclination to provide sensitive, patient-centered care. This was also raised in key informant interviews. Gcobani, who works at the Western Cape DOH, observes of healthcare practitioners:

> *They don't even have time to have a conversation. You walk in, they look at the folder [...]. You come in for this and they start writing. After five minutes, if you need a prescription, you get a prescription, you're out of there, go. (Gcobani, interview 07)*

He notes that although that is a work culture that DoH is trying to change, it is difficult given the high patient to practitioner ratio in the public system, and the pressure that practitioners feel to see as many patients as quickly as possible.

This however may be a deterrent for LGBT peoples' health seeking. LGBT people are often anxious or mistrustful of healthcare practitioners because of past negative experiences, including discrimination, or who may be aware of others negative experiences (Meer, Lunau, Oberth, Daskilewicz, & Müller, 2017; Müller, 2017). For this reason, it is especially important for practitioners to build rapport with LGBT patients, in order to create an interaction where they feel comfortable disclosing their sexual or gender minority status. This is also true of other minority peoples (DeMeester, Lopez, Moore, Cook, & Chin, 2016). This is also why LGBT people may prefer to seek services from facilities and organisations that are specifically and explicitly LGBT focused, or friendly (Duby, Nkosi, Scheibe, Brown, & Bekker, 2018), as suggested by our survey finding that one in five LGBT persons goes to an NGO for regular healthcare.

Further, limited interactions with healthcare workers, poor communication and a lack of information about their health can lead to patients feeling uncared for, and uncertain about current and planned treatment. An NGO health worker describes the impact of poor information for her client, Zandile, who is HIV positive but was not receiving ARV treatment:

> *I think she was in her late 20s, a lesbian, well she messaged me saying please help me, I'm having trouble to get the treatment I need. So, I went with her to her clinic appointment, she had been diagnosed with HIV in September 2018 and in February 2019 she was still not on treatment. She had been admitted [previously] […] for liver and kidney failure and had no understanding around anything. She didn't know why she had been admitted there, why her kidneys and her liver had failed, she didn't know what was going on, she had a skin condition which she didn't understand, she had had to leave work, nobody had spoken to her about how she could get funding to see herself through this crisis period of illness. So, I went with her and basically she was diagnosed with [another condition], it causes a terrible skin problem, but that's also got implications of how her liver is working, and how taking HIV medication also affects the liver […] But none of that was explained to her, she didn't have a clue what was going on. (Katie, interview 02)*

In this case, Zandile was in fact receiving appropriate treatment, and HIV treatment was delayed due to her other illness, but because this was not adequately explained to her, she was anxious that she was not getting the care she needed. This additional uncertainty adds another level of stress, over and above that generated by ill-health, and also does not allow the patient to plan for their illness and treatment, including taking steps to manage work or financial implication where possible.

Because staff at NGOs may engage with clients in more depth and see them more frequently and over a longer time than healthcare workers in hospitals and clinics, they are often more aware of clients' socioeconomic situation and how this impacts their health as well as their ability to deal with ill health. Reflecting on how far, to how many different places, and how often, Zandile had to travel to receive care, this NGO staff member points out that as with everyone else, LGBT people struggle with financial instability and poverty, and the toll that ill health adds:

> *And then also not earning a salary because she's had to leave because she's been so ill, she lives in Goodwood. She had to go to Tygerberg [Hospital], she had to go to [a healthcare facility in] Ruyterwacht and she had to go to another clinic and I can't remember, but how? How do you do that if you've got no funds? And you know I've never thought about, I've heard people say I have nothing, and until I was doing this job, I didn't understand what nothing is. Nothing. There is no money coming in, that means you have no food, you have no means to get to a place. […] You know, she's not only learnt that she had HIV, she then had liver and kidney failure. She then had to explain to her family that she was ill and, you know, she needed help. So the basket of care is missing, a person isn't treated as a whole, a person is treated as a diagnosis and then they just okay well you've got another appointment and you've got to get to Tygerberg. Well how? Nobody is looking at that. […] It's not that they can't access it because they're not welcome, they can't access it because of what's going on in their lives. (Katie, interview 02)*

It is worth noting that interviewees often pointed out that as with access to care in South Africa more generally, access for LGBT people is highly unequal and largely dependent on income. NGO workers felt that in the private sector LGBT people faced less judgment and discrimination and were able to access the treatment that they needed. By contrast, they felt that in the public sector LGBT people continually risked stigmatization and mistreatment. However, our survey data does not necessarily confirm this. When we compared the experiences of LGBT people who usually seek healthcare at public facilities with those of people who usually go to private healthcare providers, the differences were not very stark. For example, 16% of people who go to public facilities felt that healthcare providers treated them worse because of their sexual orientation, gender identity or sexual behaviour – compared to 13% of people who go to private facilities. 8% of both people who go to public and people who go to private facilities have been refused care because of their sexual orientation, gender identity of sexual behaviour. 12% of people in public care versus 9% of people in private care felt they were made to wait longer because of their SOGI or sexual behaviour; 22% versus 20% had experienced healthcare providers speaking ill of or gossiping about their SOGI or sexual behaviour; 21% versus 18% had had their SOGI or sexual behaviour disclosed without their consent; and 21% versus 16% had healthcare providers speak to them about morality or religion. Whilst these findings show that discriminatory experiences are slightly less in private facilities, the difference to public facilities is not as clear as NGO staff and other interviewees seem to think.

Additionally, some services are unevenly distributed, making them inaccessible to some people based on their location. An NGO staff member in Gauteng points out that although she thinks Thuthuzela Care Centres13 provide good care for survivors of sexual assault, and she frequently refers clients to them for health, psychosocial services and reporting to police after an assault, they are simply not accessible to all areas.

> *The problem is that there are no, the Centers are very separated and it's insufficient because there are only two that are in Pretoria and they are at the furtherest end. In the north there is no Thuthuzela Centre so that is also a problem on its own. But it [Thuthuzela Centre model] works, but make the service available to the people, make it accessible so that somebody who is violated does not have to get onto a taxi or two taxies to access the service, because currently a person from Pretoria North would have to take four taxies to get to a Thuthuzela Centre and that is completely, it defeats the purpose and I guess that is why people will not go there if it is too far. So I think the problem the Thuthuzela Centers there isn't a problem with the service that they provide the problem is that there are insufficient Centers within South Africa. (Justice, interview 09)*

Further, this NGO worker was concerned that many people do not even know that the specialized service exists, perhaps because it is so remote to them. She goes on to say:

> *The people in Mamelodi are very well, are very well aware of it, people in Atteridgeville know about the one in Laudium. The people in Pretoria North, I had a dialogue session I think a week ago back and none of them knew what a Thuthuzela Centre was and it was such a defeated process knowing that this Centre basically should be promoted as a right to every woman, every woman should know about the centre and not only women only, all people who live in spaces where there are very high chances that you will be violated, they should know about it and it would probably help somebody because, you know the one stop centre you get a police officer you get a doctor, you get a psychologist so you don't have to go knocking on fifty doors to get assistance and they are also sensitized [to LGBT clients] so basically that factor of being secondary victimized [is limited]. (Justice, interview 09)*

Whilst some government healthcare services or at least some personnel within them are knowledgeable, competent and sensitive to LGBT people, the director of an LGBT advocacy organisation points out that these tend to be in urban areas:

> *So it's not even just 1% of public health facilities providing competent service, but also it's about where are these services located, they are located in the big metros, like Tswane, like Johannesburg and Cape Town, so that means, when you have a trans person from Northern Cape or the Eastern Cape or North West or Mpumalanga or Limpopo, you are more likely to have […] persons not accessing service. (Blake, interview 12)*

NGO-based LGBT services are also unevenly distributed. As one DOH official points out, constantly referring LGBT people from public clinics is not sustainable. People might attend their nearest public health facility and may not be able to travel to LGBT organisations.

> *So you see the LGBT communities also have these, they also don't have money and so on. So sometimes it's not very practical to be sending somebody to a place where they don't even have bus [fare] […]. That's why I'm saying it's not everybody, those that can afford to can take a bus there or get themselves to Green Point at the Ivan Toms clinic [LGBT clinic in the centre of Cape Town], then they refer. Those they can't, it's just to actually keep them [in the public system]. (Clara, interview 13)*

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[13] Thuthuzela Care Centres, or simply TCCs, are primary care-based, comprehensive medico-legal services for survivors of sexual violence. At one visit, survivors receive counselling and medico-legal examinations and are linked to the local police services for further investigation if they wish to report the assault.

In addition, within the health system, not all services that patients have a right to are easily accessible. Within the public sector access to mental healthcare and psychosocial services are extremely limited and constrained by a lack of resources. There is a shortage of social workers, psychologists, and psychiatrists, as well as acute observation and treatment facilities and long-term facilities for people with mental health concerns. Whilst this affects the general population, it is a particular problem for LGBT people for two reasons.

First, as one interviewee raises, LGBT people have higher than average levels of mental ill health and higher than average levels of substance use (01). In the international literature it has been found that compared with their heterosexual, cisgender peers, sexual and gender minority people suffer from more mental health problems, such as substance use (including alcohol, tobacco and illegal drug use), affective disorders (for example, depression and anxiety disorders) and suicide (Logie, 2012; Meyer, 2003; Pega & Veale, 2015). This has been attributed to minority stress – the long-term ever-present stress created by widespread stigma, prejudice, discrimination and structural stigma (social stigma that is institutionalised or codified, such as laws that criminalise consensual same-sex behaviour) (Hatzenbuehler et al., 2014; Hendricks & Testa, 2012; Meyer, 2003). This has also been borne out in recent work in South Africa (and other African countries) funded by COC Netherlands and coordinated by the GHJRU, that found that the levels of depression, anxiety, suicidality and substance use were higher in LGBT population as compared to those reported for the general South African population. Fifty-seven percent of participants were classified as depressed and thirty-four percent reported signs of moderate/severe anxiety. Moreover, LGBT participants had higher prevalence of alcohol drinking (83%) as compared to general South African population (28%) (Alex Müller et al., 2019). Whilst LGBT people may not need specific mental health and substance use rehabilitation services, general services do need to be open and accepting of LGBT people. This is particularly a concern where long term residential services are gender segregated, and often not open to transgender people.

> *And what's like really interesting is that we know that LGBT people have higher than average levels of mental ill health and higher than average levels of substance abuse, and get absolutely no programming devoted to them[...] Yeah, so we did, I had an intern a while ago just on a whim call like 4 of the in-patient private substance abuse facilities where you go for rehab, and to just ask them do you have any counsellors or sessions or anything that specialise, or that can deal with LGBT people? And like got no understanding of anything of what we were talking about.*
> *(John, interview 01)*

Further, historically existing substance use treatment facilities have been established and/or run by religious organisations, particularly churches.

> This is again if you look at how the DSD farms out this work as well, I would be super interested to be, to do a [unclear] request to find out who is getting all of this money and like how many of them are expressly religious organisations, because many of the shelters in the Western Cape are expressly religious organisations and government themselves accordingly, despite getting money from the national government. So yeah, I think what's interesting is about substance abuse and our responses to it, which are very poor for queer people and um...yeah. (John, interview 01)

Whilst not all religions organisations are homophobic, many may not be open to LGBT people, or may be judgmental. Even if they are not, LGBT people may be reluctant to seek services from religious organisations before of past experiences with religious people or organisations, or because of the perceptions that religious organisations are homophobic.

Second, LGBT people are much more likely to struggle with social isolation, familial and social rejection, which can precipitate or exacerbate substance use and mental health problems, but also means that they have few buffers and support structures in times of crisis. One case described by NGO healthcare workers demonstrates how LGBT people might be exposed to significant stressors due to their sexual or gender minority status, and how these then intersect with mental health concerns and their ability to address and manage them. An NGO nurse describes how the social isolation of LGBT people plays out in their interaction with mental health services:

> *I think the difference with LGBT and others is that – and I'm generalising here, I mean there are other straight people that have no family – but the majority of the time the clients that we need to really get involved and help physically to get them into a safe place, is because they have no one else to call on. [...] And I think in that way, that's where the difference is with health services and you know, just trying to keep track of someone [because there is no one else]. I mean the amount of clients that were lost in [hospital name]. We had been told that they've been discharged and they are sitting in the isolation room. I think that's why we end up with clients that we actually have to physically help, you know (Katie, interview 02).*

Even though both Triangle Project and OUT Well-Being provide counselling and support services, interviewees expressed a need for more psychosocial support for LGBT people both within the public and the NGO sector (interviews 09, 11). In the NGO sector there is limited funding for support and counselling services, where donors tend to focus on HIV and sexual health related care.

> *That already says a lot with the fact that where do funders see the whole mental health issues but it needs to be re-prioritized because it is real, and depression is real, and all of these issues create a bigger [problem] and there is bottled inside is going to create a huge stumbling block for the people who we are serving. So I think that mental health should definitely come back to their priority list. (Justice, interview 09)*

Further, whilst there has been considerable emphasis on NGO training and sensitization of those providing primary healthcare services – doctors and nurses – to reduce SOGIE-related stigma and discrimination, such efforts have not typically focused on those providing psychosocial and mental healthcare, including psychiatrists, social workers, counsellors and therapists (interview 01).

NGOs still interface with psychosocial services and providers, but in a much more ad hoc way, outside the scope of their usual funded work, and usually in times of crisis. An NGO nurse for example describes how she and her manager were called to assist a young LGBT person who was experiencing acute psychosis.

> *Nurse: We then took him back […] to his mother who really could not cope with what was going on, so in the meantime I was trying to find services to at least get him onto medication to try and help him through the psychosis. I got recommendations, try [hospital name], there's mental health there, try, oh various places, sent emails, didn't get responses. It was about a week and a half, two weeks that I was trying to find services for this young client. In the meantime, his mother and her partner were having problems and he was kicking them out the house because he wasn't coping with the psychosis*
>
> *Manager: Or the [LGBT] identity.*
>
> *Nurse: Or the identity. So then we got a phone call saying we're now sitting outside in the rain, this is the whole family now. Now we've got the whole family that we've got to try and help. So that's when we moved the family out to the-*
>
> *Manager: At 10 o'clock at night with bags and pots and a two hour drive off.*
>
> *Nurse: The reason we have to get involved is because of the other family issues. So in other words yes, it may not just be because he is searching around his identity and sexuality, but he is now without a home because her partner can't deal with the LGBT issue.*
> *(Katie, interview 02)*

This is a clear example of the intersection of mental illness, familial stress and rejection due to both mental health issues and LGBT identity, relative economic insecurity, and a lack of public services. NGO staff played a crucial role in helping clients access the public system and advocating for their needs within the system, but also responded to familial crises and homelessness. Because much of the work done to support and find adequate treatment for LGBT people with mental health concerns is not directly funded, this kind of response to individual emergencies is undertaken entirely on the initiative of NGO staff.

In most cases, barriers to access to general SRH services in the public system are due to limited availability of specialised knowledge, equipment or facilities. However, in the case of access to abortions this is exacerbated by moral or religious objections, known as conscientious objection, by healthcare providers who refuse to provide, participate in or, in some instance, even refer for abortion services because of personal beliefs (Harries, Cooper, Strebel, & Colvin, 2014; Shanawani, 2016). This is harmful to all people seeking abortions, but especially so for those who become pregnant as a result of assault. Another example provided by the same NGO health worker, about a lesbian woman who was sexually assaulted, is illustrative:

> *Unfortunately, by the time we knew of her rape and we were providing services to her, and then we tested and she was pregnant. And then talking to her around her options of what she could do was extremely difficult because of her culture and her religion. But you know, allowing her to make her own decisions, but in a very emotional state, and also knowing that we had time frames to work with. So we, she didn't want to see a counsellor, but our community empowerment and engagement programme manager and myself saw her on a regular basis and kind of you know, pushed her to make a decision because of the time of termination. So then she then said yes, she would like to terminate. And then we had a problem finding a provider to take her to.*
> *(Katie, interview 02)*

As in this instance, for many survivors, the traumatic experience of sexual assault and the resultant pregnancy, as well as the complex and difficult decision about whether to terminate the pregnancy is then made more challenging by the dearth of available services. Based on the statistics released by the South African National Department of Health, 505 medical facilities are designated to perform terminations of pregnancy in South Africa (South African Government, 2018). Accordingly, 37 facilitates (70% of all governmental facilities) in Gauteng province and 32 public hospitals and 5 clinics (36% of all governmental facilities) in the Western Cape province are providing termination of pregnancy. However, according to a recent investigation by Amnesty International, only 246 health facilities out of the 505 reported facilities are actually providing first and second trimester termination of pregnancy services (Amnesty International, 2017). Participants also highlighted that although access to abortions are limited for everybody, for LGBT people "there is like an additional barrier to just getting it into the facility or treated badly within the facility". (Amina, interview 18)

Access to gender affirming care

In the last several years there has been a greater recognition of transgender and gender non-conforming people and their specific health needs, both globally and in South Africa. However, within South Africa, whilst advocacy efforts have led to an improved awareness and an inclusion of trans issues in wider LGBT organizing and in conversations about access to healthcare, healthcare policy and implementation has not kept up. This is a point made by one NGO staff member who engages with policy makers and does high level advocacy:

> *So, you're dealing with a lot of just like big gaps in knowledge and I think when it comes to especially gender affirming healthcare, I don't think we've seen a leap in the way we deal with gender affirming care, like a health issue. [...] I mean we went from, if you think about the year 2000 where the debate [was], [...] the South African health debate did not include trans people of any description in the year 2000, that queer politics maybe included the odd trans person but didn't see trans people like a collective identity. Like we were not talking about gender identity like we are now, ten years ago, never mind 20 years ago. But I think in many ways we just have a health system that has not been able or hasn't been interested in either keeping up with the changes that they need to be keeping up with. (John, interview 01)*

As there is no national policy or guidelines addressing transgender health and gender affirming care, most healthcare workers are ill-equipped to engage with trans patients in a sensitive and affirming way or to address their health concerns. This NGO staff member continues:

> *So, I do actually have quite a lot of empathy for healthcare staff who are finding themselves in something that they have gotten very little training for, they got like very little context for, and also they are themselves working in a healthcare system that's like crumbling around their ears. No excuse, everyone needs to do better, the whole world changed around you in 20 years, and guess what, you need to unfortunately change with it. (John, interview 01)*

Unsurprisingly then, gender affirming care in the public health system is generally very limited across South Africa, and in the two provinces that we focused on. One DOH programme manager summed up access to gender affirming care in the public system as follows:

> *You get access when you know the people that know the people and it sounds horrible when we say that. It is not a service that markets it openly and you have to belong to some of the in groups in the population. I know for a fact that these academic hospital offers on some of the services, that when you look at PHC level, a primary healthcare level, at a clinic level, that is not offered. It is a specialist service that is at a certain hospital and access is limited. It is difficult to know where to access them. (Faith, interview 17)*

In the Western Cape, only the Gender Clinic at Groote Schuur Hospital provides hormone therapy and gender affirming surgeries, and Triangle Project provides psychosocial support and referral to the hospital. In Gauteng, Steve Biko Academic Hospital in Pretoria provides hormone therapy and surgeries, and in Johannesburg, Baragwanath Hospital provides some surgeries and hormone therapy, and Helen Joseph Hospital provides some surgeries (Spencer et al., 2017). However, with exception of the Gender Clinic at Groote Schuur, even within these institutions, practitioners provide gender affirming care almost exclusively on their own initiative and are usually unsupported by wider structures, such that access to care is dependent on whether a transgender person is fortunate enough to access a sympathetic and knowledgeable healthcare provider.

The Gender Clinic is in very high demand but has very limited capacity for surgeries. It gets four operating theatre slots a year and resultingly has a waiting list of 15-20 years (Bateman, 2011; Spencer et al., 2017). Similarly, Triangle Project has more than 160 current transgender clients and a backlog of about 40 to 50 people waiting to see their counsellor to be referred to the Gender Clinic, or to receive counselling for themselves or family members (interview 02).

Outside of Johannesburg and Cape Town, access to gender affirming care in the public system in each province is even scarcer. However, practitioners may still provide ad hoc care. The Health and Support Services Manager at Triangle Project recalls one rural doctor who was very open and eager to assist a transgender patient, although he had no prior experience with gender affirming care:

> *We've had some really nice things with that too, being open to say "Give me some reading, let me read, let me understand what…", you know, I'm thinking of one particular case that was quite a long time ago, it was in the Northern Cape. Well not that long ago, in the Northern Cape and the doctor was like I want to do this for my patient, I really want to do this for my patient but tell me, I don't know what I have to do. So I send him the guidelines, send him the protocols send them what they have to do as a doctor, let them do it. (Sarah, interview 03)*

Because there are relatively few out transgender people in any given area and trans services and organizing is relatively limited, people often know each other, and information about friendly providers and facilities, or at least those that are not hostile, spreads relatively quickly. For example, one DoH official focused on nursing in the Western Cape, describes that in Cape Town she has become aware that many transgender people outside the city centre access hormones therapy at one specific clinic.

> *I'm specifically speaking around transgender clients and they felt the most comfortable in that facility and that's why for us, it's the people who are…you go…you'll know, in general, we try, we meaning the Department of Health, trying to control where people go for services, but in that case it was the people that decided that is where we are feeling comfortable, no problem with anybody there so that is where we feel that we can access the services the best and on this side of the mountain and so it's just a pattern, so when I start to feel comfortable I tell my friend and that friend and so that's where most of our clients ended up there, so it's just something that we as healthcare, having the service, that's what we are doing and just the nature of people's behaviour actually, led the clients to go there. (Clara, interview 13)*

Whilst this official describes this as a positive development, where one particular clinic has become known for being affirming of trans people, this also means that the other clinics in the area are known to be less friendly or inaccessible. Whilst the openness of particular staff or the facility in general is commendable, it does mean that affirming and accessible services are the exception. Another DoH official, whose area is focused on HIV, points out that this leads to the perspective that those who provide services to minorities or stigmatized groups, including LGBT people and youth, are going above and beyond the scope of their work, that they are "passionate" about that group, when in fact it is the duty of those working within the public health system to provide appropriate and sensitive care to everyone (interview 07).

Nevertheless, most transgender people struggle to make themselves, and their health needs understood (Safer et al., 2016). The result is what the nurse at Triangle Project describes as "phenomenal stories about what people take and where they get them from". She explains that because being transgender or gender non-conformity is not widely understood in the healthcare system, and there is pervasive transphobic social prejudice, people may be reluctant to share their gender identity with healthcare workers for fear of being ridiculed. For this reason, they may seek to start gender affirming hormone therapy themselves, through informal supply mechanisms, in order to transform their appearance toward their desired gender identity, before seeking further assistance.

> *It is difficult for the rural areas, and then I think also where a client's having a problem to disclose, [...] for example somebody that presents extremely masculine, but identifies as female, will maybe not want to go and have a discussion with somebody about how they feel and try and get hormone treatment to start the process of becoming, or looking more female before they actually go forward for those services. So, in other words a masculine person will start taking female hormones so that they get more female, ja because they're scared somebody is going to laugh and say but look at you, you're so masculine, how are you going to be a female? So, they try first to start the hormones. (Katie, interview 02)*

It was also reported that due to limited access, people may share their doctor prescribed hormone pills with friends.

