A summary of **INFLUENCING ISSUES** related to Sexual and Reproductive Health and Rights (SRH-R) of sexual and gender minorities, drawn from learning through the *Bridging The Chasm* project.
**BACKGROUND**

*Bringing The Chasm* is a two-year Positive Vibes project, in partnership with Amplify Change. The project focusses on increasing quality access to effective, appropriate sexual and reproductive health services for sexual and gender minorities; on promoting a rights-forward approach to health and wellbeing; and on equipping partner organisations in five countries to utilise local evidence to improve policy-engagement, advocacy and influence on practice.

Monitoring and accountability – including concepts of public participation, active citizenship, the democratisation of public health, and principles of good governance – figure prominently in the conceptualisation and operationalisation of project activities.

In 2019 – its first year of operation – the project worked directly with LGBTIQ and Sex Worker organisations in Zambia (TBZ), Zimbabwe (GALZ), Botswana (LEGABIBO) and Namibia (MPower; Voice of Hope) to apply Setting The Levels amongst their constituencies in, respectively, Lusaka, Harare, Francistown and Walvis Bay1. *Setting The Levels* is a participatory methodology for community-led monitoring of health facilities to draw diverse community members and healthcare workers from specific facilities into reflection and dialogue around their distinct perspectives, perceptions and experiences of healthcare.

That engagement with and immersion in the local experience of health confirm a core belief underlying *Bringing The Chasm*:

...that the artificial separation of health systems (perceived as professional; educated; technical; clinical; service-providers) from community systems (perceived as informal; uneducated; local; service-beneficiaries) creates an unnecessary and problematic disconnect between human beings who – being equal under the law, and in fundamental rights and dignity – occupy a shared local system for health, comprised of complex and delicate relationships, interactions and interconnections.

At the same time, local participation generates substantial learning that, across four countries, clusters around a small set of recurring themes:

1. An almost universally common standard for “good” care.
2. Low awareness of, experience with or expectations around the exercise of public accountability by citizens.
3. Unequal availability, quality or priority of care across sexual and gender minorities, determined by a combination of public health driven risk-perception and patriarchy.
4. An incompatible conflict between public health priorities for so-called Key Populations, and the human rights and identities of LGBTIQ people and sex workers.
5. The questionable, problematic and harmful ethics of targeted public health strategies, programmes and initiatives.
6. Technical health facility programme design, and effective clinical practice (including comprehensive primary healthcare, and integrated services).
7. The impact of poor policy, and inefficient health administration at district and national management levels (eg. essential drug procurement and stock-outs).
8. The effect of healthcare worker approach, attitude and awareness on user-experience, access and service-uptake, and the need for more robust sensitisation.

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1 Early 2020 will see Uganda added to the list of countries implementing Setting The Levels in two to three local settings around the country.

This report draws from these recurring themes and lessons to highlight potential advocacy and influencing GAPS, action around which would contribute significantly to bridging the SRH-R chasm for sexual and gender minorities.
“SRHR” has become commonplace terminology in health and development communities, in and around discourse about public health strategy and interventions, healthcare services, and human rights.

Health facilities and programmes offer a range of SRHR services. Civil society organisations working with and for minority or underserved populations frame their work within an SRHR paradigm. National governments and regional bodies draft policy around an SRHR agenda. Yet, despite its familiarity and frequency of use, the term is commonly all too narrowly applied.

“SRHR” is commonly unpacked – by healthcare workers and civil society organisations alike, including organisations whose core constituency are LGBTIQ people and sex workers – to suggest “sexual and reproductive health rights”, as opposed to “sexual and reproductive health, and sexual and reproductive rights (SRH-R)”.

That distinction is seldom interrogated, with problematic implications.

Focussing on health rights – including access to healthcare or health services – makes it possible to deliver programmes and interventions in the public health domain without engaging with human rights, with sexual orientation, with gender identity; to avoid thinking about the meanings of sexual rights and reproductive rights, and aligning practice and policy accordingly.

“Sexual Rights” and “Reproductive Rights” train a critical Human Rights lens on sexual and reproductive health services, to regulate the delivery of care that is non-discriminatory, dignified, ethical, inclusive; that respects rights to consent, to confidentiality, to choice, to privacy.

By contrast, health services delivered in the absence of a strong rights framework are frequently harmful.

It makes it possible to avoid structural reform of polices and laws that marginalise and criminalise human identities.

It makes it possible to normalise health service-delivery practices that violate human rights, to call them ‘strategy’, and thus legitimise and standardise them amongst healthcare workers and community members alike.

Amongst sexual and gender minorities already vulnerable – to social and economic exclusion; to stigma and discrimination; to structural injustice; to violence – sexual and reproductive health services without regard for sexual and reproductive rights have a counterproductive effect: access, uptake and health outcomes decrease, as people feel targeted, abused, violated, and consequently avoid presenting for services.
NO RIGHTS, NO HEALTH...