> *Health Manager: [Nurse] just found out by accident with one client phoning her and shouting at her, you know there was a little deficit in [the hormone therapy supply of] both the clients. It is really sweet, so they support one another, you know, provide emotional support to one another, but they can be very demanding. And the one was giving the other all her hormones, so like sharing them.*
>
> *Nurse: And they're dropping them off with me to take it out to Wellington, and then [I had] to try and explain [that] I can't do this. As a nurse I can't give you somebody else's tablets that are prescribed. (Katie, interview 02)*

Whilst a poignant act of solidarity, and demonstrative of the ways that people make do given limited access to care, this also means that both individuals are receiving a sub-optimal dose of the hormone, slowing the gender affirmation process. This also highlights that very little is known about how people cope given limited access to care and what informal and alternative measures they might use to access hormone therapy for example (interview 16).

Lack of services for sexual and gender minority people with uteruses

A significant concern for both organisations, OUT Well-Being and Triangle Project, is that SRH services, and more general health services, are not readily available for lesbian, bisexual and queer (LBQ) women, transmen, gender non-conforming people or anyone else who has a uterus. On the one hand, general SRH services for women available in the public sector are largely not affirming, welcoming, or targeted at lesbian, bisexual, queer and intersex (LBQI) women, let alone transmen and gender non-conforming people who have uteruses. This results in this group lacking health information and experiencing stigma and discrimination when seeking services in the public sector. On the other hand, these groups are not adequately catered for within the health service offerings of the LGBT NGO sector either. This latter point is the focus of this sub-section, as we address negative experiences within the public sector in the next section, including how it pertains to LBQ women and others with uteruses. In this section, we focus specifically on the constraints that OUT Well-Being experiences in providing care to people with uteruses, as Triangle Project has a considerably different model and approach to service provision, and they do address LBQ, transmen and gender non-conforming people's health, including SRH. This is detailed later on. However, Triangle Project is relatively unique, whereas OUT Well-Being's situation is indicative of many LGBT organisations in South Africa, and thus tells us about how LGBT health service provision is gendered in the country, and what the barriers to more equitable access are.

Interviewees at OUT Well-Being are keenly aware that the diversity of LGBT people is not fully accounted for in the services that are available through the organisation. They explain that due to a surge in funding that particularly addressed HIV among 'men who have sex with men' (MSM), gay men and transwomen (although the latter are often subsumed under 'MSM'), HIV-related services make up the lion's share of services in the LGBT sector in general, as one key informant explains:

> *So if you have LGBTI, sometimes people assume it's everything in one and everyone needs the same thing and I think it needs to be unpacked that lesbians have needs, gays have got different needs, transgender have different needs and so forth and I think for me that's where we would note a limitation, because of each population's need would be addressed differently. If you take gay men, I think we've done quite a lot of work to really ensure accessibility and diversity of...and sensitivity of trainings that have been provided over these years and you go across the country, MSM programme is implemented, MSM clinic exists. (Blake, interview 12)*

This funding agenda, whilst responding to an urgent need to address HIV in South Africa, has led to a narrow view of SOGIE-related health needs, one that has largely excluded those whose main sexual and reproductive healthcare needs are not related to penile sex. On the one hand, there are now HIV-related healthcare services for gay men (and, to a certain extent, for transwomen), but on the other hand, this has meant that organisations such as OUT Well-Being now largely provide health services to men only:

> *OUT is an MSM clinic. And while, historically, it [the organisation's mandate] used to be broad, now it's specific to the population they're serving and maybe this could be funding-based.*
>
> *INTERVIEWER: So from your perspective, OUT used to be serving a broader community and now it's more focused on gay men.*
>
> *BLAKE : Ja, right now it's focused on gay men, it's focused on injecting drug users. So which then means you have very little lesbian women who'd go to OUT for health services because their focus is no longer there. It's very little effort that you'd see for trans people going to OUT, so you have minimal ones that would go but ultimately, it's a tailor-made effort. [...] The education, information and messaging, it's also very crucial, so if the package of service and your messages or your education is not focused on whatever LGBTI, or lesbian, or trans, surely you will not attract them into your service, so you will attract those you are servicing, those you are informing, those you are targeting, so that's exactly why I'm saying that with OUT, it's going through that, because one is funding, which then means if your funding is only wanting to focus on MSM, your targeted population would be MSM, your messages would be MSM for the clinic. (Blake, interview 12)*

As a result, even HIV testing and related services are less accessible to LBQ women and others outside of the MSM category. Whilst OUT Well-Being is clear that they do not turn women away, they also do not advertise their services to women:

> *Our clinic is integrated into the public health system, or the network of public health facilities, we cannot really turn a female person/ person with uterus away. Whenever a person comes in, we would offer the services that's available to our key populations, which is MSM. We just do not actively market our services for any other population than MSM. Should a female person come to our clinic, if they request PrEP we would put them on PrEP, and we have a couple of female clients who are on PrEP and who are adhering, we also have a couple of HIV+ clients who are female and we manage their HIV. So we do offer the services but we don't actively market it as such, and as a result that number of persons [women, persons with uteruses] are far in the minority.*
> *(Tim, interview 21)*

The clinic's focus on MSM, according to one NGO worker, might mean that LBQ women and transmen prefer to access healthcare services in the public system, where they often conceal their minority status to avoid discrimination:

> *If you try and look for let's say HIV HCT services specifically sensitized for lesbian, bisexual and queer women, you would have to access it in services that are funded for gay men and MSM men and that comes through, it's either that or you have to go through to a public health facility to do the screening test that they do. One of our clients came through and said that the way that I am going to work through it is that, I don't even declare [that I am a lesbian woman], I just let them assume whatever, so while the person is doing the screening tests this person would say: "So are you heterosexual, are you having sex with men?" "Yes, yes, yes" and everything in order to not to divulge [her sexual orientation] and in order not to be discriminated against. So they refuse to declare their sexual orientation or their sexual practices. (Justice, interview 09)*

This participant, however, was very clear that OUT Well-Being does not turn anyone away from services, but instead provide services to LBQ women at additional financial cost to the organisation, as these services are not covered by project funding:

> *So they have to comes through to us and when they come through, first things first, we don't deprive them of the service we definitely don't, but each and every test kit that is used, each and every blood sample that is sent through to the pathologist is directly paid by OUT because the funder does not fund any women's health or HCT services or anything like that, so that is number one. (Justice, interview 09)*

This conflicts with the mandate of the organisation, and their strategy as determined by project goals and funding priorities, as services to women, including HIV-testing, does not “count”:

> *I feel so demotivated when a lesbian woman asks me, “So can I come through to your clinic? I am just going to do testing.”, and we are like, “Yes you can.” But deep in your heart you know that firstly those stats are not going to be submitted, they are not going to be accepted even within… For example, if we have a lesbian bisexual queer women event, we can’t ask our team to come through and facilitate the testing, because that day will be a complete wasted day. The stats are not going to count. So already your genitals they do determine whether you are entitled to the service or not. (Justice, interview 09)*

The lack of HIV-testing services for women, transmen and others who do not identify as MSM, is also reflected in the lack of barrier methods for anyone who is not only having penile sex:

> *When it comes to barrier methods [it is challenging] just in general, to get dental dams, finger cots stuff like that, like the simplest things. The fact that there is no risk attached to LBQ sexual activities does not mean that they cannot contract anything. They still can contract STIs. There’s so many things that they will be able to contract and that is completely neglected because it is not attached to the whole HIV risk and all of that. So dental dams are a mission, the DoH supplied us with dental dams in 2016, and they didn’t provide us with any further than that, so we basically had to give people two dental dams each because we only received a box of five thousand and that was it. There was no further initiative […] so this is completed, we need more of this. But with the condoms it comes even without the orders, so you can show the level of inequality within that. (Justice, interview 09)*

Whilst people not having sex with men, including LBQ women, are at a lesser risk for HIV transmission, as the interviewees states, there is still some risk, and of course the risk for other STIs remains. In addition, as OUT Well-Being staff members highlight, LBQ women, transmen and others with uteruses, are in need of a much wider range of services, including related to menstruation, pregnancy, contraception, STI-prevention and cancer-screening:

> *So if then for us as LGBTI persons, we’ve got many lesbian women who, either fall pregnant or who you know, are exposed to transactional sex and so forth. And we need to take that into consideration, we’ve got many of the transgender men who biologically would still be female, so depending on the kind of relationships that they’re part of, so if a trans man is in a relationship with another man, and so forth, so all of this speaks to pregnancy you know, and […]about menstruation and […] addressing the issue of sanitary towels for people who menstruate.(Blake, interview 12)*
>
> *JUSTICE: Last year we in our last safe space for the year, we decided to have like a feedback session […] And the one thing that was identified was the need for pap smears free of charge and mammograms, which is services that they do provide in public health [facilities], but you have to go through the gruesome channel of discrimination […]. So the need for free pap smears and mammograms, the need for assistance, even if it is guidance for women who would like to go for assisted reproductive services, for women who want to do in vitro, artificial insemination, for women who would like to adopt, so simple things that are specific to LBQ women and not in a sense of like being like the general population of women but specifically related to our challenges and our circumstances. (Justice, interview 09)*

One interviewee felt that the lack of NGO services for people with uteruses, means that they, unlike gay and other men who have sex with men, have no alternative to the public health system, where their needs are not understood and where discrimination is prevalent. The next section addresses such negative experiences in public health services. Thus, she felt a great sense of demotivation and disappointment as a result, saying: “I think that it is a sign that we are sort of failing a part of our community” (Justice, interview 09).

By contrast, Triangle Project does provide services to people with uteruses, including primary care, HIV and STI testing, nutritional support, and they also facilitate cervical cancer screenings by a public nurse at the Triangle clinic. This is detailed further in the following part of this report, Part 2, that addresses the services provided by each organisation, and also in Case Study 2. Triangle Project is able to do this by being very careful about their funding choices, and their relationships with like-minded donors has been central to the ongoing provision of care beyond exclusively MSM and HIV services. This detailed in Part 3.

Heteronormativity and negative experiences of LGBT people in public healthcare

The existing literature on LGBT health and access to healthcare in South Africa documents that LGBT people experience considerable negative attitudes, judgment and discrimination in the public healthcare system (Meer & Müller, 2017; Alex Müller et al., 2019).

In order to gauge perceptions of accessibility of healthcare services, survey participants were asked "How fairly do you think LGBTI people are treated at healthcare facilities?". In response, 24% of people answered that "LGBTI people are treated as fairly as everyone else", 60% answered that "LGBTI people are sometimes treated as fairly as everyone else" and 15% said that "LGBTI people are never treated as fairly as everyone else". That is, less than a quarter of respondents felt that LGBT people are given the same treatment as the general population in health facilities, but the majority of participants felt that this differed from time to time, which could be a reflection of the role of discretion and the dependence of care on individual providers attitude toward LGBT people (Butler et al., 2016; Meer & Müller, 2017). The graph below demonstrates perceptions of fair treatment at different places.

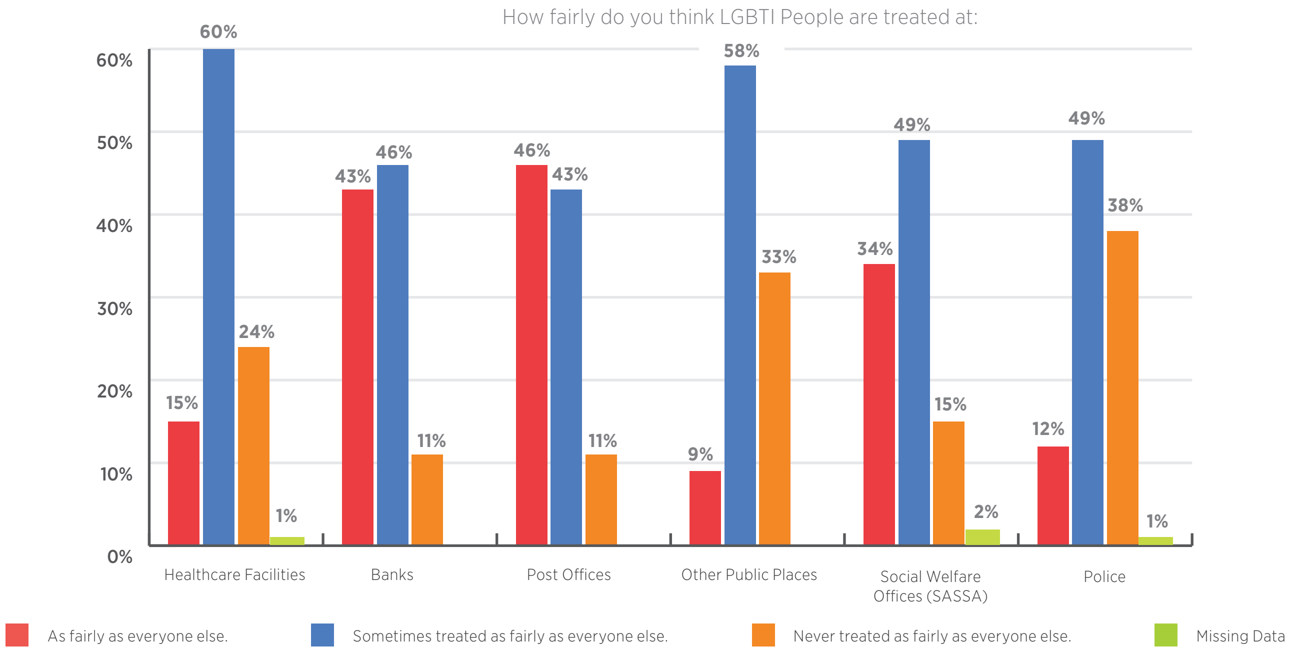

Figure 3: Perceptions of fair treatment by place

Compared to healthcare facilities, banks, post offices, social welfare and other public spaces, the largest number of participants responded that "LGBTI people are never treated as fairly as everyone else" by the police, and, after other public spaces, this was also where the fewest answered that "LGBTI people are always treated as fairly as everyone else". This low confidence in police resonates with the wider literature (Dario, Fradella, Verhagen, & Parry, 2019; Miles-Johnson, 2013). Similarly, one DoH official asserts that the Department of Health can only go so far in enforcing the rights of LGBT patients, if police are antagonistic toward LGBT people (and sex workers), as police officers are also important points of contact (interview 07), such as in the case of sexual assault and biased-motivated violence.

Whilst we did not expressly enquire in key informant interviews about negative experiences or discrimination, as this was not the focus of this research, interviewees frequently raised the problem of pervasive heteronormativity and stigma experienced by LGBT people as a barrier to accessing public healthcare. Poor treatment at healthcare facilities remains a significant concern for LGBT people. As one former NGO programme manager points out, for a lot of LGBT people this "starts at the gate". He expands with an example of a trans person going to a clinic:

> *Because they're waiting to see the nurse, so by the time they get to see the nurse, they've come across around two or three people who might have discriminated against them. It could the security guard at the gate. It could be while they were sitting down. It could be one of the people who, like the receptionist for instance... (Carl, interview 06)*

Discriminatory behaviour from those who work at the front end of healthcare facilities such as security guards and administrators might discourage LGBT people from waiting to see a healthcare professional, or from returning. These staff members do much to shape the space of the healthcare facility as welcoming and open, or as exclusively heteronormative and exclusionary for LGBT people (Meer & Müller, 2017).

When it comes to consultation with healthcare workers often LGBT people do not fare much better, and many practitioners lack knowledge, or are unwelcoming, hostile or invasive when providing care to LGBT people. Although not discrimination per se, pervasive heteronormativity in the healthcare system, which considers heterosexuality as the norm and a privileged standard (Gunn, 2011) often makes it very uncomfortable for LGBT people in healthcare settings. Heteronormativity is often not intentional, and healthcare workers simply default to addressing all patients as though they are heterosexual or cisgender (interview 18). As one NGO manager points out, much of the casual stigma and hostility that LGBT people face in the healthcare system are "microaggressions" (01), small actions that serve to remind someone that they are unwelcome or disliked. Whilst this may seem harmless, this may in fact make LGBT feel unable to identify themselves as such and share their specific health concern, particularly where it is related to SRH.

> *The terminology is most of the time, that's where the problem begins. Because as they start questioning or asking, just to probe, to find out why is the client there or what is happening, the manner that they'll be phrasing the questions are actually the reason why clients end up not saying why they are at that certain institution. Because once one starts asking: "And then you said you are here because you've got a sexual related problem, where is your girlfriend?" for instance, or "Where is your wife? You have to bring them with". So then from just the kind of questions that were phrased to certain individuals, then they would decide no I can't actually continue saying that now I've got anal warts but if I say anal warts then it might start raising certain issues you know... .*
> *(Beth, interview 11)*

Poor attitudes, limited information and prejudice pervades all levels and kinds of care and is not restricted to SRH care. To make this point, one NGO staff member gives the example that "We're not [just] talking about lesbians going for a Pap smear and having difficult questions, we're talking about lesbians going for a flu jab and having difficult questions. [Being asked questions like] 'Where's your husband?'" (John, interview 01).

Another example of pervasive heteronormativity is the dismissal of individual's sexuality, and choices about their sexual and reproductive lives, when it is disclosed:

> *We have to literally save up and then you get to a doctor who is semi-sensitized and you communicate these challenges and the first answer that comes out of their mouth is: "Why don't you just have sex with a man, it is cheaper and you get what you want." So maybe you can see that, ja and it is not one doctor, it is not two doctors, we have heard it from several, and it's so defeating, on and on you have to sort of explain yourself, "No, I do not want this because it is not what I want', and then it is received with a the response of, "Actually, you don't know what you want because God created this method [heterosexual sex] so that's the easiest way, just use it and forget your sexual orientation for two seconds." So it is very defeating, very demotivating the fact there is no equality in this sense and those are the questions that I, I find within my safe spaces.*
> *(Justice, interview 09)*

In this instance, a dismissal of a patient's reproductive choices combines with religious beliefs – that "God created this method... just use it". The role of religion is a significant one for many providers and was repeatedly raised by interviewees as a barrier to access for LGBT people (interview 11).

Judgmental and stigmatising attitudes often combine with a lack of healthcare provider knowledge. One NGO staff member observes that when LBQ women seek cervical screenings for cancer, they are "asked fifty-seven questions and being asked 'Why do you need these services if you are having sex only with a woman?' " (interview 09). In addition to the invasive and inquisitorial attitude that is a hallmark of LGBT discrimination in healthcare (Müller, 2017, 2018), this points to a misunderstanding among healthcare providers about risk for cervical cancer and sexual activity/sexual orientation. This is related to heteronormative attitudes which only see male-female penetrative intercourse as sex, and thus as the only possible exposure to HPV, the main risk factor for cervical cancer.

Because heteronormativity means that many healthcare workers do not acknowledge any other way of identifying or practicing sexuality than heterosexuality, it also creates an environment where people *expect* judgment, rejection or even punishment because they do not fit this norm (de Vos & Naudé, 2010). Key informants explain that within the healthcare system, coming out is a risk for LGBT people, and individuals are also often afraid of being outed, or having their personal information shared by healthcare providers at their local clinics:

> TIM: *It was provided by government, but LGBTI people preferred a service where they know that they will not be judged, where uncomfortable questions won't be asked, where they will not be stigmatised. Where they know they will be safe if they enter the premises, they know that it is safe for them to enter and do so, and it is also confidential. So in other words, as opposed to a government clinic where it's usually in the community where the people live, whenever people see them walking in by the gates, people would know what is happening, and often the government facilities are, um, or employ, nurses that live in the community. And LGBTI people would then be very scared or hesitant to disclose any personal information for fear that, that very person is also living in the same community where they live, might disclose or accidently disclose some personal information of theirs. And it was not only a fear, it was something that really happened, and it even happens today, so the reason for the existence of our clinic was because of that. (Tim, interview 05)*
>
> CARL: *So what I will find is that a lot of the LGBTI people, it was very difficult for them to go to their local clinic. They would rather go to a clinic where nobody knows them. So, for instance one – that person who lives in Mamelodi, will rather not go to Mamelodi clinic, but go to another clinic of another township. Because they are not known or because usually, they won't be outed. So, then the issue becomes now, where – now in terms of administrative things, you cannot really do that, because the get to the clinic – when you go up there, they want your proof of residence, where are you. Exactly, so that didn't exactly work. Now I found out that the actual issue was the fact that if those people are, it is double the stigma, being gay is a stigma and also having an illness, it's a stigma. So, now how do we make sure that a person can go to a clinic and not be outed for their, whatever their ailment is, and also their sexuality. (Carl, interview 06)*

Whilst interviewees knew of cases where providers breached their own professional and ethical obligations by breaching patient confidentiality, in small communities, where people know each other, and gossip spreads easily, and where LGBT people are stigmatized, individuals may be discouraged from seeking services for fear of being outed or spoken about, even if it has not or may not happen. Such fear of seeking healthcare in ones' own community has been recorded in the literature. In eSwatini, a recent study conducted among 20 HIV-positive MSM found that HIV-positive MSM were more likely to travel to more distant clinics in order to avoid stigma from their close communities (Kennedy et al., 2013).

Worse still, due to fear of mistreatment, some people may delay seeking care for as long as possible, to their detriment of their health:

> *If you don't have private medical health, you will be forced to get into a government clinic and ask for a pap smear and then while they are doing that pap smear you will be forced to take in that discrimination because you don't want to be mistreated further so if you declare you will take in the discrimination if you don't declare you will be assumed to be heterosexual and they will give you the service and you will walk out of there and reclaim your sexual orientation reclaim your identity and move on and that is generally how people are doing it and I think that it is a sign that we sort of failing a part of our community. (Sarah, interview 03)*
>
> *So also from that, one then doesn't see or feel the need to continue [...] well then they just feel like no, they'd rather go to a private institution. If then they can't afford, then they rather stay until such time as they're okay, or it has complicated to such an extent that they can't just go on with just not going to see a clinician anymore. (Beth, interview 11)*

International research confirms that people who identify as LGBT are more likely to delay seeking healthcare, which can lead to poorer response to treatment and thus worse health outcomes (Quinn et al., 2015). This may be especially true for transgender and gender non-conforming people, who may be less able to pass (disguise their minority identity) and thus who bear the brunt of hostility in public spaces, including healthcare facilities (Meer & Müller, 2017). Even as social discourse around LGBT people has evolved, and some healthcare workers are familiar and accommodating of sexual minorities, trans and gender non-conforming people are still the least understood (Lambda Legal, 2009), as described by one NGO worker:

> *So, of course a lot of trans people don’t even – they don’t even access these spaces at all, because to start with they don’t have to only deal with their, either their sexual orientation or whatever, but they have to deal also with their gender identity and now being cross-questioned “Exactly what are you?” You know, whereas for gay men the issues may not be as intense as of a trans woman. So, for a lot of trans people, for them to access services is even more difficult. (Carl, interview 06)*

This is worrying as transgender people are also those among LGBT people most at risk for violence and ill-health. In fact, the quantitative findings of this report reveal that 28% of transwoman in our sample disclosed that they were living with HIV. This the highest among our sample, with 12% of lesbian women, 25% of gay men, 19 % of bisexual people, and 0 transmen identifying as living with HIV. However, it is quite possible that this discrepancy is also a large result of these groups electing not to disclose, as evidenced by the graph below.

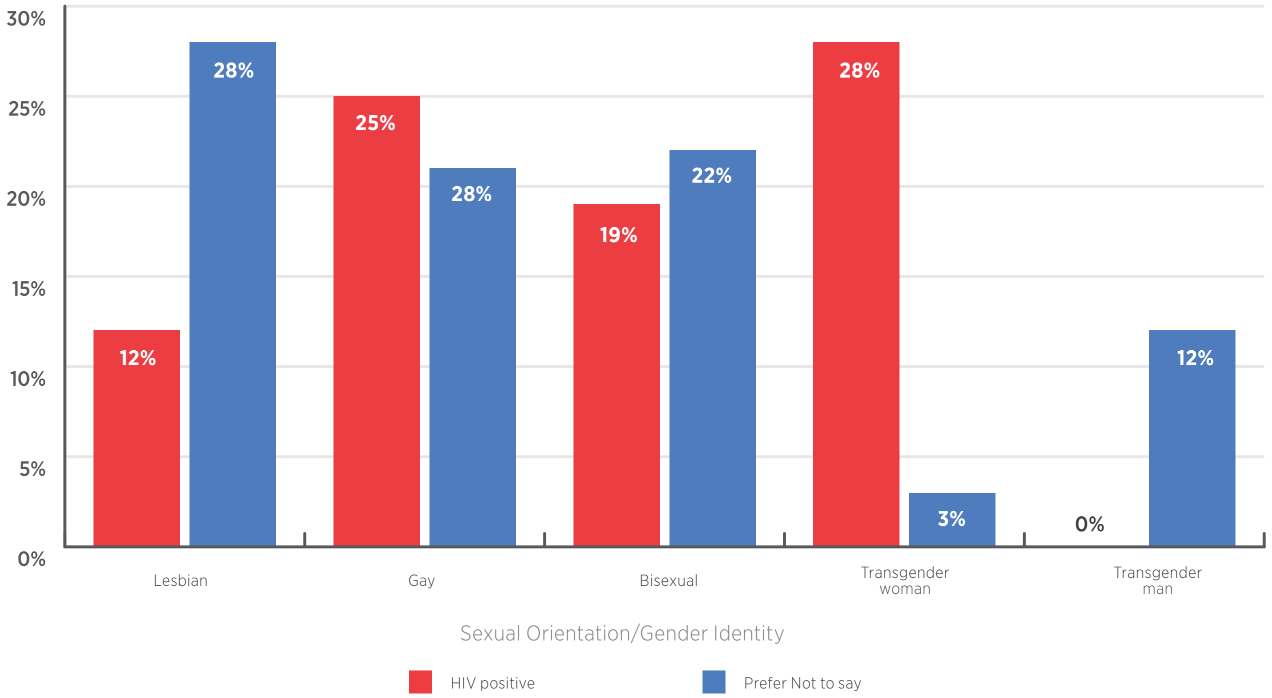

Figure 4: HIV Status by Sexual Orientation and Gender Identity

A sixth-year medical student observes that often discriminatory attitudes are couched as humour. She said that during her clinical rotations she often observed doctors making jokes about LGBT people and the need to be sensitive and appropriate in addressing them. She noted that instead of simply using the appropriate language or term, doctors might instead say

> *‘Oh, I can’t say that, right?’, but you know being in a very kind of obvious way, like ‘this is ridiculous that I am having to now inconvenience myself by this [person or by using new terminology]’ (Amina, interview 18).*

On the one hand, it is possible that these doctors were trying to overcome their own discomfort in a situation and their relative lack of knowledge about LGBT people and health by making jokes, but on the other, this could simply be a veiled expression of homophobia. Whatever the case, it is unacceptable and not in accordance with professional, patient-focused, non-discriminatory care.

The issue of healthcare practitioners’ discomfort engaging with LGBT people came up in other interviews. A registered nurse who works for the Western Cape DoH, described how South African practitioners, and perhaps society in general, struggle with a general uneasiness and reluctance when it comes to talking about sexuality that affects everyone, especially LGBT people, but also youth. He explains:

> *I am aware that while the services are supposed to be available, [but] it's not easy to request services when staff have their own ideas and perceptions on LGBTI groups. [...] I think that my colleagues are really challenged to speak to, say for instance the young women, young girls, because the colleagues whom I work with, they are older women and they are sometimes conservative, very conservative and many times religious, so I will admit that they struggle to speak to young girls and they are not open to the needs and I will also admit that it's even more difficult to have a person from the LGBTI group in front of them and trying address reproductive or family planning issues. (Jacques, interview 14)*

Similarly, another DoH official notes that when youth and LGBT status intersect, prejudicial attitudes, or fear thereof, can be an especially high barrier to healthcare, and accounts for why few LGBT youth frequent the facilities that she is responsible for:

> *But my question is: "Are we accommodating the young lesbians and gays?" Do you understand. We are not, because they are not coming. We are only concentrating on this boy and this girl that come in and say "Sister, I would like to have PrEP" and then we test them and if they're negative and we give them, but yet we are having gay youngsters that are having unprotected sex, that have burst condoms, but we are not giving them PrEP. (Clara, interview 13)*

Another, senior, Western Cape DOH official describes how the taboo on speaking about sexuality plays out in healthcare facilities, where healthcare workers personal beliefs hinder their ability to carry out their professional obligations:

> *The challenge is how do you get your providers to act in such a way that talking about sexuality is not taboo, because that's the current method doing the rounds. In some cultures, you're not – you're not allowed, really? So, it's getting people to sort of like make that shift, because the questions are simple. It's not a complex exercise. I mean you ask a simple question that you ask everybody, and you will get to where you want to get, but it's me who decides no I can't. And of course, [LGBT people] will respond in kind. No, I can't discuss my sexual life with that woman. You know, "she is old enough to be my daughter, or I'm old enough to be her father", but that is stuff we're bringing in in order to explain why we're not doing things, but I mean if you follow what the policy says, then we should be there. We might need some professional courses in service training as you can remember. Not everybody is a boy, not everybody is a girl as you think, so that's going to have to come in, because I think the language approach and this world view has been bad to the point where people think it's normal to exclude other people. (Gcobani, interview 07)*

This official expands this point, asserting that because these personal world views have such a strong impact on health professional's conduct, they may see healthcare work that clashes with it as optional, that they may elect not to do. As a result, those that do provide open, accessible and friendly care to stigmatized groups like LGBT people and youth are seen as the exception, as those who have chosen to take this work on:

> *I don't think we are at a point where the staff out there feels comfortable, or put differently, are made to feel that's actually part of their work, it's not optional. I mean there's a word used in the department, "so and so is passionate about the youth." It's like, no, you're paid to service the youth! So, that's a thing that we need to change in the department, that actually – yes it can be passionate, but actually remember you're paid every month to do work, this work.*
> *(Gcobani, interview 07)*

However, his colleague, also a policymaker in the DoH, has a conflicting view, saying that it was ok if healthcare workers did not want to treat LGBT people themselves, all they had to do was provide a referral to a service that would:

> *CLARA: So that they can also know to refer and if they do know somebody that they cannot deal with, that they shouldn't just show them out the door, they must refer them appropriately and as you make healthcare providers to say it's okay if you feel that it's against your religion or the Bible says a man is not supposed to be a man, it's okay. But the bottom line is you need to refer appropriately on top of that.*

> *INTERVIEWER: Okay, so you're saying like for example if a lesbian woman comes for health service and the healthcare provider doesn't feel, you know they feel it's against their religion to help serve that person that they should rather to refer them?*
>
> *CLARA: Yes. As I said they would refer them, they would have to refer them either to the Ivan Toms Clinic or refer them to the Triangle Project or another healthcare provider that would be comfortable to deal with them. (Clara, interview 13)*

The idea that LGBT people can be turned away within the general healthcare system, and that healthcare professionals who "cannot deal with" specific groups should refer them, is extremely troubling, especially coming from a DoH official. This key informant echoes the language of conscientious objection to abortion, which itself has been shown to hinder access to care for people with uteruses (Harries et al., 2014). Even so, conscientious objection to termination of pregnancy is not equitable to refusing care to LGBT people. Contentious objection to providing abortions is the refusal to performing a specific procedure, whereas not "dealing with" LGBT people, even if referrals are provided, is a refusal to provide care to an entire group of people based on their sexual orientation and gender identity. Section 9 of the South African Constitution is clear that such exclusion based on identity constitutes discrimination and is thus illegal.

Further, given the barriers to access created by socio-economic hardship, as detailed in the previous section, refusing care to someone who has come to a healthcare facility, and referring them to another service, elsewhere, may in fact be tantamount to barring their access to care. People often simply do not have the means to make another journey to a different service, which may be located even further away. Ironically, this same DoH official seemed to be aware of this, and indeed was sympathetic. However, her solution was to have a "one-stop-shop" public facility for LGBT people:

> *Because remember, as much as we can refer [...], the Ivan Toms [Centre for Men's Health] have moved now to Green Point and Triangle [Project], it's in town. So you see the LGBTI communities also have these, they also don't have money and so on. So sometimes it's not very practical to be sending somebody to a place where they don't even have bus to and that is why our main goal is to try to at least have one particular, one or two people in a facility that could be sensitised and be able to deal, because there is several things that we can even do better with at our healthcare facilities, because we have doctors, we have a team that we can refer to as opposed to maybe Triangle will deal with the emotional factor, we must not still refer if it starts something expensive. [...] That's why I'm saying it's not everybody, those that can afford to can take a bus there or get themselves to Green Point at the um Ivan Thoms clinic, then they refer. Those they can't, it's just to actually keep them. [...] Like I would say, we have a one-stop shop for everybody within the health system, you should also have a one-stop shop for them. When there's a flu, they should come, when there's STI, they should come, when they have a mental problem, they should come to us because that's why we are saying one-stop shop and that's why I'm excited about the guidelines. Because the guidelines are including them within the one-stop shop. (Clara, interview 13)*

The idea of the "one-stop-shop" does not address the full complexity of access to healthcare. LGBT people struggle with access not only due to heteronormativity and discrimination, which a specialised sensitised one-stop-shop service would address, but also access based on distance and financial situation, as we have detailed in the previous section. The notion of a one-stop-shop stems from the Thuthuzela Care Centre model: specialised centres for sexual assault survivors that provide care at the intersection of health, justice, and psychosocial care. However, sexual assault survivors need very specialized services, including medico-legal services, such as doctors who know how to take forensic evidence from a survivor and fill out evidence forms, often under severe time constraints. By contrast, most often LGBT people need basic primary care services, which is what Triangle Project or the Ivan Toms clinic that the key informant refers to, provides. These are not in fact specialised services and should be fully within the ambit of the knowledge and skills of any primary care provider at a public health facility. One the one hand, creating a service specifically for LGBT people that addresses the full gamut of health concerns and may enable safe, non-discriminatory services is obviously beneficial for those who can access the clinic. On the other, this will do nothing for the many more who will not be able to access this specialised service, and who will have to rely on their local clinics. Worse still, the promotion of a specialised LGBT service may entrench the idea that this is a special population that doesn't have to have access to general care within the wider system, when in fact the public health system should be affirming, welcoming and accessible to everyone.

Finally, it is worth noting that because of the casual and pervasive nature of heteronormativity and its myriad microaggressions, it may be especially difficult for LGBT people to express their concerns and make them understood within the complaints mechanisms of the public health sector. As one NGO manager puts it, given the seriousness of allegations against the public health system, “whilst LGBTI affirming healthcare is an issue in and of itself and a public health issue, it becomes more difficult within a context of a largely failing public health system” (01) to make these issues understood as worthwhile and urgent. Our data support this opinion: one in four (23%) of survey respondents would not file a complaint about discriminatory treatment at a health facility. Of those, 60% said that they did not think it would make any difference, and 24% were afraid they would face negative repercussions when seeking healthcare in the future.

Findings Part 2: The multiple roles of LGBT NGOs

In the previous part, we have outlined the context in which LGBT people in South Africa seek healthcare – as we have shown, the South African public healthcare system, which most people use, is overburdened and under-resourced and does not offer all services needed by LGBT people. Further, prejudice and stigma related to sexual orientation and gender identity result in significant barriers to access to care for LGBT people.

In this following section, we analyse the role of LGBT NGOs in this context. By example of two NGOs, OUT Well-Being and Triangle Project, we show that LGBT NGOs play five distinct roles in improving access to sexual and reproductive health (SRH) services for LGBT people in South Africa:

First, they provide certain SRH services themselves, tailormade for LGBT people and free of SOGIE-related discrimination. Second, they facilitate linkage to existing public health services. Third, they hold public and private health services accountable, and facilitate access to public health services for LGBT people – by, for example, accompanying LGBT people to public health facilities and making sure they are treated without SOGIE-related discrimination. Fourth, they educate and train healthcare providers to reduce SOGIE-related discrimination – this is mostly done ad hoc, and in facilities that have been identified by LGBT healthcare users as problematic. Fifth and last, LGBT NGOs participate in health policy development, for example in the public participation process around South Africa's National Health Insurance Bill.

We complement our analysis by three case studies, which highlight different examples of how LGBT community organisations have influenced SRH service provision and policy. These case studies illustrate three distinct approaches to engaging with government health services and bringing the needs and lived realities of LGBT people into conversations around and the provision of SRH. Case study 1 traces how OUT Well-Being built relationships with the Gauteng Department of Health by providing sensitisation training and expertise related to LGBT health, and how this culminated in a collaboration with government to open a primary care clinic with dedicated services for key populations at OUT Well-Being's office. Case Study 2 relates how Triangle Project partnered with a healthcare provider from a government facility to provide cervical cancer screenings at the organisation's office, thus offering an inclusive and affirming service without incurring further costs to the organisation. Case study 3 highlights how Triangle Project ensured that their constituents – LGBT persons from various regions of Cape Town – could meaningfully contribute to the public consultation process around a new health policy, the National Health Insurance.

The roles we outline here are not exhaustive and are not the only ones that NGOs perform. These rather reflect the NGO functions that came through strongly in our research in relation to SRH care. It is important to bear in mind that because NGOs often respond to the emerging everyday needs of their constituents, what they actually do can be more wide ranging than the roles and responsibilities outlined in their mandates, defined in their funding agreements and captured by research such as ours. In line with the goals of this report, the roles that we have identified here clearly show the many ways in which LGBT NGOs ensure that the sexual and reproductive healthcare needs of LGBT people are included in healthcare service provision, health advocacy and health policy. This obviously varies in degree from organisation to organisation, and there is certainly a difference between the two organisations that we focus on, as will be borne out throughout this report.

Role 1: Direct healthcare provision

In the previous section, we have shown that a significant amount of LGBT people have experienced sexual orientation or gender identity and expression (SOGIE)-related discrimination or stigma in public or private health facilities. As a result of this, many respondents said that they had delayed access to care.

Both OUT Well-Being and Triangle project provide health services at their organisations. According to OUT Well-Being, this is because of "inadequate mainstream service provision"[14], and because "[m]ainstream service providers very rarely provide appropriate services (such as targeted HIV messaging), are unable to provide relevant LGBT materials to their LGBT clients, and often their policies do not include the interests of LGBT people".[1] Both organisations have a long history of providing health and support services to LGBT people. Both organisations provide services at their organizational office, as well as through community outreach workers.

LGBT people can access health services at these organisations free of charge and without a referral. At times, LGBT people are referred by healthcare providers in public health facilities, who either do not want, or recognize that they cannot provide specific services that LGBT people need. For example, one interviewee, who works at the Provincial Government of Health in the Western Cape, explains that:

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[14] OUT website: https://www.out.org.za/index.php/about-out/vision-and-mission (accessed 28 October 2019).

> *Before, I used to actually cut the glove and give it to the lesbian people that would come to me [ie. make a dental dam out of a glove], but [now], I would actually refer them to [the NGO]. Even [for] the condoms that we don't have [condoms for anal sex], because the Department of Health only has the normal male and female condoms which not everybody can actually use. And some of the staff members also that know that I am involved with the LGBTI community and they feel comfortable to speak to me, I also refer them to Triangle [to learn more about SOGIE and health]. (Clara, interview 13).*

Both OUT Well-Being and Triangle Project thus perform an important role within the public health system, even if they are not an official primary health facility. This role is recognised by the provincial Departments of Health in Gauteng and the Western Cape, where the organisations operate, who provide some funding (in different forms for each of the organisation) to support their health service delivery.

Healthcare provision at OUT Well-Being

OUT Well-Being started to provide health services in 1994. Its initial service was a telephonic counselling and information line. In 1997, the organization began to offer HIV-related information and advice. In 2004, the organization officially registered as a non-profit organization with the Department of Social Development. In 2006, OUT Well-Being institutionalized its sexual health services by opening a sexual health clinic based at the organization, which is staffed by registered nurses. Additionally, the organization worked with universities and other organisations on research related to the health and well-being of LGBT people (Wells & Polders, 2006).

In 2010, the organization began to offer so-called peer education, a “strategically planned, high- quality informal method of education whereby specially trained and motivated young people provide on-going information and support to their peers in order to change negative peer norms and develop the motivation and skills to make informed choices and adopt health-promoting behaviour.”[15] The peer education programme was funded the South African National Department of Health (NDoH). It was linked to a primary care clinic based at the organization, to which peer educators could refer people. The clinic was staffed by a full-time nurse and provided voluntary counselling and testing (VCT) for HIV, as well as HIV management: blood tests for CD4 count and viral load count. However, the clinic could not dispense medication, and patients who needed antiretroviral treatment were referred to private health facilities in the area, where they had to purchase antiretroviral medication.

OUT Well-Being's health services expanded in 2015, due to a unique collaboration with the South African Department of Health, and a new grant by an international funder for HIV care and treatment. Through the collaboration with the Department of Health, the clinic based at the organization became the first LGBT-specific health facility that has been integrated into the South African public health system. It focuses on sexual health, and specifically on men who have sex with men and other key populations (transgender people and people who inject drugs). Its services currently entail the HIV- and STI-related services offered previously, but now also encompass treatment for HIV and STIs, which patients can access for free.

OUT Well-Being's expanded mobile sexual health services provide the same services as the clinic in the catchment areas of the organization, the wider Pretoria/ Tshwane region. Staffed by community members who are trained as peer educators and lay counsellors, together with a registered nurse, the mobile clinic has a dispensing license and provides basic primary healthcare related to HIV, STIs and TB. The outreach services are a key part of the overall health services offered by OUT, by providing direct healthcare in remote places, and by at the same time spreading information about the clinic-based services that are available at OUT's offices:

> *We almost had this idea that people are just going to be rushing in picking up services, you know, and it was not quite like that. It also needed that – people also need to be told about those services. So, how do we reach them, how do we get them to that access them, you know? So, we had to now depend on peer educators for instance, they were sort of the awareness around those issues, around the services that are available now for LGBTI people (Carl, interview 06).*

Beyond healthcare, in 2013, the organization broadened its focus beyond sexual health and healthcare and started a programme focused on violence against people based on their sexual orientation and/or gender identity. This so-called ‘Hate Crimes Programme’ combined research and advocacy related to SOGIE-motivated crimes and violence with direct service provision in the form of a legal clinic at the organization.

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[15] OUT Wellbeing (not dated). Lessons Learned: OUT's Peer Education Programme for MSM/ LGBT's in Tshwane, Pretoria. Amsterdam: COC Netherlands. Available at: http://lessons-learned.wikispaces.com/English (accessed 31 October 2018).

Overall, the survey findings show that OUT's health services, both mobile and clinic-based, are well used by the LGBT people that were interviewed through the organization. Table 3 shows a detailed list of all health services provided at OUT.[16]

Table 3: Health services provided by OUT LGBT Wellbeing

OUT Well-Being, Pretoria	
Psychosocial support services	Face to face counselling session, by appointment
	Online counselling through two websites (one for men and one for women)
	Telephonic counselling a hotline during office hours
Clinic-based services (*Ten81 Clinic* at organization)	HIV Counselling and Testing (HCT)
	Provision of Pre-Exposure Prophylaxis (PrEP)
	Sexually Transmitted Infection (STI) screening and basic treatment
	Tuberculosis (TB) screening and referral
	Provision of Post-Exposure Prophylaxis (PEP)
	Anti-Retroviral Treatment (ART)
	HIV management (CD4 and viral load)
	Basic wound care and clean needles and syringes
	General medical, sexual health and safer sex consultations
	Individual and couples counselling
	Condoms and lubrication
Mobile clinic	HIV Counselling and Testing (HCT)
	Provision of Pre-Exposure Prophylaxis (PrEP)
	Sexually Transmitted Infection (STI) screening and basic treatment
	Provision of Post-Exposure Prophylaxis (PEP)
	Tuberculosis (TB) screening and referral
	Anti-Retroviral Treatment (ART) initiation
	HIV management (CD4 and viral load)
	Basic wound care and clean needles and syringes
	General medical, sexual health and safer sex consultations
	Individual and couples counselling
	Condoms and lubrication
Sexual health information and barrier methods	Peer education programme with information on HIV and STIs, run by men and women in constituent communities
	Barrier method distribution service to various venues
Training for healthcare providers	Sensitisation/ values clarification upon request

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[16] Based on information provided by OUT (https://www.out.org.za/index.php/about-out/programmes/health-wellbeing, accessed 28 October 2019).

In the survey, almost one in three people who answered the survey through OUT said that they had sought health services at an LGBT NGO in the past year (30%; see Table 4). Whilst we do not know for sure, we can assume that the majority of those sought services at OUT, which is the only LGBT organization that provides health services in the catchment area of the survey in Gauteng. Outreach workers, through OUT's peer education model, played a key part in linking LGBT people to healthcare: one in three people (32%) said that they had received HIV counselling, testing or treatment through an outreach worker in the past year, and two in five (41%) had received health-related information from an outreach worker.

Table 4: Outreach and health services use at OUT

OUT LGBT Wellbeing (n=210)	**n**	**%**
In the last 12 months...		
Have you received information about your health from an NGO outreach worker connected to an LGBT organisation?	87	41.43
Have you received HCT or HIV treatment from an outreach worker connected to an LGBT organization?	68	32.38
Has an outreach worker referred you to health services at an LGBT organization?	56	26.67
Have you used health services at an LGBT organization?	64	30.48
Have you sought advice or other non-health services at an LGBT organization?	60	28.57
Have you participated in events organized by an LGBT organization?	116	55.24
Have you shared information about health and wellbeing with other LGBT people?	110	52.38

Case study 1: Building relationships through healthcare provider training

OUT Well-Being, the LGBT NGO in Gauteng, had been providing sensitization trainings for healthcare providers since 2006. For these, the organisation worked closely with the provincial Department of Health (DoH) and the Department of Social Development (DSD).

This programme started with an initial grant from AIDSFonds, which was meant to build a clinic specifically for key populations. From 2006-2011, OUT Well-Being hosted a clinic with a full-time nurse and medication, laboratory services, and a medical doctor that was on site once a week, to provide comprehensive care related to HIV and STIs. As part of this clinic, they also provided sensitisation trainings to healthcare providers through the Gauteng Department of Health. In 2013, a member of the organization was part of a research team that developed and tested a training manual for healthcare providers to raise awareness and knowledge about the health of 'key populations.' When we interviewed this trainer, they remembered:

> *2013, we were the main writers [of the manual]. [...] We did pilot trainings and we worked with government, with Department of Social Development and Health, at their training centres, and [...] I think we covered four or five provinces. We worked a lot. [...] I think we were three or four master trainers and we had a programme: we identified five people in the training, and then we did the first training. [When] we got back, they [the five people] were supposed to do 25% of the second training, 50% of the third training, 75% of the second last training, and then the last training they do it completely on their own. (Carl, interview 06)*

OUT's health manager describes how the cumulative interactions with DoH increasingly led to a good relationship with the Department:

> *We were involved in the development of a training manual, an integrated manual with COC for three key populations, for MSM, sex-workers and people who inject drugs. So, we were quite well known. We used to have outreach programs, progress, under the Department of Health. So we built quite a name and reputation over the years and government knew about us and knew about what we were doing. And I would say [...] the Department of Health started to realize that there is a definite need for a parallel, but independent type of service, like the one we offer, specifically for key populations because it started to become clear to them that key populations preferred to access the services where they know that they are understood and where they are not judged. [...]*

> *Because of our profile, our reputation, that we were so widely involved in many aspects: with the Department of Health [through training], with the Department of Justice through our work on the National Task Team through the human rights programme, in the training of healthcare providers, in research, all of our mainstreaming and advocacy efforts. This had happened over a long period of time, the organisation started in 1994, but the real work we started around 2001/03 already, we managed to build a profile, a reputation, and some confidence from these stakeholders in what we were doing. (Tim, interview 21)*

After the grant from AIDSFonds came to an end, the organisation struggled to keep their clinic services open, but with a limited offering:

> *From 2011 to 2015 we managed to keep the clinic going, but it was tough because we didn't have direct funding for the clinic, so in all other programmes we had to make provisions to keep the clinic going. It was quite difficult. In 2013/14 we considered closing it because it was too difficult. For those years [2011-2015] we didn't have medication, just the clinic with one nurse. We had loyal clients who preferred to use the services here, because the services would be non-judgmental and safe, they could talk about anything, they didn't have to be ashamed [...], so clients still preferred to come here as a first point of contact, and then would go and buy their medication. We secured an agreement with a private clinic nearby where they could buy their medication at cost price. (Tim, interview 21)*

This arrangement was not sustainable, however, and in 2015, the organisation considered closing the clinic:

> *At the time [in 2015], we were actually considering closing the clinic because it became increasingly difficult to find the necessary funding to keep the clinic operational. And because we could not provide ARV treatment free of charge it also became quite difficult, as you can imagine, that only resourced clients were able to access the services, and under-resourced clients would not be able to access the services, so we were considering at the time to close the clinic. (Tim, interview 21)*

It was at this moment that the Department of Health stepped in. As the health manager of OUT Well-Being recalls:

> *In 2015, somehow, the HAST [HIV, STI and TB programme] manager of the Gauteng Department of Health heard that our clinic was under threat and that we were considering to close the clinic. She knew about the clinic because we offered training to healthcare professionals through COC, that training was going for the same time as our clinic since 2006. Via that training government was aware of the clinic, of what we were providing and the rationale for the clinic. So when they heard that we were considering closing the clinic, that HAST manager approached us and said that it would be a shame if the clinic would close its doors. She opened the door to start negotiations between us and the Department of Health to get an MoU in place and was also instrumental in getting the agreement for medication [the dispensing license] and lab work. We assume that government somehow heard of what we were doing, then they realized the importance [of our clinic]. (Tim, interview 21)*

As a result of OUT Well-Being's good relationship with the DoH, nine years after starting to provide healthcare provider sensitization, the Department supported the organization's tenuous direct healthcare provision by becoming a partner in the clinic. In 2016, the Gauteng Department of Health and OUT LGBT Wellbeing jointly opened the TEN81 clinic, with additional funding by an international donor. The clinic remains located at OUT's offices, and is aimed specifically at providing sexual and reproductive health services to 'key populations': gay men and other men who have sex with men, transgender people, and people who use drugs:

> *We are incorporated into the government public healthcare network. It is a three-way partnership, a triangular model: DoH offers medication, some of the commodities and laboratory services free of charge. We, as the partner NPO, we offer the expertise and the services, the environment, the venue. The international funder funds most of the overhead costs, including personnel costs for the healthcare staff. (Tim, interview 21)*

This case study highlights the long-term benefits of engaging with government stakeholders, and the value of building relationships and networks. Building such individual relationships often takes longer than particular funding cycles, and it is work that does not necessarily fit into specific project activities. Nevertheless, such engagements build rapport with individual government officials, who then have the potential to become people who are "willing to take up the issue and go the extra mile" (Tim, interview 21).

Healthcare provision at Triangle Project

Triangle Project started providing health services in the 1980s, under its precursor organization 'GASA6010'. GASA6010 started to provide counselling and medical advice, as well as a telephonic hotline to gay men in 1982. In 1984, GASA6010 started to explicitly work on issues related to HIV/ AIDS. After the organization changed its name to Triangle Project, to "reflect the multi-faceted nature of its services"17.

Today, Triangle Project, through its Health and Support Services Programme, runs a daily general medical clinic that provides general primary care (see Table 3). The clinic focuses on providing holistic primary care, which includes support with adherence to chronic medication such as antiretroviral treatment and TB treatment, and referrals to other health facilities or practitioners. Outreach and home visits form an important part of the clinic's functioning, to ensure that their services reach people who are too sick, or do not have the means to visit the clinic in person.

Triangle Project provides HIV testing for people of all genders. In addition, they provide screenings for syphilis. They do not provide comprehensive STI screening as the laboratory costs for such a screening are prohibitively expensive, at approximately ZAR5000 per screening.

Triangle has also set up a collaboration with a public health facility to be able to provide preventive services for people with uteruses (see Case Study 2). Whilst this was initially conceived of as the Triangle Project Women's Clinic, the organisation has recently changed the name to the Everybody with a Uterus Clinic. Whilst they recognize that the name is a little unwieldly, it better reflects the goals of the clinic and who they intend to serve. They have also spread the word about the reconceptualized name of the clinic on social media to hopefully reach as many people as possible. At the Everybody with a Uterus Clinic, Triangle Project facilitate the provision of pap smears, or cervical cancer screenings, for people with uteruses. Whilst the Triangle Project nurse does not conduct the pap smear tests herself, individuals book a pap smear with Triangle, and when they have ten people, a local nurse from a government hospital visits Triangle Project, with her equipment, and collects the pap smears at the clinic. She then takes the samples to the government laboratory and returns the results to Triangle Project. Any tests that suggest abnormal cells are then flagged and referred for follow up at the government facility, or another facility that is known to Triangle Project as LGBT affirming.

The health services at Triangle Project seem very well used by the organisation's constituents. In our survey, half of the people surveyed through Triangle Project said that they had accessed health services at an LGBT organization in the past year (see Table 6). Given that Triangle Project is the only LGBT organization in the catchment area of the survey that provides healthcare services, it is likely that most of these people had used services at Triangle Project. Similar to OUT, community-based outreach services played an important role both in providing health services, and in linking people to Triangle Project's health services that are offered at the clinic located within the organization: more than half of people who answered the survey had received health information from an outreach worker (56%), and almost half had received HIV counselling, testing or treatment from an outreach worker (47%).

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17 See Triangle Project's website: http://triangleproject.org.za/about (accessed 28 October 2019).

Table 5: Health services at Triangle Project

Triangle Project, Cape Town	
Clinic-based services at the organisation's office	HIV and STI testing
	Referral pathways for treatment if required
	Viral load and CD4 count testing for people living with HIV
	ARV and TB treatment adherence monitoring and support
	Pap smears for anyone with a cervix
	General health check-up (Weight monitoring, blood glucose and cholesterol testing, etc.)
	Non-prescriptions medicines dispensing
	Referral pathways for other health support services including alcohol and drug use and abortion and family planning.
Mobile clinic and home-based care	All services offered at the office clinic are also offered in the community by the Triangle Project nurse and Community Care Workers
Psychosocial support services	Individual and couples counselling by experienced and skilled clinical psychologists and clinical social workers
Support groups	For transgender adults
	For transgender adolescents
	For parents of transgender children
Sexual health information and barrier methods	Peer education programme with information on HIV and STIs, run by men and women in constituent communities
	Barrier method distribution service to various venues
Gender affirming care	Assistance with injecting hormones
	Counselling and psychological support
	Referral pathway to Groote Schuur gender clinic (tertiary service)
Training for healthcare providers	Sensitisation/ values clarification training upon request

Table 6: Outreach and health service use at Triangle Project

Triangle Project (n=198)	**n**	**%**
In the last 12 months…		
Have you received information about your health from an NGO outreach worker connected to an LGBT organisation?	111	56.06
Have you received HCT or HIV treatment from an outreach worker connected to an LGBT organization?	94	47.47
Has an outreach worker referred you to health services at an LGBT organization?	96	48.48
Have you used health services at an LGBT organization?	99	50.00
Have you sought advice or other non-health services at an LGBT organization?	109	55.05
Have you participated in events organized by an LGBT organization?	140	70.71
Have you shared information about health and wellbeing with other LGBT people?	142	71.72

Case Study 2: Establishing an inclusive cervical cancer prevention service

Triangle Project decided to provide cervical cancer screening for people who uteruses, because they recognized this as a crucial gap in the current SRH services provided to LGBT people through NGOs. Other NGO services for LGBT people mostly provide HIV-related counselling, testing, treatment and support and focused on men who have sex with men. These services are largely funded through funding specifically earmarked for HIV prevention among MSM (for example, PEPFAR or USAID funding). For a detailed analysis of this, see Part 3 of our Findings.

In this context, Triangle Project wanted to offer cervical cancer screenings to all people who have uteruses. This framing – people with uteruses instead of 'women' – was a very deliberate decision to ensure that services are inclusive and are perceived as affirming for all people who have the anatomy that the services focuses on (uteruses with cervixes), regardless of their gender identity.

One of the key challenges in starting such a service was the lack of funding that would allow to establish services for people with uteruses. Most health-related funding was tied to meeting targets on HIV-related services for MSM (see Part 3). For this reason, the organization did not have the necessary funds to provide cervical cancer screening by themselves, because the organisation's funds could not cover the costs for the pap smear kit or the laboratory analyses of the pap smear.

The organization built on their existing relationships with government facilities to bring government services to its own offices. They identified a healthcare provider who is based at a government facility 20 minutes outside the city centre. This nursing sister had participated in one of Triangle's healthcare provider trainings, and Triangle staff knew her to be supportive of the organisation's work and wanting to provide non-judgmental services to LGBT people. A member of staff of Triangle Project describes this:

> *[Triangle Project's nurse] has built up good relationships with particular public sector clinics that have been sensitised – there is now a nursing sister who does pap smears and has been sensitised to understand trans men, use their correct pronouns and so forth. This relationship began with sensitization training and then deeper conversations around how trans men and queer women were not accessing services like pap smears. (Sarah, interview 20)*

Triangle Project approached this nurse to suggest that she provide cervical cancer screening at the organisation's clinic at an as-needed basis. Based on this suggestion, the following arrangement is now in place:

> *We (Triangle Project) advertise that we provide pap smears, and when we have 10 people [who want to have pap smears], the sister comes [to the Triangle clinic] and brings her testing equipment and slides, and lab forms. [The government facility] sends the samples to the lab, so Triangle does not have to pay the lab costs. The results come back to Triangle, and if someone needs a follow up the sister comes again. (Sarah, interview 20)*
>
> *The whole service is at no cost to Triangle Project: the sister brings all the necessary equipment and the facility pays for the laboratory tests. Triangle does what we usually do for our clients: follow up with them, with takes time but is do-able. Essentially it is a no-cost exercise. (Sarah, interview 20)*

Triangle Project staff describe this collaborative service between the organization and government health services as:

> *[...] beneficial for both [DoH and Triangle Project]. In essence they [government facility] also need the numbers. Uptake of pap smears in clinics is low. And if our clients are able to be seen in the comfort of our own space with a sensitized person, that's great! (Sarah, interview 20)*

By using its good relationships with individual healthcare providers that have developed through sensitization work and continuous follow up, the organization is able to provide an important SRH service without the need of additional donor funding. Through the involvement of the community organization, LBQ women and others with uteruses have access to a streamlined public health service that is accessible and acceptable, and affirming of their sexual orientation and gender identity. At the same time, the community organization supports the government health facility to expand its patient base and to widen the reach of its cervical cancer screening programme.

Socio-economic care

Triangle Project staff were very aware of the wider barriers to healthcare that LGBT people experience beyond their sexual orientation or gender identity. This is summarized in the 'basket of care' that they provide:

> *We offer a basket of care. We don't just look at that person's health, we look at their social situation, we look at their emotional situation, how are they coping with this. (Katie, interview 02)*

The organization puts measures in place to provide socio-economic care for people who seek healthcare at its clinic. One of the staff members explains:

> *We also provide support, care packs for indigent or struggling LGBTQ people who use our services. It's literally a food parcel - we call it a dignity pack – it includes things like your toothpaste, roll-on [deodorant] and soap for the month or however long it lasts, so we also give that. It's free of charge and it's often linked to… [trails off] say somebody has come for direct services at the clinic and has expressed the need in that sense, and then also sometimes basic medication like flu tablets, vitamins, those things that people get, but very minimal. (Margaret, interview 16)*

These dignity packs are meant to provide a minimum of food security, which many people on chronic medication (for example antiretroviral treatment or TB treatment) need in order to be able to adhere to their medication regimen and take their medication daily.

Staff at Triangle Project were very conscious of the relationship between health and wellbeing and the ability to partake in social and economic opportunities. The following quote illustrates this relationship, and underlines the organisation's comprehensive approach to well-being, which sees health as intricately linked to socio-economic wellbeing, and vice versa:

> *[it is] often the case that our clients haven't finished school. Not only are they ill, but they also, what do they do when they're better? I actually like the word [empowerment] because for me, I suppose it's partly enabling somebody to step up or to continue, but I think when you've been that sick or that confused and disorientated, I think you do lose part of you. You do lose your power. You do lose that confidence in yourself that: "Actually, what am I going to do? Without this medication I can't actually function." I think we do empower people by getting them to a clinic, by getting them the services that they need, [by] getting them on the medication so that they can come out of that psychotic episode and carry on with their lives. Getting our client to a college in Citrusdal [rural town in the Western Cape], that's the empowerment. The empowerment is to use what we can to help the person to continue on their journey of life. I don't take their power away, I help them to gain that power that they've lost due to being raped or to being ill. And [when] I say I, I mean Triangle project. […] It's not a handout, it's a step up, and that's exactly what it is. Yes, sometimes we have to hand out because people have nothing and therefore we have to hand out, but once they step up, then they can continue independently and with strength and their own power. (Katie, interview 02)*

In addition to the health services provided at Triangle Project's office, the organization supports so-called 'safe spaces' or 'solidarity networks: community groups where queer people first start to organise themselves and then team up with Triangle Project who provide broad, infrastructural support. By decentralizing their work through supporting these community groups, Triangle Project builds local community capacity, while also remaining closely linked to issues and concerns within these communities. One of the Triangle staff members elaborates:

> *[Our] work around our solidarity networks and working with poor under-resourced LGBTIQ people inevitably in peri-urban areas or in rural areas […] is more the capacity strengthening, helping them to articulate, first of all understand the social political context in which they find themselves and psychosocial context in which they find themselves, be able to analyse that context and then for themselves design or think through conceptualise, an advocacy, community based advocacy strategy. How do we respond to the fact that, for example, access to housing is such a critical issue for, especially queer women in Black townships? Because that's a key issue, how do we understand that there is an intersection in terms of the experience of queer women and gender-based violence, sexual violence, rape, etc. and that of other women in that local community? How do we begin to cross over and build solidarity networks so that it's not just… you know in solidarity networks for me, it responds to two things, one is your immediate need, practical needs right now, in other words: "Do I need to be moved out of my space, do I need transport from where the incident happened or from my house to go to the police station or to the hospital?" Those practical, in-the-moment needs, if you can't respond to that I think sometimes that's more problematic than anything else, but I mean those kinds of solidarity networks that responds to needs. And then the high level stuff that looks at the broader context in which we are in, asking questions around policy but also in terms of service delivery and how do we respond to that, what is needed for us to push back or to support, or to undermine or to begin to critically question…" (Margaret, interview 16)*

The idea of the 'safe spaces' or 'solidarity networks' is that LGBT people need to rely less on organisations, and more on resources and support within their own communities. Our quantitative data suggests that LGBT people already aid each other in sharing information and managing difficulties. The clientele of the two organisations reported being relatively empowered to take an active role in their communities, with 51% asserting that they were very confident and 35% that they were sometimes confident about giving advice to other LGBT people, or speaking their opinion in front of a large group of people. Findings were also positive when respondents were asked if they had ever helped another LGBT person when they were having a problem with police, a healthcare worker, a person in a public space, or a regular partner with 56%, 59%, 85% and 83% answering "Yes" respectively (for detailed findings, see Table 2).

Role 2: Linkage to care

Besides providing direct health services, LGBT NGOs also link LGBT people to public health services. Throughout the interviews, it was clear that this was one of the key roles that LGBT NGOs played for LGBT people's access to sexual and reproductive healthcare. NGOs link people to healthcare in three distinct ways: through direct, formal referrals to specialized services within public health facilities, through informal referrals – by pointing people to facilities that NGOs know to be affirming and to provide a specific health service, for example, an abortion; and by taking individual LGBT people to health facilities as patient advocates, to help them navigate the system and to provide health-related information.

Formal referral to public health facilities

Triangle's clinic does not have a license to dispense medication, so they refer people for medication or further treatment. Triangle Project described a unique, direct referral mechanism from their organization to the Groote Schuur Gender Clinic, the only facility that provides gender affirming care in the Western Cape. Transgender and gender non-conforming people who have seen the clinical social worker at the organization are able to receive a direct referral to the Gender Clinic, which is based in a tertiary health facility. This is a unique pathway. Usually, in order to receive care at a tertiary facility, patients need a referral from a primary care facility. Because of the range of factors that make primary care services largely inaccessible to transgender people seeking gender affirming care (see previous section on Gender Affirming Care in Part 1), it is very difficult for transgender people to receive such a referral through the public health system. The direct referral through Triangle Project, then, is a crucial entry point into the health system, and towards accessing gender affirming care.

> *Triangle project is the only organisation in Cape Town that provides the gender affirming services, as in, a client will come for their first intake where they discuss with the counsellor how they feel, how they have felt all their lives, their dreams and their ambitions and their goals, and then from there for transgender clients, they will be referred for further counselling, if needed, or they will be referred directly to Groote Schuur gender affirming clinic. (Katie, interview 02)*

A similar referral mechanism is possible through the clinic at OUT Well-Being. Because the clinic is integrated into the public health system, and run in partnership with the Department of Health, its staff can refer patients to other facilities if needed. Clinic staff have contacts at several other facilities in the area and refer patients to facilities they know to be LGBT affirming.

Both organisations thus serve as accessible entry points into the public health system, where LGBT persons can receive primary healthcare in an environment without sexual orientation or gender identity-related stigma or discrimination. For health concerns that surpass the organisations' primary care capacity, LGBT persons receive referral and guidance to affirming public health facilities, as well as some sort of guarantee that the facility they are referred to will be affirming of their sexual orientation or gender identity.

Locate affirming healthcare facilities/ informal referrals:

Whilst the TEN81 clinic at OUT Well-Being is integrated into the public health system, and as such can officially and formally refer clients/ patients to other government health facilities, referrals at Triangle Project are somewhat more informal at times.

In making referrals, both organisations can guide LGBT patients towards health facilities or providers that are known to them to be affirming of different sexual orientations and gender identities. Whilst some of this might happen through formal referrals as described in the previous section, we also found that often, referrals happened more informally – by guiding clients to affirming healthcare providers who are personally known to the organisation's staff.

The nurse at Triangle Project, for example, explained that often she will phone the health facility to which she refers a client, to ensure that the facility will provide non-judgmental care, but also to ensure that the facility is aware of the client and that the client receives the care they need. In this way, the NGO acts as a conduit to facilitate access to the public health system, in which the sheer number of patients can impede personalized care for individual patients. A patient that comes with a personal referral from the NGO, whose nurse is known to the healthcare provider, can ensure better care. An interviewee who works for the Department of Health sums this up:

> *You get access when you know the people that know the people and it sounds horrible when we say that. (Faith, interview 17)*

In this context, the personal referral, even if informal, from the nurse at Triangle Project (who 'knows the people who know people') can open the door for LGBT patients who seek healthcare at public government facilities. Such informal referrals work based on individual relationships with certain providers. The healthcare staff at Triangle gave an example of a young queer woman who wanted an abortion after being raped. Triangle Project, where the woman had gone for counselling after the rape, found a healthcare provider who could provide the abortion through their NGO networks:

> *She [said she] would like to terminate and then we had a problem finding first a provider to take her to. […] Luckily Sarah knew of Nicola [pseudonym] and then we went through the SRJC [Sexual and Reproductive Justice Coalition, a South African network of SRHR advocates and healthcare providers] and she helped to guide us of where to find the services. (Katie, interview 02)*

Besides personally referring individual clients to health facilities or individual healthcare providers, organisations also provide contact details for providers or facilities that they are known to them to be LGBT affirming. One interviewee from an LGBT organization thinks of these contact lists as 'references' (06) for healthcare providers: receiving a contact from an LGBT organization can reassure an LGBT client/ patient that this healthcare provider will treat them with the dignity and care that they deserve. The interviewee from OUT Well-Being describes how such a reference can encourage LGBT people to seek care:

> *In terms of people accessing a service without actually being there and I mean these people – I mean I would see around quite a lot of clients and a lot of them – for them to come into [a healthcare facility], there was no way they would do that. They were like "I am not ready to do that". If they need to get treatment, I would rely on another strong mechanism, where it's around a reference. They needed a strong reference, where a person says, "I am in this area, I can't come to you guys, but do you know somebody who can help me?" And we have a list of doctors who we know, we've trained before and they are very gay friendly and then we say to them "the nearest doctor who is very affirming is this one, so rather go to that one. (Carl, interview 06)*

Both Triangle Project and OUT Well-Being have such referral lists, with contact details for specialized healthcare providers, but also for other services that are related to health concerns. The organisations use these lists and the identified service providers to expand the services available to their clients. Especially for services that the organization cannot provide themselves, the organization uses these identified service providers to refer clients to. This is particularly useful for services that are not covered in the current funding provisions of the organisations, such as healthcare related to fertility options and social services related to adoption. One staff member of OUT Well-Being explains:

> *Over the years, we built up quite an extensive list of contacts of services that we know are either LGBT friendly or sensitized, or we know that this person is LGBTI themselves and they offer the services. We have quite an extensive list that we have access to and we can refer people to those kinds of services, but we don't provide the services ourselves directly, we would refer.*
> *(Tim, interview 05)*

In our interviews with healthcare providers and health policy makers, it became clear that it is not only LGBT people themselves who rely on OUT Well-Being and Triangle Project to identify and refer to affirming providers. Healthcare providers themselves used Triangle Project as a pathway to identifying healthcare providers for LGBT health-specific services, or providers who are LGBT affirming. As has been described elsewhere (Spencer et al., 2017), healthcare for transgender people, including gender affirming care, is almost non-existent in South Africa, and transgender people as well as healthcare providers rely on informal networks to identify sources of care. Against this backdrop, a regional manager in the Western Cape Department of Health described how she relied on Triangle Project to identify government healthcare facilities that where transgender patients would be able to receive care without experiencing gender identity-related discrimination or stigma:

> *Usually we [the regional HIV/AIDS, STIs and TB programme in the provincial Department of Health] get the info via Sarah [health manager at Triangle Project; pseudonym], Sarah will tell you. [Transgender people] got close contact with Sarah [...] and she will then give me feedback and say "That facility, it's great, and they were very accessible and they were treated very professionally [...] and this other facility that transgender people like to go, is also a very...[trails off] [...] and the counsellor there is really providing a service that they can really feel at ease and also come back" (Candice, interview 15)*

This means that effectively, in this role, Triangle Project supplements government health facilities by providing a referral directory (even if this is informal).

After referring a client, LGBT organisations often continue to follow up on behalf of the client, to ensure that the client actually receives the services they need (see also role 3: NGOs hold health facilities accountable).

Patient advocates at healthcare facilities

The healthcare staff at Triangle Project were cognizant that sexual orientation and gender identity-related discrimination was not the only barrier that LGBT people experience when seeking healthcare. As described in part 1 of the findings, for many LGBT people socio-economic hardship can be a significant barrier to accessing healthcare. The organization recognizes that lack of transport money can be a more important barrier to care than sexual orientation or gender identity-related discrimination. For that reason, Triangle supports their clients to physically access health facilities, and also provides nutrition so that people are able to take chronic medication. On the one hand, this means that Triangle Project's nurse physically takes client from their home, or Triangle Project's clinic and drives them to health facilities. This is especially important in cases where people live in areas that are not well served by ambulances, or where people live on the street:

> *Our people that live outside will call for ambulances, and an ambulance won't come for days. It just won't come. So I then end up having to go with my little red bakkie and load the patient up and take them to hospital. (Katie, interview 02)*

Ideally, the public health system should ensure that people are able to get to and from its health facilities, whether by public transport or ambulance. In this context, Triangle Project directly support the functioning of the public health system and takes over one of its roles. Often, however, the organization does not only take clients to the health facility but stays with clients to also accompany them to their appointments. The nurse at Triangle Project describes how she takes on the role of a patient advocate, and actively supports persons when they seek care at government health facilities:

> *[To] state facilities I often go with the client: one, if they feel that they can't go on their own; or two, if they are having obstacles or problems to get the treatment that they need. That basically just means sitting, waiting to see and then going in to see the doctor with the client. [...] (Katie, interview 02)*

By accompanying LGBT clients to health facilities, and by sitting in during their medical consultations, Triangle Project staff ensure that their client receives non-discriminatory healthcare, that their client understands their medical condition and its treatment options, and that all of the client's health needs are met. The presence of the Triangle Project nurse, who has medical training, acts as an accountability mechanism to the healthcare provider and the health facility, and she can speak up on behalf of her client:

> *Just by taking [the client] to the clinic, being there for all of his appointments, so whoever he saw, whether he saw the social worker, whether he saw the psychologist, whether he saw the nurse, whether, I was with, so just by being there […] [I am] using my white privilege as well in that when I walk into a tiny rural clinic and they see a white whatever they see, woman/man, whatever, walking into the clinic, there is a difference, unfortunately, whether it's the language, whether it's, I don't know, whatever it is. But I use it and say I am coming in with this client, the client is giving consent, and therefore I will come in, because the client will not ask you questions. Our clients don't ask doctors, they feel they can't, they must just take the medication that they're given and go. They don't know what the medication is for, how long the treatment is going to be. (Katie, interview 02)*

In this way, Triangle Project staff act as patient advocates and are a key source of information for the clients they accompany. This includes information about where and how to access healthcare services, as well as information about specific health conditions and treatment options. The following example that Triangle Project staff gave during our interview illustrates this role.

Triangle Project nurse was contacted by Zandile (pseudonym), a young lesbian woman who was living with HIV – we introduced her already in Part 1 of the findings. She had been diagnosed with HIV in September 2018, and in February 2019, when she contacted Triangle Project, she had not received antiretroviral treatment yet, despite numerous medical appointments. She thought she was denied HIV treatment, and that it might be because of her sexual orientation. Triangle Project's nurse accompanied her to her medical appointments and learned that the reason for the delay in starting HIV treatment was that doctors suspected she might have another rare condition that would cause serious side effects if she were to start treatment. Triangle Project's nurse then took it upon herself to learn about the suspected condition and explain this to the client:

> *I gather from being with her at these appointments that she wasn't on treatment because they were looking at the liver failure, but they were looking at porphyria as well. But none of that was explained to her, she didn't have a clue what was going on. And then just by going with her and you know, even while we were sitting in the waiting room I read her file, because otherwise I didn't have an idea of what was going on. Then I went onto our Google, medical advice and read up about porphyria and then I was able to explain it to her a little bit about, maybe this is why there's been this delay. Because I hate, I don't like saying to a client oh this rubbish, they should be giving you the services, why aren't they? Because that's not going to help them access the services, so I try and stand up for our medical personnel and say look, there's a reason that there's been a delay and this is, this looks like this is the reason (Katie, interview 02)*

Through Triangle Project's intervention, Zandile understood her health concerns and the reason for the delay in antiretroviral treatment. Her example illustrates the important role that Triangle Project plays for ensuring that LGBT people understand their health and health concerns, but also to negotiate the relationship between LGBT people and the healthcare system, which is based on mutual understanding. Without Triangle Project's intervention, Zandile might have thought that she was withheld medical care because of her sexual orientation, and this perception of discriminatory treatment might have meant that she would not attempt to seek care elsewhere – ultimately jeopardizing her health. Additionally, as the following quote from Triangle Project's nurse shows, this example also again illustrates how socio-economic barriers to healthcare impede people from accessing care:

> *We had to go to one clinic, then to another clinic, and then eventually ended up at the HIV clinic in Tygerberg again, because the other clinics felt they couldn't manage this because of the complication of the porphyria, so she couldn't go to a normal HIV clinic, you know, her local clinic. And then also not earning a salary because she's had to leave because she's been so ill. She had to go to Tygerberg, she had to go to Ruyterwacht and she had to go to another clinic and I can't remember, but how? How do you do that if you've got no funds? (Katie, interview 02)*

NGO's role of referral and facilitating access to services goes beyond immediate healthcare. Beyond providing support to LGBT people seeking services in the public healthcare system, OUT Well-Being started a legal advice desk (a so-called 'legal clinic') in 2018. This legal clinic sits at the intersection of medical and legal services and supports LGBT people to navigate the medico-legal nexus, for example in cases of sexual or physical assault, by accompanying them to specialized medico-legal facilities (Thuthuzela Care Centres), or police stations. As such, the legal clinic supports LGBT survivors of hate crimes to access healthcare. Most of its current clients have come to the legal clinic through the TEN81 clinic:

> *A lot of [LGBT people] access the [legal] service [...] through the TEN81 clinics. A person would say they are coming through into the clinic and then, while having a discussion with the nurse, they would divulge that they have a legal problem. They will be given a business card, which has an email address [...] A lot of the requests for [legal] assistance come through via email. (Justice, interview 09)*

LGBT survivors of sexual and other forms of violence face numerous barriers within the criminal justice system, from reporting violence at law enforcement to having their cases prosecuted and sentenced adequately (Meer & Müller, 2018). As a recent report by Meer & Müller (2018) has detailed, LGBT NGOs can play a crucial support role throughout the criminal justice system and facilitate access to justice, as well as support for LGBT survivors.

Role 3: LGBT NGOs hold public services accountable

There is a second aspect to Triangle Project accompanying LGBT people to health facilities. By ensuring that their client has a patient advocate who asks questions and explains health information, the fact that someone from the organization is present in the health facility also works as an accountability mechanism. That is, having a second party present in encounters between healthcare providers and their patients can ensure that discriminatory attitudes are documented and contested. Often, LGBT patients themselves do not push back against healthcare providers (Müller, 2017). On the one hand, they might be afraid that challenging a provider who shows discriminatory attitudes could jeopardise receiving any healthcare at all. On the other hand, they might simply not feel up to it in a context where they seek care for being ill. An accompanying staff member from an LGBT organisation is better placed to play this role, as the quotes from Katie, in the previous section, show.

One senior official at the Western Cape Department of Health suggested that one of the reasons why complaint mechanisms might not be working is because it is difficult to change the culture of a health facility without clearly spelled out rules. He uses an example of a healthcare provider reluctant to engage with healthcare users beyond the impersonal and distanced communication through boxes in which patients are supposed to leave their complaints:

> *This discrimination with license needs to come to an end [...] the change is going to have to be palpable, because this one sister is saying to us and she is like quite old-ish, she will say "if anybody has complaints, there's a complaints box, just put your complaint in". No, there's young people next door and we had a group of young people next door and we had the session with the service providers in this room and the young people in the other room, so we bringing feedback from that room into this room and the feedback was, actually they would like to have a name that we can contact if a problem crops up. And her response was "no, I'm not going to give them my name though, I'm not going to give them my number. If they have a problem, put the complaint in the box." It's changing that sort of thing, because people are quite rightly saying "look, some of these issues can be resolved in time", but as a peer educator, a youth leader, I need to have a number and a contact person that I can phone to say "There's a young person sitting in your waiting room crying because of this and that, can somebody attend to that?" And this nurse was refusing. [...] Somebody told them afterwards: "Don't worry about her, she's retiring in six months' time". No, she was adamant, "I am not giving my name". It's like changing that kind of stuff and my understanding is, that can only happen if people feel that's the way they should be operating or conducting their duties and at the moment I don't think that's spelt out in very clear terms. (Gcobani, interview 07)*

In this context, LGBT NGOs may be crucial in mediating between LGBT patients and reluctant healthcare providers. On the one hand, they are better resourced and connected than individual LGBT patients, and on the other hand, providers might also feel more accountable to an organisation.

The accountability role that organisations play, similar to their role for referrals, is usually more informal than formal. Triangle Project learns about discriminatory treatment in health facilities or by healthcare providers when LGBT people seek healthcare at their clinic or seek advice or counselling. A formal response to learning about health rights violations would be to lodge an official complaint either with the manager of the facility in question, or with the provincial Department of Health. Staff at Triangle project were quite clear that the organisation has hardly engaged in these formal processes:

> *We have never to my knowledge...engaged in a, I think maybe we've engaged in one formal process. I think our benefit as well is because we are like within and without the system, we also don't have to do formal processes sometimes [laughs], which is bad, because the processes need to have more inputs put into them to be useful. (John, interview 01)*

Rather than following official, formal complaint mechanisms, the organisation takes up complaints directly with individual healthcare facilities or providers – and often uses this as a motivation to conduct sensitisation or values clarification training in facilities where complaints have surfaced. Whilst this approach might be effective to address the attitudes underlying discriminatory healthcare provision, its individuality and bypassing of the official complaints system might also impede awareness of the scope of the problem of SOGIE-related discrimination in healthcare at the Department of Health. If a complaint is addressed directly at the individual facility without registering it through the official process, then it is possible that knowledge of the issue at hand is not registered at higher levels, ie. within the regional and provincial structures of healthcare.

This was not because NGO staff were unaware about formal processes. In fact, many emphasised how important formal complaint processes were. However, at the same time, NGO staff we interviewed also acknowledged that the immediate need to facilitate access to services for LGBT people often outweighed considerations about lodging an informal complaint. A staff member at Triangle Project gave an example about access to shelter spaces for LGBT persons:

> *[Shelters get] funding from National DSD [Department of Social Development], this means that [...] they're not allowed to turn queer people away. [But] they obviously routinely do. When that happens to us, we do nothing about that shelter, generally, because it's just [...] ... no one at DSD is going to do anything, so we just use all of our back channels again and we phone all the shelters we know and we speak to the matrons personally and say: "Do you have a bed for X", and something like that. Which is really problematic because these are not channels that exist for the general public. Um... and it's... I don't know, it's not unethical because you're helping an individual person, but there is definitely something not great about the way that these back channels end up working. (John, interview 01)*

Whilst not directly related to SRH services, this quote illustrates an important point. On the one hand, it provides another example for the ways in which NGOs facilitate access to public services by advocating for individual clients through their networks. In the example, the NGO staff phones all the shelters they know to inquire about bed space – which should be done by the initial shelter that is unable to accommodate the person, or by a social worker. On the other hand, the quote also illustrates that where NGOs try to respond to many immediate needs that might surpass their capacity, they prioritise finding a solution to the problem at hand (finding shelter space) over addressing structural or systemic failings (the fact that a publicly funded shelter discriminated against someone based on their sexual orientation or gender identity). The perception that lodging a complaint about this discrimination would likely not yield a favourable outcome further disincentivises the NGO from investing time and effort into a formal complaint process.

Beyond addressing individual cases for access to healthcare, both organisations participate in the *National Task Team,* a high-level process convened by the Department of Justice and Constitutional Development to improve access to justice for LGBT persons who have experienced hate crimes by ensuring that the criminal justice system responds adequately. It is well-documented that many LGBT survivors of hate crimes, especially sexual violence, experience manifold barriers to reporting such violence, and that in most cases, the criminal justice system is not able to identify, prosecute or try the perpetrator (Meer & Müller, 2018). Given that services related to gender-based violence form an important part of comprehensive sexual and reproductive healthcare, the participation of both OUT Well-Being and Triangle Project in this process under the National Task Team is work that aims to hold public services accountable. One important element of the task team's work is to monitor existing cases throughout the criminal justice system, and to ensure that cases are processed without undue delays:

> *When a hate crime is reported, the rapid response team would come in, because in the past, cases used to take very much longer to conclude. You know, it used to take over 5 or 8 years before the matter is concluded. Now, with the rapid response team, when a case is reported, SAPS takes responsibility to follow up with the investigating officer monitor, track and then the National Prosecuting Authority takes care of the prosecution aspect of it, so many of the cases we've had in the last few years has been really... I think about 70% of those cases have been dealt with within in less than 3 years of time. If it's more years than that, it's often the case of whether there's an issue with witnesses or evidence and so forth, but in most cases, cases have been dealt with and been finalised in a shorter time (Blake, interview 12).*

This task team had been established in 2011 at the pressure of civil society organisations (including OUT Well-Being and Triangle Project), and a range of LGBT civil society organisations have been instrumental in its continued functioning:

> *Around that time (in 2011) there was quite a number of gay murders, gay men, and then soon after that there was the so-called corrective rapes of lesbian women. So because of that, the task team was brought to life and we were involved with the conceptionalisation of the task team from the beginning to develop the terms of reference, to deter … to develop work plans and activities and so on. And we had been involved with that process to hold government accountable in terms of meeting those, um, indicators and outputs, so we are quite closely involved there.*
> *(Tim, interview 05)*

If OUT Well-Being identifies a case of sexual violence or another hate crime through their legal clinic, they bring these cases directly to the attention of the National Task Team, whilst also providing victim support services:

> *People who report hate crimes […] at the police station or other institutions, we forward the cases and monitor them through the Department of Justice, a rapid response team, the provincial task team and the national task team to ensure that the case is being attended to [and] it is moving. Because you know, in the justice system, if a case gets absorbed and nobody pays attention to it, then nothing will happen. So we lobby for that process to happen, we follow up constantly and we also provide the aggrieved client with information, saying that this is still in investigation phase. This is the person you have to talk to, this is the court that you will be referred to and the potential outcomes and what they should expect, what they should not expect, and basically providing them with the overall information that they would need. (Justice, interview 09)*

Role 4: LGBT NGOs educate and train healthcare providers

The survey findings point to the need to conduct values clarification/ sensitization with healthcare providers, so that LGBT people encounter less discriminatory attitudes when access healthcare. Interviewees echoed this need, but also pointed out that beyond values clarification, specific knowledge on health concerns related to SOGIE was equally necessary. Interviewees acknowledged that the challenges that existed in the public health system also affected the work conditions of healthcare providers, and that healthcare provider training on SOGIE-related health issues often takes place within an environment where staff are over-burdened, under-resourced and ill-trained:

> *But I think in many ways we just have a health system that has not been able or hasn't been interested in keeping up with the changes that they need to be keeping up with. So, I do actually have quite a lot of empathy for healthcare staff who are finding themselves in something that they have gotten very little training for, they got like very little context for, and also they are themselves working in a healthcare system that's like crumbling around their ears. (John, interview 01)*

One senior representatives from the Department of Health conceded that "previously we had a few issues [of SOGIE-related discrimination] at our facilities, so I'm not going to say it's not happening, I am aware that it's happening" (Georgina, interview 10), and emphasised the need for sensitisation training as "the only way that we will be able to break down the barriers" (Georgina, interview 10). The sensitisation training that NGO staff do with healthcare providers in these contexts then,

> *[is]reactive work. [There] is an active discrimination, when somebody reports on it, and then we would go on site and have that conversation. [That] conversation for me is also a way to build capacity to change norms and values in the space, so let's expand our understanding of what that training is, and what the purpose is. So there's the norms and value conversations that we have on site in response to an act of discrimination…so that would include both management at site or that particular person who's provided services. (Margaret, interview 16)*

As this quote shows, NGO staff identify specific health facilities or healthcare providers that are in need to sensitisation training through complaints by their constituents and offer training "in reaction to an incident if and when it happens" (interview 13). In other cases, however, it is healthcare providers themselves who get in touch with NGOs to organise sensitisation training for their facility, as the following example shows. Some healthcare providers themselves were aware that their colleagues might hold prejudicial attitudes against patients because of the patient's sexual orientation or gender identity and expression. One of the healthcare providers we spoke to, who worked as a nurse in a rural public health facility, explained:

> *I would say it's mostly staff attitude and perceptions – that is the main thing. [...] That is the reason why I actually requested Triangle Project to come and speak to us. I am aware that while the services are supposed to be available, it's not easy to request services when staff have their own ideas and perceptions on LGBTI groups. (Jacques, interview 14)*

When this nurse picked up discriminatory attitudes against LGBT patients by other staff members, he felt compelled to act. He was sensitive to this because he himself has a gay family member and did not want LGBT people to be discriminated against in 'his' health facility. Through word of mouth, he learned of Triangle Project and promptly contacted them to ask if they could do a sensitization/ values clarification training. NGO staff confirmed that most of the requests for sensitization/ values clarification training come from individual facilities, often prompted by individual staff members.

> *So it is them approaching us, um, to do training, It is three hours maybe four at a stretch.*
>
> *KATIE: Not the Department of Health though, because they have their in-house training.*
>
> *SARAH: Yeah no, but, when I'm saying Department of Health, I mean clinics and you know...*
>
> *KATIE: Yes, individual clinics that come to us [cross talk] (Katie & Sarah, interview 02/03)*

Often, clinic staff had seen someone from the organization present somewhere else or had heard of them by word of mouth.

> *They [healthcare staff in clinics] will approach us and say look, there's a lot of transgender people in our area, we heard you present there or we saw you presenting there, could you come and do training by our staff? (Sarah, interview 03)*

The initiative of such individual healthcare providers are important entry points for LGBT NGOs, who can then support these staff members by providing sensitisation training to the entire facility:

> *With Triangle [Project]... I mean they found and they were able to assist in a process where a single nurse on the West Coast decided these [LGBT people] are my clients and I will service them. It's not in the protocol or whatever in the department, but as I told you, and people go that nurse. I don't know what will happen when she goes. But that is sort of thing that you will find, and again I'm saying, that's probably better service than what you'll get in your normal clinic.*
> *(Gcobani, interview 07)*

The NGO staff we interviewed saw themselves as uniquely placed to do sensitization training, as they could draw on personal experiences and thus make the training content relatable and personalized. One interviewee, who identifies as a queer non-conforming woman and often draws on her identity during training with healthcare providers, remembered a 'Train the Trainer' programme for OUT Well-Being, where they taught healthcare providers how to sensitise other healthcare providers. They remarked upon the difference that it can make to be able to contribute lived experiences of queer persons:

> *You can see a difference in the training. You can see the difference when [healthcare providers] train, it's very clinical, it's very, it's good. But when I stand in front of people and I share personal experiences [...] to use yourself as a learning tool [...] I do feel that it's got a bigger impact. [...] In the last training my one colleague was talking and I could see, I could just feel the people wasn't okay, they couldn't grasp what he was saying, and it was going over their heads, and I stood up and I said: "Can I share my personal story, my personal experience with religion and how it worked for me?" And you know afterwards five or six [participants] came to me and they asked me questions, and I felt that that worked. (Karen, interview 04)*

The Department of Health recognises that LGBT NGOs have the specific expertise to provide sensitisation training, and frequently relies on NGOs to raise issues around sexual orientation and gender identity, which tend to be overlooked in healthcare provider education and everyday healthcare delivery. One senior manager in the Department of Health describes this succinctly:

> *These are trained nurses, who are supposed to be treating patients, in the patient's best interest, but for some reason they need a refresher course or what we call a sensitization. So we would get people mainly from kind of these NPOs to go into these groups and take them on. The response was actually not bad, because people would then say: "Well, this is what they should've told us at college, or this is what they started talking about and then once you get into the job, it kind of gets off the table", and they concentrate on babies and mothers and that becomes the norm. Um, so that's, that's what has happened, and I think for that reason, we're still in the process of saying: "How can we as health services claim to address the need of the patients as opposed to this is the menu that we're offering?" (Gcobani, interview 07)*

NGO staff members, individual healthcare providers and policy makers agreed that sensitisation training can help shift attitudes and increase knowledge among individual healthcare providers. As one NGO staff member, who was involved in training healthcare providers, describes:

> *The perception changes a bit. There's a strong mind shift and then [...] people are likely to say "I used to do this, now I wouldn't do this, I was not aware that I was harming people, now I'm aware."[...] And some people they come and say, "I am empowered, I can do more". Some people it just becomes, "Yikes, I'm really homophobic, and you know what, I am still going to remain that way." You get those too and for me then, I say to the nurse: "You know what, if you are homophobic, own it. Do not abuse things like culture or religion or whatever. If you're homophobic, then own it, but then be aware that now you're going against the highest law of the country." So, we have this kind of conversation and you get them to also realise that their own belief systems must not take play in their service delivery. (Carl, interview 06)*

The following quote from a healthcare provider who had received sensitisation training by an NGO exemplifies the aims of the training to distinguish between personal beliefs and professional obligations:

> *For example, in my religion it is not acceptable, but there needs to be like values clarification and treat a person as a person and not via my options, that meets the goal. Open the mind for the time being and most of them, they also said…it's like an abortion, we need to still provide the service although we are not comfortable with it. (Candice, interview 15)*

At the same time, NGO staff recognised the limitations of training individual facilities or healthcare providers. Because the public health system is chronically under-resourced and overburdened and working conditions are challenging, staff in public facilities often do not stay in one facility for long and move on quickly towards another facility or to the private health system. This of course jeopardises the continuity of the information and skills imparted on staff during the NGO trainings:

> *Having a training programme for healthcare providers means that you have a programme that goes on forever, because of the high staff turnover in public facilities – once you train all healthcare providers in one facility, one month later half the staff changes and they [the new staff] know nothing. So doing training, it is not necessary futile, but it just has to be an ongoing thing and you have to repeat it the whole time. (Tim, interview 21)*

A representative of the Western Cape provincial Department of Health gave the example of one specific health facility, where "the training that was facilitated via Triangle was very good for the staff", but where staff attrition undermined the sustainability of the change:

> *I know for the facility, that we've done the training on, about 20% of the staff that have actually had the training have left. And from our side, we were not able to continue with something that we've started, so that is a gap. Not just somewhere out there but within the system at the moment, the sustainability around [sensitization training]. (Georgina, interview 10)*

Because of such frequent changes in staff, interviewees emphasised that training individual healthcare providers should be part of a larger strategy that challenges the heteronormativity of the entire healthcare system to ensure that it sustainably affirms sexual and gender diversity:

> *We've spent many years training, sensitising, but [...] part of the problem is that you don't only change people, you change the whole system, how the system communicates, how services are provided and so forth. So if you say we are a sensitised organisation or clinic, but then your messages, your pamphlets, your booklets are still heteronormative, you have not changed the whole system. So for me it's about terminologies, messages, it's about service, it's about competency, it's about refresher courses, because ultimately you see ARV doesn't change, commodity does not change, how you examine an STI or whatever, it does not change, [...] the language is the one that must change, the messages are the ones that must change (Blake, interview 12)*

Such systemic changes, however, are beyond the purview of individual civil society organisations. Whilst organisations can point to the problem (heteronormativity in the healthcare system) and can remedy certain symptoms of it (sensitising individual healthcare providers), the responsibility for systemic shifts lies with the Department of Health. A representative from the Western Cape provincial Department of Health, who used to work for Triangle Project, pointed to possible entry points for including information on sexual orientation and gender identity more sustainably into government training programmes:

> *I feel that [issues of sexual orientation and gender identity] should at least be included in the family planning training, in the new guidelines particularly in reproductive health. [...] In the guidelines which I saw the draft of, at least now they are including non-gender conforming people so that we can actually keep it in mind, acknowledge the fact that we're not only dealing with a man and a woman or a heterosexual couple and so on, and also include them, [...] and I'm hoping that we can incorporate the training into our sexual reproductive health. (Clara, interview 13)*

Often, LGBT NGOs provide training to public health facilities without remuneration, even though NGOs are effectively providing a specialized service to these government departments. In part, this is because there is no budget for such training within government budgets, but there also seemed to be the expectation that NGOs would do the work for free. This is reflected in the following quote by a registered nurse at a public health facility, who had organized for Triangle Project to conduct a healthcare worker training at his facility:

> *I would really love to from my personal position, however, we kind of are dependent on people coming and doing their own thing and responsible for their own costs, and we give the okay afterwards and the presents and we say thank you very much, um. Really. That is where I am. Yeah. So no, we did not pay Triangle project in money. I must be honest, I can't remember asking Sarah how much we owe you or do we owe you, and as I say we gave her a present and said thanks very much and that was it. (Jacques, interview 14).*

Effectively, this lack of remuneration can be an important barrier to being able to provide the training at all. As one of Triangle Project's staff members explains, the costs of providing training can be significant for the organisation, and will need to be covered by donor funding:

> *Next week I'm going to Caledon [a town 120km out of Cape Town], like a little hospital, well the only hospital in Caledon. It's like fine, send me anywhere, as long as it makes a difference for whoever is living in Caledon and has to access the services, that's fine. But that's how it happens and the Department don't pay for it. They don't pay. You just do these things. So I must find another funder who will pay for me to go to Caledon. I've got to drive to Caledon, [stay there overnight] and drive back, but the Department don't pay and they can't pay, because they are paying another big blue chip to roll out this training. But I know, I can say no sorry, go through your training department because you've got a training department, go through your training department and get them to come and do the training, but I well know that there, I know what that training will look like, and what the focus of that training will be and I will drive to Caledon and go and do it. (Sarah, interview 03)*

What Sarah alludes to when she speaks about the training available through the Department of Health's training department is that the training that is provided through the department is a modular training focused on so-called key populations: men who have sex with men, transgender people, sex workers and people who use drugs. These are currently the focus of donor-funded healthcare provision and healthcare provider training. We explore this further in Part 3 of the findings.

Contributing to university health sciences education

Both OUT Well-Being and Triangle Project do not only train healthcare providers who are already in the healthcare service, but also health professions students during the course of their studies. In doing so, the NGOs address topics of sexual orientation, gender identity and health, which are largely absent from health professions education in South Africa (Müller *et al,* 2017; Müller, 2013). NGO staff see this as a more sustainable approach to training compared to sensitisation sessions with individual healthcare providers:

> *It's easier to get people before they get into their positions, meaning if a person is trained to be a social worker and when training to be a social worker, this should be included. Like you know, health nursing colleges, they need to have this in their curriculum […] We need to get them at a tertiary level, so that when they get into the positions of wherever they're working, they're already sensitised on these issues. I think that will have more impact than expecting them to get into their structure already and then educating them there. (Carl, interview 06)*

Triangle project has a relationship with the Health Sciences Faculty at the University of Cape Town, which has led to the NGO co-teaching a regular seminar for medical students in the fifth (pre-final) year of studies. In addition, the NGO has an informal relationship with a medical student interest group, which organizes public talks for health sciences students, and invites Triangle Project to give presentations on sexual health and pleasure.

> *We had an event with the Triangle Project before and it was about protection in safe sex for all sexual encounters. That was the name of it, and it was about talking about safety in […] non-normative, or like non-'penis and vagina' sex. I thought that was really, really a very good session. I thought it was really brilliant and it gave a lot of practical information. (Amina, interview 18)*

At this talk, the NGO nurse and health manager spoke about sexual health for queer women, about ways in which queer women have sex, and about how to use dental dams and finger cots to minimize the risk of sexually transmitted infections. They also gave out so-called 'pleasure packs', small bags with a dental dam, condom, female condom and finger cots. The students re-distributed those packs during the time that they volunteered at student-run outreach clinics, thus both queering the idea of healthcare provided at those clinics and providing much-needed sexual health information and commodities to queer women who might attend these clinics.

As a result of the interactions in the regular seminar with 5th year medical students, Triangle Project now hosts medical students in 6th year who choose to spend 2 weeks at the organisation's clinic to learn more about LGBT health and healthcare. Students approached the organisation, whose contact details they received during the seminar, and asked if they could do their elective placements in their clinic. While this started as an ad hoc, once-off placement on the initiative of a particularly interested student, more students have since expressed interest and the organisation is exploring options to become officially registered in the list of elective placements at the university. Hosting medical students at the clinic allows Triangle Project to draw on their clinical skills and get some support, while at the same time providing experience and knowledge to the students to ensure that they will be LGBT affirming providers once they graduate.

Similarly, OUT Well-Being welcomes medical students from the nearby University of Pretoria to see and experience the health services they offer at their clinic. This usually is initiated by individual lecturers as part of a community engagement in the course of the curriculum. Whilst these student visits are usually only for short periods of time, they are an important opportunity for OUT Well-Being to raise awareness about the nature of and necessity for their clinical services.

Information for healthcare providers

Besides providing training and education in specific sessions or seminars, Triangle Project serves as a central information repository that individual healthcare providers can access. There is little to no content on SOGIE and health in medical and nursing education (Müller et al., 2017) or in professional development courses for healthcare providers who already practice. In this context, where knowledge around LGBT health concerns is not readily available, Triangle Project has become an important point of contact for healthcare providers who want to provide competent healthcare to a patient who identifies as LGBT. When healthcare providers contact Triangle Project, the health manager provides relevant information by email:

> *We've had some really nice [experiences] with [doctors] being open to say: "Give me some reading, let me read, let me understand." You know, I'm thinking of one particular case, [...] in the Northern Cape. The doctor was like: "I want to do this for my patient, I really want to do this for my patient but tell me, I don't know what I have to do." [...] So we sent him the guidelines, sent him the protocols sent them what they have to do as a doctor, let them do it."*
> *(Katie & Sarah, interview 02/03)*

This is especially important for gender affirming care for transgender people. Access to gender affirming care is very limited, and its provision is dependent on individual providers and their initiative (see Part 1 of findings, as well as Spencer, Meer and Müller, 2017). For this reason, liaison with providers who might be willing to provide gender affirming care but lack the necessary clinical knowledge is a critical intervention into widening access to care. Usually, providers receive clinical knowledge from professional associations such as the Health Professions Council of South Africa (HPCSA), through Continuous Professional Development (CPD) seminars or professional publications such as the South African Medical Journal. Within all of these avenues, however, LGBT health in general, and gender affirming care in particular are neglected areas, and are almost completely invisible (Müller et al., 2017). Information provided by LGBT NGOs contributes towards filling this gap.

Role 5: LGBT NGOs participate in, and monitor, health policy development and implementation

There are two main ways in which civil society organisations can participate in law and policy development. On the one hand, organisations are invited to specific consultative bodies, which are hosted by government departments, in which they contribute expertise to policy development processes. On the other hand, organisations respond to public consultation processes when new laws are proposed through parliament. Both are important mechanisms for including concerns related to sexual orientation, gender identity and sexual behaviour into health policies.

The South African National AIDS Council

The most important consultative body in which LGBT organisations directly interface with the South African government is the South African National AIDS Council (SANAC). It aims to create a collective national response to HIV, TB and STI among government agencies, civil society organisations, donors of funds, United Nations agencies, the South African private sector and people living with HIV, TB and STIs in South Africa, and is responsible for leading the implementation of HIV-related health policy, the so-called *National Strategic Plan* (NSP). SANAC is co-chaired between government and civil society. LGBT organisations are well established as one of the 18 sectors of civil society that are represented on SANAC, and one of the current co-chairs represents an LGBT organisation:

> *SANAC is a multi-sectoral body which was established in 2000 to respond to HIV, TB, and STI epidemic in South Africa, and really the mandate of this multi sectoral association is to coordinate and ensure effective response to the epidemic. It has various partners or stakeholders, it seats government, which is chaired by the deputy president and myself as the co-chair, coming from civil society, so all those spheres of structures of SANAC, it's co-chaired between government and civil society [...] Coming from civil society, [there are] 18 sectors and these sectors vary, it's labour which represents trade unions or federations, it's LGBTI sector, it's human rights sector, it is women, it is youth, it is health professionals, traditional leaders, it's all these spheres, 18 sectors are represented. (Blake, interview 12)*

Both OUT Well-Being and Triangle Project regularly participate in SANAC meetings among other LGBT organisations, and thus actively contribute to shaping HIV-related health policy and its implementation:

> *We regularly meet with the Department of Health and whenever it's necessary. We are involved in quite a number of forums where we are usually invited to, once again, because OUT is known in the arena, so we often attend meetings with SANAC, the South African National Aids Council*
> *(Tim, interview 05).*

SANAC recognises the specific vulnerabilities and health needs related to sexual orientation, gender identity and sexual behaviour. As a result, it developed and released a briefing document that focuses specifically LGBT people, the *South African National LGBTI HIV Plan, 2017-2022.* According to the introduction by the South African Minister of Health, the plan "will guide all stakeholders in HIV and STI prevention, care, and treatment for all members of the LGBT populations in South Africa, inclusive of all sexual minorities living in the country", to ensure that "members of the LGBTI populations can realise their health and human rights in an environment that is affirming of their sexual orientations, gender identities, and gender expressions".

SANAC's importance as a coordinating mechanism was recognised by both civil society interviewees and government representatives:

> *At SANAC level we do have sectors meeting whereby all the key population factors are represented. [We] have mandated SANAC to take the lead in terms of coming [together], because you know even the LGBTI it is not issues about health only, there are other issues that are multi-set so what we always talk at that level, we say that [the Department of] Health will have to take its responsibility and run with it. Special developments, [...] we do sit together in one room and then with all and everybody say, and we are able to take information in terms of the needs and requirements, and then also come here to inform our principles in terms of what is needed and how can that be implemented. (Whitney, interview 08).*

Whilst not the only LGBT organisation working with and through SANAC, OUT Well-Being and Triangle contribute to the coordinated and collective civil society sector, which has brought issues related to sexual orientation, gender identity and sexual behaviour onto the agenda at SANAC.

Public participation in legislative development

The second way to participate in law and policy development is through the public participation processes that form part of the development of new legislation. New legislation is developed in Parliament's so-called Portfolio Committees, composed of members of parliament. The first draft of a new law is called the 'Green Paper', the second draft the 'White Paper', and the final version the proposed bill. After an initial reading in Parliament, the proposed new law in its various stages (Green paper, White Paper and proposed final Bill) is published in the government gazette. At this point, South Africans can participate in public consultation about the proposed law public through a two-stage process: first, people are invited to submit written feedback on the proposed law. Based on these submissions, the Portfolio Committee then invites oral presentations in front of the committee. This public participation process is an important opportunity to provide specific expertise that might not exist within the parliamentary portfolio committee. Especially in relation to LGBT-related health concerns, it provides the opportunity to identify and counter heteronormative assumptions in the wording or the intent of the proposed legislation, to ensure that concerns related to sexual orientation, gender identity and health are adequately considered, and that LGBT people stand to equally benefit from the proposed legislation.

Triangle Project regularly makes written submissions on proposed laws, to, in the words of a staff member "try to shoehorn LGBTQI people into whatever [we] can" (John, interview 01): to provide an analysis of the proposed law that is framed around concerns related to sexual orientation and gender identity,. In recent years, this included submissions on the Civil Union Act Amendment Bill (2018), on the Green Paper on International Migration (2016), on the White Paper on Safety and Security (2015), as well as the health-related submission on the White Paper for National Health Insurance Bill (2015).[18] Case Study 3 describes how Triangle Project combined community-based research with community education to develop a policy submission on the proposed National Health Insurance Bill, to ensure that the health concerns and needs of LGBT people were brought to the attention of the parliamentary portfolio committee on health.

Case study 3: Bringing grassroots community participation into health policy submissions – Triangle Project's NHI submission

Over the past eight years, the South African government has worked towards a thorough reform of the financing of the healthcare system. Through its proposed National Health Insurance, government aims to reduce the disparities between the well-resourced private healthcare – accessible to only 16% of the population – and the under-resourced and overburdened public health system, which is the main point of care for the vast majority of South Africans. The suggested reform will reform healthcare financing, but also expand the infrastructure of the public system. Its aim is to provide a set of healthcare services for free for every South African. What is included in this so-called 'basket of care' has been the target of a lot of community advocacy.

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[18] For details, see Triangle Project's website at: http://triangle.org.za/what-were-here-for/research-advocacy-and-policy/ (accessed 29 November 2019)

In 2015, the South African government issued the draft bill that would guide the healthcare reform for National Health Insurance. As with all draft bills, there was the opportunity for public consultation. Civil society were given two months to provide comment, in writing, on the draft Bill. Triangle Project developed a submission on the draft NHI bill through a consultation with various LGBT community groups, called 'safe spaces'. At first, recognising that not everyone knew about the proposed changes in the healthcare system, the organisation set out to do community education workshops:

> *Our NHI submission, our community involvement, had sort of two prongs. The first was getting all of the Safe Space leaders together in a room to workshop some ideas [and] explaining to the best way you can [how] NHI is actually supposed to work [...] So it was getting people together to workshop some ideas and things like that, and before that meeting, because this is also the problem, we have meetings on Saturdays because some people work and Saturdays are the best day to do stuff. And that means that we don't have, we like have a half day on a Saturday because no one is going to give up their whole Saturday. If I had my way it would be all of the safe space people together where we sit down and develop the survey that we eventually use with the safe spaces. What we ended up doing because we have such limited time is that we put together a survey before that and explained everything to people and uh... just explained the NHI.*
> *(John, interview 01)*

Next, the organisation surveyed about 200 LGBT people who were linked to the safe spaces about their experiences and interactions in healthcare facilities:

> *[The second part was a survey about] health usage. How they interacted with the health service. So each Safe Space got however many copies they wanted, between like 20 and 30 I think, and it was just a simple two page questionnaire like I have used health services, I have felt they're useful, I felt they weren't, I use private, I use public, that kind of stuff and then that also went on to our Facebook page for an online survey... (John, interview 01)*

Based on the survey responses, Triangle Project developed a submission to the NHI White Paper. This submission combines an analysis of the proposed law with concrete recommendations for changes to the law. Each recommended change is substantiated by the lived experiences of LGBT people that were identified and quantified through the survey:

> *Those findings that we used were really useful to our argument, some of our key arguments for the NHI, which was that nothing in the document so far really spoke about ensuring quality of affirming care for [LGBTQI] people, or how those were really going to be measured and monitored and things like that, or how anyone was going to set any money aside for training or continuing ongoing training or something. So we used that to say like whatever those figures were, overwhelming negative reactions to using both the public and the private healthcare system from LGBT people, regardless, from trans and gender non-conforming people especially, but like and also stuff that you wouldn't think about, or like we would think about, but like other people wouldn't. Like we're not talking about lesbians going for a Pap smear and having difficult questions, we're talking about lesbians going for a flu jab and having difficult questions. Where's your husband? That kind of nonsense. So that formed part of our final submission that we made on the NHI as well where it had, where we had annexed the whole research report but then also built the findings into our summary arguments. (John, interview 01)*

The final submission, which was endorsed by a number of LGBT organisation across the country, points out that "the NHI White Paper fails to acknowledge the identities, vulnerabilities or diverse and specific needs of LGBTI people, despite several of these identities being recognised by other health policies" (Clayton & Jones-Phillipson, 2016: 15), and then goes on to provide specific examples based on the findings from the community survey. Further, the submission points out the lack of gender affirming healthcare for transgender and gender diverse people, as well as mental and reproductive healthcare in general, and makes recommendations for how to address this under NHI.

Through this community participatory process, Triangle Project brought the experiences and opinions of LGBT people directly into the policy-making process and to the attention of the parliamentary portfolio committee, and at the same time raised awareness of the upcoming health system reform among the LGBT people who participated.

Conclusion and looking forward

As our data show, OUT Well-Being and Triangle Project play a number of crucial roles in ensuring access to SRH for LGBT people in South Africa. Both organisations provide direct health services. These services are well utilised, although often constrained by the limited focus on HIV-related services, which are the services that funding is mostly available for.

As our data also shows, both organisations fulfil crucial roles beyond direct healthcare provision. They facilitate access to government healthcare services for LGBT people through referrals as well as the organisation's informal network. For this, the organisations are well recognised among healthcare providers, who emphasised that they themselves use the organisations' advice and networks if they need to find care for an LGBT patient.

Both organisations have well-established relationships with individual healthcare providers, as well as with government stakeholders. Often, these relationships have developed over time through repeated engagements through trainings and participation in policy-making processes. Healthcare providers and government stakeholders rely on the two organisations to train other healthcare providers on issues of sexual orientation, gender identity and health. Additionally, universities located near the organisations have begun to invite the organisations to teach health sciences students.

Whilst HIV remains an important concern, one medical practitioner suggests that as awareness and uptake of testing and treatment has improved, perhaps HIV is over-emphasised as the primary concern for LGBT people:

> *I might imagine that the access to HIV care or at least testing is quite good also just because it is like a universal policy and everybody loves testing, although apparently it is not actually going so well but anyway we don't have to talk about that. It is going well, going too well and we are over testing apparently. People are repeat testing […] but it is besides the point. In terms of other services, I mean I think it is related to [..] the types of things that people are dealing with and in terms of accessing healthcare at all. (Amina, interview 18)*

This concern was also raised in interviews with NGO staff, who pointed out that the concerns of LGBT people are evolving over time, and thus so should the role and scope of LGBT organisations.

One staff member pointed out that older LGBT NGOs, like Triangle Project and OUT have historically been set up by and for a specific white western client in mind, including within western paradigms of personhood, queerness and health. However, as their client base has shifted over the years, organisations are having to shift and to find other ways of understanding health and identity:

> *I think some of it's cultural, some of it is also us not understanding what are the strategies that people employ to be resilient. And so part of it is, for example, yes people go to sangomas, what is their experience? I'm saying part of it is access to language right, that people don't necessarily have the language to articulate this, secondly is that there's an assumption that this will cost money, so in their local communities they don't have access to it, if they come to Triangle Project. Historically it used to be largely white people and mostly Afrikaans and English in terms of language, that we offered. We have the past 3 years, we've consciously tried to employ Xhosa speaking social workers. So that hopefully begins to help in terms of access. But I think there's a broader cultural thing about what is wellness right, so the conversation is around how people would most likely use sangomas, there's also a way in which people lean into religion as a way to figure out what their spiritual practice is, rather…organised religions, so I'll go to church and pray it away […] I haven't really thought through this properly to understand it, I just know that I do think we need a combination or a response that is a combination of cultural and religious practices and then getting Western paradigms, whether it's psychology or social work and finding that combination to make sure that our response, at least in some way, is affirming for people, either way, right. (Margaret, interview 16)*

As outlined in this quote, shifting the organisation's understanding of health and identity includes, on a very basic level, the provision of services in a diversity of languages. However, in the long term, organisations may have to consider what a context specific culturally intelligible approach to LGBT wellness may be, and this may also mean having to be able to accommodate non-Western and traditional healing practices into their notion of health and wellness.

At the same time, as the clientele of NGOs has changed over time, organizations are now addressing a much wider segment of the South African population, a large percent of which are economically precarious or disenfranchised. This means that the clients of organisations themselves have different priorities for the issues that they are willing to advocate for. Organisations like Triangle Project have seen a shift in LGBT people's interest from health issues towards initiatives that address the wider socioeconomic context:

> *I think things are beginning to change in terms of the kind of activism that LGBTI people are willing to do at community level, very few people are still willing to go to a court for example or to go and picket in front of the department of health or to go and picket in front of DSD [Department of Social Development], there are different ways in which people are beginning to organise, a lot of that organising is happening on social media for example, and a lot of the, what I am seeing, is a lot of the work is leaning towards economic justice in particular, people are asking practical things, […] that even if I can't get access to clinics and services, more than anything people want jobs, they want to be gainfully employed, or they just want a bloody income, so it seems that there is a shift away from while there are more organisations providing support around sexual health and reproductive rights, especially in the context of Cape Town, there's Triangle project, there's GDX [Gender Dynamix], there's Anova Men's Health, there's a cluster of organisations that provide that work, I don't necessarily know if that responds to the needs of LGBTQ people and how they are articulating that, and so for me there's that disjuncture. (Margaret, interview 16)*

In response to the changes in their constituency, as well as the shift in community advocacy needs, Triangle Project has been seeking to politicise their work, such that the organisation's work keeps up with the needs and sentiments of its expanded client base.

Because wider public services are very poor in many communities, the organisation facilitates the identification of social issues and networks of support that go well beyond healthcare and health service provision:

> *Then we've got our broader work around work […] around our solidarity networks and working with poor under resourced LGBTIQ people inevitably in peri-urban areas or in rural areas and that is more the capacity strengthening, helping them to articulate, first of all understand the social political context in which they find themselves and psychosocial context in which they find themselves, be able to analyse that context and then for themselves design or think through conceptualise, an advocacy, community based advocacy strategy, how do we respond to the fact that, for example, access to housing is such a critical issue for, especially queer women in Black townships right, because that's a key issue, how do we understand that there is an intersection in terms of the experience of queer women and gender based violence, sexual violence, rape, etc. and that of other women in that local community, so how do we begin to cross over and build solidarity networks so that it's not just, you know in solidarity networks for me, it responds to two things, one is your immediate need, practical needs right now, in other words do I need to be moved out of my space, do I need transport from where the incident happened or from my house to go to the police station or to the hospital, those practical, in the moment needs, if you can't respond to that I think sometimes that's more problematic than anything else, but I mean those kinds of solidarity networks that responds to needs and then the high level stuff that looks at the broader context in which we are in, asking questions around policy but also in terms of service delivery and how do we respond to that, what is needed for us to push back or to support, or to undermine or to begin to critically question… (Margaret, interview 16)*

Conclusion: Successes and challenges/issues of concern

Success: Building momentum and networks for LGBT health

The continuous advocacy work of LGBT organisations has made the health needs of LGBT people visible. Although it does not yet necessarily get the attention it deserves, and still disproportionately focuses on gay and other men who have sex with men, there is a recognition that sexual orientation and gender identity and expression shape health and well-being. This framing informs the policy agenda and there have been considerable steps toward improving care in the public sector.

This is most clearly seen in HIV policy making and service provision. In the HIV Strategic Plan 2007-2011, MSM were mentioned as a population at higher risk, and it was recommended that HIV services should focus on reaching them better (South African National AIDS Council, 2007). The following HIV health policy for 2012-2016 explicitly recognised the structural drivers of the HIV epidemic, including stigma and discrimination, and identified MSM and transgender people as so-called key populations (South African National AIDS Council, 2011). The current NSP, for the period 2017-2022, details numerous interventions to reduce the structural vulnerability of MSM and transgender people (South African National AIDS Council, 2017). As our data shows, LGBT organisations, including OUT Well-Being and Triangle Project, have continuously supported health policy processes through the South African National AIDS Council (SANAC), where the LGBT sector has a permanent representation. As our data also shows, within the Department of Health, there is a clear recognition that topics related to LGBT health, albeit mostly focused on MSM and HIV, are important and merit attention in health policy and service provision.

The increased interest in LGBT health is also visible in the invitations for healthcare provider training and health sciences student education that LGBT organisations receive. For example, the health sciences programmes at the University of Cape Town had no LGBT health-related content in 2013 (Müller, 2013). Our data shows that now, in 2019, Triangle Project teaches five seminars a year to medical students, and the medical curriculum also includes other content related to sexual orientation and gender identity and expression, and that both Triangle Project and OUT receive health sciences students for electives or community engagement training. The impact of these engagements goes beyond the exchange of information that happens during the seminar, talk or elective placement. Rather, they also contribute to furthering the network of informal information exchange and referrals that we have described in the previous sections. Once students become doctors and start seeing LGBT patients, they contact NGOs for advice, or to inquire about affirming facilities to refer people to. As one NGO staff explains:

> *The trainings we do at UCT [University of Cape Town] have been super useful, because we train the [fifth year] students and for years after we get referrals from students. [For example] five people who did trainings four and five years ago, when they've got a question, they will call Triangle and say: "Oh, we did a training, and I've got a patient here who is presenting with X, I'm not sure what to do". (John, interview 01)*

The healthcare provider trainings that both NGOs provide also contribute to building a network of providers. Even if organisations are not remunerated for the training they provide for health facilities, a key, albeit indirect benefit of these trainings is that they actively expand the organisation's network. The relationships that each organisation has built through healthcare provider trainings differ substantially between the organisations and have manifested in different ways. In Case Study 2, we have shown how Triangle Project builds on networks and relationships that have evolved from healthcare provider training to offer government health services at the organisation's clinic, and to support individual LGBT clients to find and access affirming health services at government facilities. In Case Study 1, we describe how OUT Well-Being, through the reputation and networks they developed through activities such as training and sensitisation, successfully established a key population clinic at their organisation, in partnership with the Department of Health and an international donor. The organisations attributes this, and its wider success to the "cumulative work" of advocacy, engagement, networking and outreach:

> *You never know who speaks to whom, through a network of people you get connected to the right person at the right time. The cumulative work that happens over time you cannot add up by adding up all the people who have come through OUT, and that leads to other things that is hard to account for in reporting statistics – being available, going to meetings, having your banner. You have to collaborate, that's how to build relationships that are crucial to get some other results, the data does not tell the whole story. It tells a part. For example, it's one thing to be critical of government – but there has to be a balance, at some point you have to collaborate on certain activities and programmes. (Tim, interview 21)*

Relationship- and network-building takes a long time and arises from continuous engagements with stakeholders. It is often difficult to account for in short-term monitoring and evaluation frameworks that cover either specific time periods or specific activities. Rather than being a clearly defined activity within a clearly defined period of time, developing these relationships and networks is a long-term consequence of a number of specific activities. As we have seen in the previous section, OUT Well-Being's relationship with the DoH, that resulted in DoH offering to support a key populations clinic, can be traced back to over 10 years of engagement in various forms (from healthcare provider training to policy development) and at various levels (from individual healthcare facilities to high-level meetings at the National DoH).

Success: The Continuous Provision of Healthcare to LGBT people

The provision of healthcare for LGBT people at NGOs has grown and solidified over the last decade. In a study done in Gauteng in 2004, 17% of LGBT people who participated said that they had sought healthcare at an LGBT NGO in the previous two years (Joint Working Group [JWG] & UNISA Centre of Applied Psychology, 2004). When we asked LGBT people in Gauteng in 2019, fifteen years later, 30% had sought healthcare at an NGO in the previous year. This is almost doubled from 2004, and likely indicative of the wider array of health services that are provided, as well as the wider reach of the organization, including through community outreach services. As we have shown in our data, health services at NGOs have also become more established and stable and are now provided in partnership with, and at least partially funded by, the South African DoH.

NGOs such as Triangle Project and OUT Well-Being are essential in the provision of accessible and affirming care for LGBT people. It cannot be emphasised enough how important their work is. On the one hand they directly provide care that is recognized by and supplements the public system. The OUT Well-Being clinic is integrated into the DoH's public health system, and Triangle's clinic is supported by DoH funding, and by informal collaboration with DoH services. Both organisations provide substantial outreach health services. That they have been able to consistently offer these health services, and indeed have developed their role and expanded their reach, in an uncertain and shifting funding environment, is a significant success in and of itself. A recent study from South Africa showed that NGOs were the most important source of care for HIV and other STI-related concerns, as well as for psychosocial support and counselling for LGBT people – before public or private health facilities (Müller et al., 2019). As we have shown, LGBT NGOs currently provide mostly HIV and STI-related services, as well as psychosocial support and counselling. It is well possible that if their service offering expanded, they could become the first port of care for LGBT people for other health concerns as well.

The importance of healthcare provision at LGBT NGOs is also evidenced in public sector awareness, reliance and referral to these organisations, as evidenced in the previous sections. For example, Department of Health officials and healthcare providers that we interviewed in the Western Cape all mention the Triangle Project Clinic as their first port of call for assistance with an LGBT client.

Success: Improved awareness and attitudes about LGBT people in the public sector

In addition to directly improving care, as detailed in the previous section, the organisations enable better care in the wider public system, through the identification of appropriate services or amenable personnel, sensitisation and education of public healthcare staff, and by holding the public sector accountable through patient advocacy through seeking care, treatment and complaints procedures.

This is also borne out in a shift in public healthcare worker attitude over time, as one NGO staff member points out:

> *OUT has done an amazing study some years ago, where it showed people's experiences with their healthcare workers, where it showed results of other people being denied services because of who they are. So, once in that space where we showed healthcare workers this kind of information, they do experience a shift. I wouldn't say we have behaviour change, because behaviour change is more difficult of course, but what I've been successfully doing is that the perception changes a bit. There's a strong mind shift and then you get – I mean there's a situation that shows itself where people are likely to say "I used to do this, now I wouldn't do this, I was not aware that I was harming people, now I'm aware." You know. Very eye opening, all this kind of feedback that you get, so there is a definitely a shift in people's perception of how they view LGBT people. But in terms of like, have they changed their behaviour yet, that's still quite a difficult one to measure of course. (Carl, interview 06)*

Organisations have been able to develop relationships with specific service provides or facilities in the healthcare system. This means that in their respective areas, there are affirming government services that LGBT people can frequent, and that NGOs can rely on for additional services that they do not provide themselves, or that may be more accessible for clients based closer to the government service than the NGO.

At OUT Well-Being, for example, although the organisation does manage HIV care for some women, they do not provide other SRH care. However, they are able to refer clients for cervical cancer screenings or other concerns to LGBT friendly providers in the public sector:

> *If a person with a uterus needs a pap smear or other sexual health service that is not provided, we unfortunately would have to refer to one of our nearest government facilities. It is not the ideal, but we do have a working relationship with the government clinics closest to us, and we have to refer the person to access the services there. There are LGBT affirming providers that we know [at those facilities]. (Tim, interview 21)*

Similarly, Triangle Project has developed a relationship over many years with several clinics that are further away from the Cape Town CBD, where the organisation is located. This means that these clinics can often manage care for LGBT people, without having to refer patients to Triangle, which may be too far away.

> *[Our nurse] has built up good relationships with particular public sector clinics that have been sensitised – there is now a nursing sister who does pap smears and has been sensitised to understand trans men, use their correct pronouns and so forth. This relationship began with sensitization training and then deeper conversations around how trans men and queer women were not accessing services like pap smears. [...] Findings these little hotspots, like [clinic name], that we build relationships with. They got good. Some of the best care at rural sites where time has been spent with staff to sensitise. (Sarah, interview 20)*

In addition, in emergencies, for example when psychiatric care is urgently needed, Triangle Project may be able to seek assistance from these clinics when services in the centre do not have space, or are unwilling to assist for whatever reason:

> *But that particular little clinic, it really is, and it's been client by client, but it's been such good exposure, because they've had the younger trans that have been, that had a young trans woman who has been, they have [client name], whose gender questioning and so that's the person who is, they're actively psychotic, but getting the most outstanding care, because the psychosis is now under control, meds are under control, attends all the appointments and sees the psychologist once a month and has you know... So everything is nicely taken care of by a little rural clinic. (Sarah, interview 03)*

Success: provision of HIV-related healthcare services

There have been considerable gains in the provision of HIV-related healthcare for gay and other men who have sex with men, due to domestic and global efforts to stem the transmission of HIV among this group. As the focus is on addressing transmission through penile sex, particularly anal sex, these services also address transwomen, although they are often conflated under the term MSM.

Advocacy efforts by NGOs and global funding initiatives have led to significant policy developments within South Africa. The current *National Strategic Plan for HIV, TB and STIs* recognises MSM and transgender people as key populations, and the *South African National LGBTI HIV Plan, 2017-2022* provides detailed guidance for operationalising the NSP.

In response to these policies, there are notable initiatives between NGOs, government and donors that create dedicated HIV healthcare services for key populations: as an example, we have shown the collaborative clinic between OUT Well-Being, the Gauteng Department of Health and an international donor in Case Study 1. Another example that was announced in November 2019 is a network of newly established primary care clinics for transgender people, through a partnership between Witwatersrand University and an international HIV donor. At these clinics, transgender people will receive "services to prevent HIV transmission in high-risk populations include health information products, HIV testing and counselling, distribution of male and female condoms, and oral pre-exposure prophylaxis (PrEP). HIV positive clients will receive antiretroviral therapy (ART) and adherence support. The clinics will also provide primary healthcare, family planning, Tuberculosis screening, and treatment for sexually transmitted infections."[19]

Our quantitative findings bear out the relative accessibility of services for gay men, or men who have sex with men, and transwomen. Ninety-two percent of our survey participants knew their HIV status. Fifty-eight percent had tested for HIV in the previous year.

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[19] According to the press release: http://www.wrhi.ac.za/media/detail/first-dedicated-clinics-to-open-for-transgender-care-under-key-populat (accessed 03 December 2019).

Challenge: Funding Conditions and Priorities

As NGOs rely on external funding, the timeframes and conditions of funding can radically impact the day to day work of organisations. Funding agreements typically run for a few years at a time, which can be problematic for the establishment and functioning of health-based services. For example, the establishment of a clinic can take many years, and a substantial initial outlay of resources, however, if funding is not renewed the entire initiative can be threatened. This was the case for the OUT clinic, which fortunately was revived by a partnership with another funder and the Gauteng Department of Health, detailed in Case Study 1.

This new tripartite agreement between the international funder, OUT and the provincial Department of Health has enabled the continued operation of the clinic. However, maintain this partnership has a high administrative burden. One the one hand, the agreement between the NGO and the DoH has to be renewed every 3 years, and on the other, the agreement with the international funder our agreements runs for 5 years at a time. These different funding cycles require the NGO to accrue documentation and renew contracts at different times, and because the model only works with all three partners, should one party choose not to renew, the remaining years of agreement between the other two are also jeopardised. In addition, renewing contracts with government departments can be especially challenging as administrative processes are unpredictable and the time frames for the renewal of contracts can be very protracted.

In addition, NGO's struggle to raise funds for roles that are not for service provision. Most NGO funding, particularly that related to HIV, is for direct service provision, and there is little funding available to build sustainable community structures, including for advocacy, health education, and engagement in policy development.

In this regard, the support of COC Netherlands has been notably different, in allowing organisations to develop capacity outside of service provision:

> *COC has done as a funder, of all the work that, and that includes all the major LGBTI organisations in the region, not just in South Africa. You see what the work they have done to capacitate communities, organisations and stuff, design manuals, programmes, products, lots of strides working with healthcare providers. (Karen, interview 04)*

Further, NGOs incur frequent additional costs, related to the needs of clients. For example, when Triangle Project is alerted to a client experiencing a mental health crisis, much time and resources are expended in addressing that person's immediate needs, including shelter and food, appropriate psychological or psychiatric referral, transport, patient advocacy within the public system or with private doctors, one-on-one support, and family mediation and counselling. This falls outside of standard programmatic work, and often happens at odd hours, and in more remote areas, where NGO staff have to urgently respond in their individual capacity. Whilst not standard in-office service provision, this work is essential to ensuring the wellbeing of vulnerable LGBT people in moments of crisis and when they may not have other support structures.

Additionally, these unplanned, emergency interventions, often have the unintended, longer term consequences, that they create linkages with individuals or sites within the health system. Through exposure to one NGO health advocate assisting one LGBT client, who may have been seen as "unmanageable" or "extreme", healthcare providers might begin to understand the intersection of poor mental health and sexual and gender identity, and take an interest in improving their knowledge, skills and services. Further, through conversation, and sometimes complaints mechanisms, NGO health advocates may force recalcitrant health workers to reconsider their position. These moments lead occasionally to more sustained engagement with specific providers or facilities. However, funding often does not directly cover the costs of this emergency work, or their spin-off engagements.

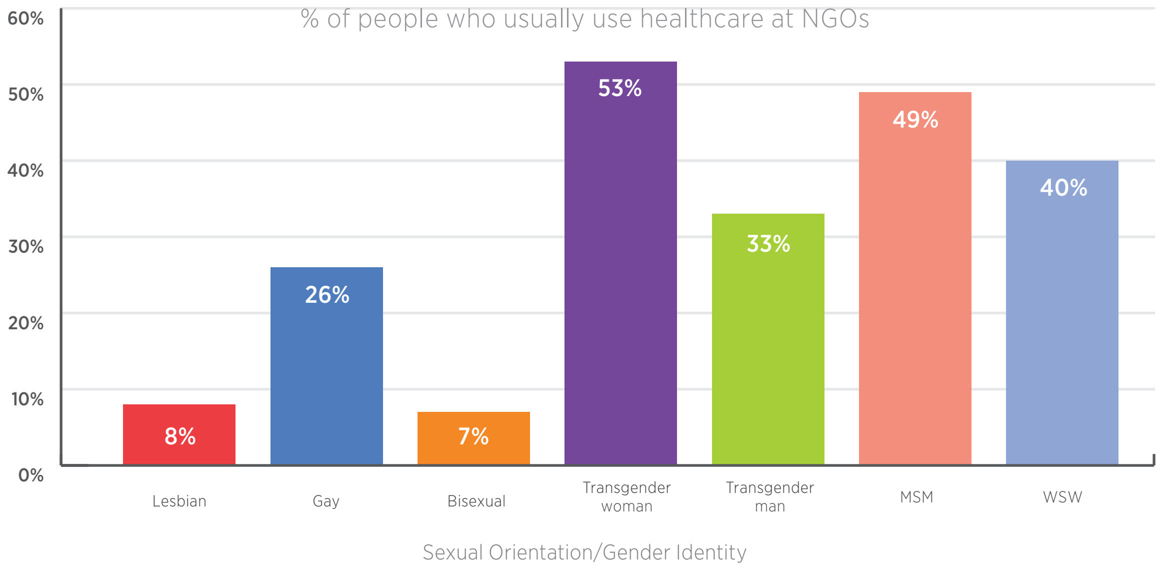
Another area that is difficult to raise funds for is staff wellness initiatives. Due to the high burden of work, there is a considerable risk for staff burnout. This is exacerbated by the fact that many staff members identify as LGBT themselves and may be struggling with, or have experienced, many of the issues they see among clients.

Finally, because of the focus on HIV-related service provision particularly for MSM, NGOs struggle to raise funds for programming for other sexual and gender minority groups, as delineated in Part 1 with regard to people with uteruses, and for other health concerns, including mental health, also addressed in Part 1. This is further addressed in the next two sub-sections.

Challenge: Focus on HIV prevention for MSM

When looking at the services that LGBT people say they have accessed in the past year via our quantitative finds, there is a clear bias towards HIV prevention (VCT) and/or HIV treatment services. Eighteen percent of survey respondents said they were living with HIV, so HIV clearly is an important SRH concern. More than half of people (52%) reported accessing condoms and more that 40% accessed lubricants at organisations. However, access to other barrier methods is not as pervasive. OUT Well-Being, for example, does not provide dental dams and finger cots for safer sex that is not limited to penile intercourse.

When we asked about using healthcare services at NGOs, we saw stark differences between respondents of different sexual orientations and gender identities. Forty-nine percent of MSM and 26% of gay men said they usually go to NGOs to access healthcare, but only 8% of lesbian women said the same (as well as 4 out of 10 women who identified as having sex with women – but the WSW group was too small to make definite comparisons). A high proportion of both transgender men (33%), and of transgender women (53%) usually use NGOs to access healthcare, with transgender women being the highest of all categories.



There are at least three explanations for the relatively higher use of services by same sex practicing men and transgender people, particularly transwomen. First, existing data shows us that transgender people, are at extreme risk for discrimination and violence, often because they are very visible as not conforming to the sex-gender binary (Herman, Harrison, & Grant, 2012; Valentine & Shipherd, 2018). In addition, transgender people also tend to struggle financially, as it is difficult to secure formal sector employment if one does not pass, or if one does not have identity documents that affirm ones' identity (Husakouskaya, 2013b). Thus, transgender people may be more dependent on NGO services because of the high levels of discrimination they fear or face in public health facilities, but also because often, NGO services are financially more accessible by providing outreach services. In addition, there is a relatively high proportion of transgender people who are sex workers (Nadal, Davidoff, & Fujii-Doe, 2014), another key population targeted for the provision of HIV services through NGOs.

The imbalance in NGO service-use also speaks to the kinds of SRH services available at NGOs. This was a theme often raised by interviewees, who pointed out that current services are often focused on HIV (and, to a lesser extent, on STIs) and may not provide key SRH services that women and other people with uteruses need, including cervical or breast cancer screenings. This is also detailed in Part 1 of this report.

Our data shows that HIV-related services are the most accessed health services among LGBT people. This is corroborated by another recent study, which also found that HIV-related services are by far the most used healthcare services among LGBT people in South Africa (Müller, Daskilewicz and SEARCH, 2019).

Second, because NGO services are skewed towards HIV-related services, it seems logical that the people most affected by HIV would be accessing these services more than people less affected by HIV. In our sample, there is a higher HIV prevalence among transgender women (28%) and MSM and gay men (25%), compared to lesbian women (12%) and transgender men (0%). But this does not mean that lesbian women and transgender men do not have other healthcare needs – only that within the current framework these are less catered for if at all.

Third and finally, because NGOs depend on donor funding, the kinds of services that are available, and for whom, is heavily reliant on what donors want to fund and what is seen as a priority in the global health agenda. As one previous staff member of OUT, now working in another LGBT civil society organisation, describes, whilst the organisation still caters to LGBT people broadly, available funding has drastically reshaped OUT's health service provision in favour of services for men, and other key populations (transwomen, injecting drug users, and sex workers):

> *I'm definitely sure if OUT had enough resources it would have kept its own focus on LGBTI in service delivery, acting around SRHR. So, for other programmes I'm sure they still do LGBTI broad scope but for SRHR or health services it's predominantly MSM and drug users. So when you don't have funding, funding changes your focus and OUT's focus changed over time because of the kind of funding they had received. (Blake, interview 12)*

Because current health funding in the LGBT sector is mostly focused on key populations – MSM, transwomen, sex workers and injecting drug users, it is extremely challenging to provide SRH services to lesbian and bisexual women that do not fall into these prioritised groups. When describing how LGBT organisations serve different groups under this acronym, another OUT staff member observes:

> *The G is the loudest and the L is coming up now is coming up now, and the B is very silent and the T and the I, are sort of like hanging on by a thread. So, for me, I would say, if the organisation is to claim that it services LGBTI people, it needs to have a specific programme for each letter, no matter what letter it is. Even if when the funders say it's an MSM programme, okay fine, so be it, but then the organisation needs to have some sort of ability to say "what can we do for the T, what can we do for the I?" You know what I mean? And I know it's difficult. I know it's wishful thinking. It's difficult work and capacity is a huge problem within these organisations. (Carl, interview 06)*

However, organisations such as OUT, whose health provision is quite structured by this focus, try their best to provide broader services given the constraints of their funding. As OUT staff noted they do not turn women away, even though services are not marketed to them and these clients do not count toward their key population targets, but instead make existing HIV services available to them (09, 21).

The key population focus that shapes funding for NGOs also shapes healthcare services in the public sector, because the global health agenda also informs national policies, as described in Findings Part 2 (policy development); but also because NGOs are responsible for much of the sensitisation and training in the public sector. One NGO staff member notes that resultantly even training for public sector staff from LGBT NGOs are also skewed toward HIV and MSM, such that staff are still uncertain about how to address the needs of other groups, especially when not related to HIV:

> *So I endlessly fight with them at Department of Health meetings to say when we're out in the field, your (DoH) staff are saying they want training, they want training. If you say you rolled out this training manual and you say that there is an organisation in place who is funded to do this work, what is missing here? And I wait for them to tell me, because I know what is missing. What's missing is [because of] the focus is on MSM. So it still comes back to well what do we do when we have a transgender client? Or what does a lesbian, like, it's so MSM focused that it forgets other things, and these are probably the most difficult. Not the most difficult, but like a transgender patient would be far more challenging for a hospital setting than a gay man [...]*
> *(Sarah, interview 03)*

This Triangle staff member argues that current LGBT service provision is based on

> *[...] a funder-driven agenda, is not a patient centred [...] And I don't think things work well when it's funder driven, because then it's got nothing to do with patient-centered. Then it's got to do with ticking boxes and that's all. (Sarah, interview 03)*

This resonates with the sentiments of one OUT staff member, quoted in Part 1, who described her frustration of not being able to address aspects of all LGBT people's health (Justice, interview 09).

Because HIV is the core mandate of many LGBT health services, this also means that the focus is largely only on SRH as a problem, and on methods to prevent STIs (and pregnancy). There are no services that address SRH in its complexity for LBQ women and gender non-conforming people with uteruses, that talks about pleasure, or fertility:

> *When we look at family planning, it is only the preventative measures are considered within a public health system, we don't provide none of those services, we don't provide for family planning of any kind and that is strictly because the funders do not pay for it. (Justice, interview 09)*

This HIV-focus in terms of LGBT health also means that other health concerns, not related to SRH are overlooked (Meer & Muller, 2019). Thus, whilst LGBT people have relatively better access to HIV-related care through NGOs, they are still entirely reliant on the public sector for everything else. This gap is especially acute in terms of treatment after violence, and for psychosocial care (addressed in the next sub-section).

> *...when it comes to physical from people who have been assaulted based on their sexual orientation, we find that they do not go for medical services at all. They one person who came to the, informed me, that no I am not going to go by and traumatized already and I do not want to be traumatized and be waiting on the line while I am bleeding and waiting for casualty staff to assist me. So you can, you can already sense that the fact that they already, they feel defeated and they feel like nobody would be able to assist them in that situation and coming to assist them in public health system which is not really working as efficiently as it should, may would be of course be demotivated to go and they know that the approximate waiting hours would be about three to six hours and still even within that you are faced with discrimination because you let them know why you were brutally attacked and they would assume that, maybe it is okay maybe it is fine they are trying to fix you, that still exists in our health system so people are losing a lot of faith. Health in regards to sexual health has been is kind of like getting there but when it comes to general health people are very reluctant to accessing these services... (Justice, interview 09)*

This also raises the question of how specific LGBT services, whilst ameliorating specific, often acute needs, do not address the wider problem of a hostile, inaccessible, and largely inadequate, health system.

Challenge: The Lack of Mental Healthcare for LGBT People

As we have demonstrated in Part 1, mental health of LGBT population has been widely neglected and barriers to accessing mental healthcare are persisting within the public and the NGO sector. However, recent research demonstrates that the LGBT population in South Africa has higher than average levels of mental ill health as well as substance use (Müller et al., 2019). This comports with the findings of international studies which shows that the minority stress experiences of LGBT persons can put them at the greater risk for developing post-traumatic stress disorder (PTSD) (Nielsen, Tangen, Idsoe, Matthiesen, & Magerøy, 2015).

However, it is extremely challenging for NGOs to provide or refer LGBT clients to suitable mental healthcare services. This is largely because psychosocial care and their effects on sexual and reproductive health do not seem to be well understood on many different levels, and there is very limited capacity for the provision of comprehensive and thorough care in South Africa. First, as one key interviewee, from Triangle Project, observes, because many South Africans live under extreme stress, subject to economic precarity, current and potential violence, many people do not have a concept of wellness that includes mental support or care, nor do they feel entitled to it:

> *... also access to wellness services, I think there's just in terms of the people we work with, there's just, not necessarily an aversion or resistance necessarily, but I think there's a lack of entitlement to wellness services or wellness support. People often don't understand how that is part of the broader conversation around sexual health and reproductive rights. Wellness would be, for example, coming for a one on one therapy session because you're processing rape for example, or you're trying to work through what intimate partner violence means and how that makes you vulnerable to other stuff. [...] I get the sense that it isn't something that they would naturally pick up, in terms of the people we work with, poor, under resourced people, there isn't a broader sense of wellness as a key for me... (Margaret, interview 16)*

Given the competing concerns in peoples' lives, it is unsurprising that people focus on material concerns at the expense of mental health. However, unmanaged mental health concerns have long term negative effects for individuals, including social isolation, unemployment and poverty, self-harm and suicidality (Milner *et al.*, 2014).

Second, even if people are empowered to address their wellbeing more holistically, the South African healthcare system is largely unable to address the mental healthcare needs of the population (Jack et al., 2014; L. Robertson, Chiliza, Janse van Rensburg, & Talatala, 2018), and there are no services that are targeted specifically at LGBT people. In general, there is major shortage of services in the country as a whole. In health policy and the rationalization of resources, mental health services are perhaps seen as less urgent given the pressing concerns of infectious diseases such as HIV and TB (Mascayano, Armijo, & Yang, 2015). Nevertheless, existing services are largely oversubscribed and there are not enough psychologists and psychiatrists in the public sector (De Kock & Pillay, 2017; Lund, Kleintjes, Kakuma, & Flisher, 2010). This means that

LGBT organisations, struggle to find care for clients who need urgent psychiatric care, particularly acute care, observation, evaluation and long-term in-patient services.

In addition, LGBT people may be even more reluctant to seek mental healthcare due to histories of pathologisation, past experience of poor treatment, or fear of poor treatment.

Further, when government services are overwhelmed, and someone is known to identify as LGBT, or their sexual orientation and/or gender identity intersects with mental health concerns to compound their ill health, public health workers may even seek out LGBT organisations, even though they lack the mental healthcare expertise. One interviewee from Triangle Project remembered a client who was referred to Triangle Project from a tertiary public hospital, although she needed clinical psychiatric care, which the organisation could not offer:

> *It was very clear she [the patient mentioned previously, a transgender woman] needs to be seen at G27 [the outpatient psych Unit], or another psych unit. We tried to phone and get her access to the psych Unit, but there seems to be a new set of admission rules, even as an outpatient, and I guess they're just overburdened. There has to now be another set of criteria for a psych unit. But she should be seen as an outpatient by psychiatry somewhere, and they [the referring HCWs] know we can't do that. There's no point taking her into counselling with a psychologist [at Triangle], she needs psychiatric care. There's no use taking it on, only to refer her down the road. I think sometimes we're just an easy way out [for the HCW who refers]. (Sarah, interview 20)*

Third, there is often a conflation between lay counselling and support services and professional mental healthcare (access to psychologists, to medication, psychiatrists, inpatient facilities etc). On the one hand, both OUT Well-Being and Triangle Project, have considerable experience with providing support to LGBT people and providing counselling in person, one-on-one and in groups, and by telephone. However, there is an increasing understanding that lay counselling and support is insufficient for the considerable mental health burden of their client base:

> *When one starts to realize a person is not going to care for his or her physical health, that's important to stress, because mental health is neglected. It should be both counselling and clinical care. With the counselling services that are available, sometimes I cringe a little bit. I am a lay counsellor myself, not a registered psychologist, but I think it is sometimes very easy for a person to call themselves a lay counsellor but then they've done a two week course and the level of counselling that you get can be hair raising and can border on being dangerous. Because often, a can of worms is opened with a client and that lay counsellor does not have ability, knowledge or capacity to contain that situation. We need professionals, and that goes to more psychiatric level treatment, mental health treatment. Lay counselling is available - but cannot deal with depression anxiety, PTSD. These go undiagnosed because a lay counsellor is trying to help someone deal with their problems the best they can, but it might be missed that there is a severe depression that you are talking about, or an anxiety disorder and that goes undiagnosed. (Tim, interview 21)*

Given the available evidence that LGBT people actually struggle with relatively very poor mental health, including substance use, depression and anxiety, as this key informant points out, it si insufficient to rely only on lay counsellors, and in some instances this may in fact do more harm than good. Ideally, counsellors should be able to seek assistance or refer to mental health professionals when clients need more than support and containment counselling but might require therapeutic sessions with a psychologist or the diagnosis and treatment of a mental health condition from a doctor. Counsellors should be trained and familiar with mental health concerns to know when to make these referrals or seek additional help.

As neither Triangle Project nor OUT Well-Being have the expertise or capacity to provide these clinical services or dispense medication, there is a clear need for mental health professionals that are LGBT affirming, and knowledgeable about LGBT health and minority stress, that is available for referral, or consultation at NGOs. However, mental health specialists are generally expensive and scarce.

Fourth, whilst the work done by Muller, Daskilewicz and The Southern and East African Research Collective on Health (2019) is an important step to develop an evidence-base from which to advocate for better mental health services for LGBT people in South Africa, there is currently little evidence from the local context about the intersection of minority stress for LGBT people, and ill mental health, including substance reliance, and other structural issues (as outlined in Part 1). In addition, there is little research of what a grassroots, accessible approach to mental healthcare, tailored to the local context, might look like for LGBT people, though it is widely understood that approaches embedded in the local context, and cognisant on socio-economic conditions are desirable (Inge Petersen & Lund, 2011). Neither is there a framework for mental healthcare for LGBT people that does not hold Western knowledge as the only way to engage with wellness, though the literature recognises indigenous healers as central figures in the provision of community-based health services and the need to co-operate with them (Inge Petersen & Lund, 2011b, Nxumalo et al., 2011), nor how indigenous practices might dis/enable wellness (Robertson, 2006), particularly for LGBT people. NGOs are central to navigating these issues as both advocates for the wellbeing of LGBT people, and as providers of healthcare.

On one hand, NGOs lack the capacity to provide comprehensive, psychosocial and clinical care for people with mental health concerns, and mental healthcare is a complex and specialized field. On the other hand, state services are simply not adequate, nor accessible and available to LGBT people NGOs are already the first port of call and often the best option for many LGBT people with mental health concerns. Thus, LGBT organisations are already doing considerable work to fill the gap in state mental health services, or to help clients seek out appropriate care, and bridge the gaps between appointments, and referrals. This is likely even more so outside of urban centres. Existing evidence suggests that "task-sharing" of mental healthcare from specialists to other providers, such as lay counsellors or primary healthcare workers is effective at improving and managing the mental health concerns of patients provided there is appropriate training, supervision and resources committed to the effort (Mendenhall et al., 2014; I. Petersen, Hanass Hancock, Bhana, & Govender, 2014). In the case of LGBT people, this may be even more effective as NGO-based mental healthcare would be more accessible than navigating the tertiary system, but would also be more wholistic, as NGOs are able to easily contextualise mental health against the other health concerns of LGBT people (such as HIV risk), and the impact of minority stress and socio-economic factors.

Further, NGOs are shouldering a considerable part of the burden of HIV and SRH care for the state, although not so long ago, the diagnosis, treatment and care related to HIV was also seen as extremely specialized. It has been through the realization that the urgency of the problem required a primary healthcare approach, that is widespread, accessible and decentralised. This has been enabled by, among other things, a purposeful funding strategy.

Perhaps, given what we are beginning to understand as the pervasiveness and severity of mental ill health among LGBT people, we might consider the urgent provision of mental healthcare in the similar terms. If so, a funding approach that is flexible and consultative, that is sensitive to what NGOs see as the mental healthcare needs of their clients, but also their capacity or potential to help meet these needs it required. This once more raises the question of how resources to make LGBT-affirming healthcare more accessible should be distributed between LGBT-specific services (such as at NGOs), and the general health system (such as primary care clinics).

Challenge: Engagement with government

Whilst the tripartite partnership between NGO, government and international donor has allowed the ongoing operation of the OUT clinic, relying on government to provide healthcare resources, including medication, has some drawbacks. For example, because the Gauteng DoH frequently has shortages in medication and other healthcare resources, which has been a concern for many provinces of South Africa, this directly impacts the OUT clinic:

> *Because we are reliant upon the availability of the resources that they [DOH] make available to us, what we can do is often influenced by the availability of these resources. What I mean by that is if government for instance experienced low levels of stock or the next order is coming in late, then it influences the availability of those particular medication or resources to us. For instance, condoms and lubrication. If government doesn't have, then it means we don't have. Most of the time we have to literally drive around and go and collect these commodities from certain places. So luckily we are in a position where we have several contact people, we know where to start looking for these type of things and then we would go there and go and pick up the stocks that we need, for instance, testing kits, condoms, lubrication, particular medication. So, all of that is dependent upon the availability that government has, so that's a big challenge all the time. Because we receive the medication from one point, we receive the condoms and lubrication from a different point, we receive the testing kits from another point. So that's why I'm saying it's quite regular, because if we manage to sort out the problem with medication for two or three months then we might experience a shortage on condoms and lubrication. When we manage to sort that one out, we might experience a shortage on testing kits. So, because it comes from different points within the Department of Health, it's a regular thing that we deal with on a daily basis. And to make it very practical for instance, some of our regular clients who are on ARV treatment for quite a while now, they can receive two or three months' supply of medication, they don't need to come and see us every month, and that's actually what the national algorithm also says. But if we don't have enough ARV medication in stock, then we can only supply them with one month's supply. Which means that*

> *next month they have to come back to come and collect another month's supply of medication … and that places a burden on the amount of clients that we have to assist during the month that our clinic has to see. So that's one challenge. (Tim, interview 05)*

In addition to persistent interruption in the supply of medications and resources, DoH collaboration also means contending with various other logistical and administrative difficulties that are prevalent in the public sector. This includes slow or unresponsive administration including in ordering and receiving new supplies, and the possibility of labour strikes in government services, which has previously affected laboratory services. This means that navigating government systems is time consuming, and sometimes slows down the work of the NGO clinic.

NGO staff members also reported difficulties around engaging in government processes for policy development or amendment. Whilst policy development and amendment are important for more sustainable and long-term change with respect to LGBT health and rights in general, however it is often difficult to generate interest in opportunities to engage with government policy processes.

Due to the historical inequality that still shapes life for South Africans, many communities feel disenfranchised from policy process that are open to the public because they do not see the processes as accessible, have no experience with or knowledge of the processes, and lack information about the issues up for discussion. As one NGO policy officer describes, he is often faced with disinterest about policy issues from local LGBT people.

> *The kind of barriers is just about the kind of level of engagement we want out of people. […] I want the queer people we work with to be as vaguely interested in policy as maybe me and some other people I know are. Like very few people give as many shits about policy as I do, or like people whose job it is. So like when I have a meeting it's just like oh my God you guys, they're like reforming the whole healthcare system, this is the biggest shift in healthcare in a generation! If it doesn't bankrupt us all, it's going to be like the biggest, I mean you don't understand, it's the biggest change in social mobility in this country's history. The NHI is a huge deal and people are like 'meh.' (John, interview 01)*

Nevertheless, NGO's are important in engaging local people in these processes and creating forums to discuss the issues that affect people, and link these to policies under discussion. As Case Study 3 demonstrates, despite inertia or reluctance to learn about and comment on policy issues, organisations such as Triangle Project has had considerable success in engaging local people on prescient policy issues. However, such work is stymied by the structure and timeframes that government puts in place. For example, government occasionally makes calls for public input of a proposed law or policy, however, it is unpredictable when such a call will be made so that NGOs cannot start discussions with their constituents beforehand, these calls are often made only in English so require translation by NGOs, and the timeframes deadlines for submissions are usually very short. This means that NGOs set-up policy input processes under extreme pressure, and with very short timeframes, and are often competing for constituents' time and effort, among a range of other initiative and events. However, existing initiatives and events can also be useful spaces to capture an audience around pressing policy and law reform issues, as this same policy officer describes:

> *Many of our community participation things we do, they are really rushed, we really rush them. So even with this, it's a, we, I definitely shoe-horned the safe spaces[community groups] into the end of this process because basically there was a meeting coming up, and I was just like oh well, we're going to, one of the things I'm going to ask people to do is to make contributions onto the NHI [proposed National Health Insurance]. So literally we handed out all of these things and the next week was Khumbulani Pride [a local pride celebration], and I just basically people had seven days to go to collect all of these things, and then I physically just hunted people down at Khumbulani Pride, and it was like thank you, thank you, thank you, thank you, for all these folders.*
> *(John, interview 01)*

Further, NGOs often struggle to follow-up with communities around the issues that they have been discussing, or report back about outcomes or next steps:

> *And just because of other organisational weaknesses, it means that what is really bad and really remiss of us and what will come up in a million community participation evaluations, is that the follow-back and the feedback is really weak, so people put in the time and effort to do this thing, and then we rush off and it's crazy and we have to meet this deadline and we spent like two weeks putting together this thing with deadlines closing, and then we submit it and we're like 'oh my God, it's done!' And then we are onto the next thing because we've got another deadline, and we don't make the time to like say first of all thank you, secondly here's what we did, and thirdly, which is I think a problem with government policy more than it's a problem with us, is that often when you make these submissions, you have no clear idea about when or where the next step will happen. (John, interview 01)*

As this interviewee alludes to, this is largely because such policy engagement is often under time-pressure, and the work on it has to be done intensively to make deadlines, and because it is often not part of the day-to-day service provision of organisations or a pre-determined project-based initiative, that is it is not directly funded, NGO staff members usually have to immediately return to their other work. This is worsened by the fact that government policy processes are episodic and unpredictable, so often NGOs themselves do not know what will happen next, and issues can go quiet for long periods, without further developments.

Thus, engaging with government is challenging for NGOs, as its systems and administrative processes are difficult, unpredictable and inaccessible. Yet, NGOs must persevere as partnership with government, at provincial and national levels, and engaging with the development of relevant law and policy is essential for strengthening healthcare and wider access to services, and the enforcement of rights for LGBT people,

Concluding remarks

Our findings have highlighted the multiple roles that OUT Well-Being and Triangle Project play to enable access to sexual and reproductive healthcare for LGBT South Africans. Through their support, the NGOs buffer the impact of SOGIE-specific barriers to healthcare, such as discrimination and stigma, but also the impact of general structural barriers like poverty, which render healthcare inaccessible. In particular, our findings highlight a gap in services for lesbian, bisexual and queer (LBQ) women, as well as for trans and gender diverse people; as well as a gap in sexual and reproductive health services beyond HIV, including mental healthcare.

Our study has some limitations that should be kept in mind when reading the findings of this report.
First, because we recruited survey participants through organisations, we were likely to have participants who are already receiving some kind of services through these organisations. This means that access to services might be better for those who answered our survey, compared to LGBT people who do not a link to LGBT organisations. Second, this is an exploratory study. Our sampling method does not allow us to draw inferences beyond the people we surveyed, meaning we are not able to make predictions about larger LGBT populations across the country. The findings from our study are therefore not representative of all LGBT people in South Africa. Third, some questions from our survey tool about confidence in using services were phrased as double-barreled questions, and thus might not adequately reflect the respondent's answer. This limits our interpretation of these answers, and we suggest revising these questions for future studies.

Despite these limitations, our findings robustly portray the current challenges and opportunities to improve access to healthcare for LGBT people through increased community participation. The three case studies that we identified show innovative approaches to promoting access to, and community involvement in, sexual and reproductive health services for all LGBT people.

Following a focus on community participation, and the emphasis on peoples' agency to make decisions about the issues that directly affect them, has led us to consider not just the role of LGBT people, as represented by NGOs, in the policy-development and implementation of healthcare provision, but also the funding regimes that shape global agendas and local foci in such provision, including NGOs own work. We then should consider how NGOs can participate in decisions about the needs of their constituents, and how resources should be allocated for these needs in relation to funding agendas. This is both because LGBT NGOs are made up of individuals who identify as LGBT (mostly), who have health needs, access the health system and have first-hand experiences of all the issues under discussion. They understand the socio-economic and political contexts from which their constituencies operate and the wider forces that shape access to healthcare and empowerment and health-seeking behaviour. And because they directly provide healthcare services. If we see LGBT NGOs as embedded in, and representative of, LGBT peoples in South Africa, empowering them to be more involved in decisions about funding agendas is also an active step towards empowerment in healthcare.

Recommendations

Recommendations for civil society organisations

- **Launch interventions that empower LGBT people to use barrier methods for safer sex.** As more than half of the participants in our study were not very confident in their ability to use a barrier method with someone, they have sex with, we recommend that NGOs reinforce their efforts at empowering LGBT people to practice safe sex. This should go beyond the distribution of commodities (condoms, lubricant, dental dams), and include conversations/ workshops about sexual pleasure, consent, and bodily autonomy.

- **Continue the implementation of outreach healthcare services and design mobile health interventions:** Due to challenges with physically accessing healthcare as well as stigmatization around sexual and gender minorities at healthcare facilities, and also in order to fulfil patient-centred care, piloting of mobile health interventions and outreaching to the community would be rewarding.

- **Expand collaboration with academic researchers.** LGBT civil society organizations are in need to expand the advocacy and championing for providing services for multiply marginalized subgroups of the LGBT community (as such LBQ women and other women who have sex with women, as well as transgender men). By collaborating with researchers who conduct evidence-based research, organisations would be able to apply for necessary funding to bridge the gaps between available services for different subgroups of the community. Research on healthcare needs and health and well-being of WSW and transgender women and transgender men, in particular, is needed to build an evidence base for funding applications and advocacy for health services for these groups.

Recommendations for government and health policy-makers (Department of Health)

- **Expand the appropriate LGBT sensitisation (pre- and in-service) training for clinical and non-clinical healthcare providers.** Based on the results on this study more than half the LGBT people we surveyed did not always feel confident about going to a government clinic or General Practitioner (GP) for STI services, when healthcare providers knew about their sexual orientation and gender identity or when they have been treated badly during previous visits. Training clinical and non-clinical healthcare providers is crucial to enhance the interaction between LGBT patients and healthcare providers.

- **Improve access to mental healthcare and psychosocial services in public sector.** Lack of financial and human resources has limited access to mental healthcare and psychosocial services in South African public health facilities. Mental ill-health is a serious threat for LGBT people, who experience isolation and discrimination due to their sexual orientation and gender identity, and often experience multiple marginalisations. Expanding mental healthcare by maintaining and prioritizing its policy could enhance the wellbeing of LGBT people as well as the general population. All mental health services should be affirming of all sexual orientations and gender identities and follow the *Sexual and Gender Diversity Position Statement* issued by the Psychological Society of South Africa[20].

- **Invest in and take responsibility for providing comprehensive sexual and reproductive health services for LGBT people.** As it has been reflected by the civil society organizations in this study, providing sexual and reproductive health services (such as abortion and etc.) and securing the sexual and reproductive health rights of LGBT persons is resource-intensive and requires dedicated personnel. Given the constitutional obligations to ensure access to healthcare, including sexual and reproductive healthcare, and the prohibition of discrimination based on sexual orientation or gender identity, these services should be provided in primary healthcare facilities, and should be included in the package of care that will be available to all South African citizens and permanent residents under NHI.

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[20] Available online at https://www.psyssa.com/psyssa-position-statement-sexual-gender/ (accessed 4 December 2019)

Recommendations for funders

- **Adopt a holistic approach to health as the basis for funding.** Based on the evidence presented in this study, most of the funding from international donors has been narrowed to a specific group (mostly MSM) and with regards to specific health concerns (mostly HIV). This approach causes a number of barriers that could severely affects well-being of LGBT persons more broadly, and of sub-groups within the LGBT community.

- **Increase the meaningful participation of LGBT civil society organizations in sexual and reproductive health services project design:** In our study, the project team included representatives from two LGBT organisations throughout design and implementation. We recommend that funders promote this approach and also include LGBT communities' input during the development of funding priorities and funding calls, to ensure that available funding meets the needs of all subgroups of the LGBT community and covers the most pertinent health concerns.

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