COMPREHENSIVE SEXUAL REPRODUCTIVE HEALTH IS POSSIBLE IF THE HUMAN RIGHTS OF ALL ARE ACHIEVED.
There may have been a time when health programming and prioritized service-delivery to so-called “Key Populations” – whose vulnerability to HIV is disproportionately high through a combination of behaviour, biology, social exclusion and structural injustice – signalled an inclusive, pro-LGBTIQ sentiment to affirm and support diversity, and to promote the human rights of sexual and gender minorities.

In recent days, however, the stark distinctions between the public health and human rights agendas in relation to LGBTIQ people and sex workers are revealed with increasing clarity.

“KP-programming” is not “pro-LGBTIQ”, despite the ease with which LGBTIQ people and sex workers have appropriated “KP” as a self-referencing term. It is not concerned with the rights of people to an identity, or to justice and equality under the law. Instead, it is a public health strategy to “close the tap on HIV” by identifying and locating populations who are considered, epidemiologically, to be drivers of the epidemic, but hard to reach with testing and treatment.

“KP-targeted” services have produced exactly that effect: not simply to prioritise LGBTIQ people and sex workers for care – to enable access; to increase safety – but to target them in ways that make individuals and populations feel harassed, objectified, pursued, instrumentalised and hunted, often by their peers.

Aggressive strategies, well-financed and executed by reputable organisations, are accorded credibility and legitimacy. They are accepted and normalised as strategy. They become standard practice. And, in effect, they draw healthcare workers, civil society organisations and community outreach workers, into dangerous, harmful ethical compromise. Despite good intentions, violation is systemic, and staggering in its scope and scale, including:

- HIV-testing by coercion, or as a condition without which other services are denied.
- HIV pre-test counselling in groups; or non-private disclosure of HIV-test results.
- Cash-incentivized HIV-testing to desperately poor people in low-income economies, with little to no provision for counselling or psychosocial support.
- Aggressive, often cash-incentivized, sexual contacts tracing through Index Testing, effectively rewarding clients and/or peer-outreach workers for disclosing the private information of third-party partners without their knowledge or consent.
- Mobile testing at “KP Hot Spots” to target populations where they may congregate socially, often late at night, with clients responding to cash-incentives to take an HIV test under the influence of alcohol.

VIOLATION OF RIGHTS by reputable, legitimised health initiatives and programmes is systemic, standardised and institutionalised.
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<th>Zambia</th>
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<td>Coercion, conditional or withheld services</td>
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<td>Cash-incentivized HIV testing</td>
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<td>Cash and/or target-incentivized “outing” through Index Testing</td>
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Policy discourse at National and Regional levels – driven, drafted and endorsed by policy makers and influencers – reflects the shallowness with which SRH-R issues for sexual and gender minorities and so-called “key populations” have been embedded in and integrated into statutory instruments.

Policy documents and strategies are developed in isolation from one another, as if in a vacuum without context. They are fragmented, with no reference to one another, despite obvious relevance. For example, in the third quarter of 2019, an ambitious SADC Regional Strategy on SRH-R was developed and workshopped around the region, and at country-level in each Member State. At no point, however, does the 2019 Regional Strategy reference the SADC Regional Strategy on HIV and SRH-R for Key Populations released in the first quarter of 2019, after six years of regional consultation. Nor was this earlier policy document – endorsed by the same Member States through their respective Ministers of Health, with approved indicators – discussed as part of the country-level dialogues for the second SRHR strategy.

Key Populations-specific policy documents, despite the frequency of use of an “SRHR” framing, remain primarily entrenched in a biomedical paradigm, focussed on expanding access and uptake of HIV-related health services. Little acknowledgement or recognition is given to structural or institutional barriers, and little practical planning is dedicated to advancing human rights, or to specific structural reform. Instead, as in the SADC Regional Strategy on HIV and SRH-R for Key Populations, the tone is stigmatising, judgemental and moralistic: that, by definition, Key Populations are groups at increased risk of HIV because of higher-risk behaviours, and the attendant legal and social issues related to such behaviour.

And despite the prominence of LGBTIQ civil society advocacy, and the prevalence of “SRH-R” and “Key Populations” discourse, policy documents remain heteronormative. “Gender” is a term reserved for women – cisgender in heterosexual relationships – as illustrated in the Government of Namibia’s 2019-2023 Gender Based Violence Strategic Plan.

In policy processes that are not explicitly specific to sexual and gender minorities, the needle on inclusion and diversity does not move from the conventional. It remains conventional, traditional, conservative. It raises questions about participation and representation, about who is in the room, around the table, when non-“KP” specific policies are discussed, and the efficacy of civil society voices to find a place in ways that challenge these compartmentalised norms and standards.
SAARC Secretariat published the SAARC Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and Rights Among Key Populations, endorsed by Ministers of Health of SAARC Member States, after a lengthy stakeholder consultation process. Development of the strategy is a commendable and positive step aligned to global efforts to end AIDS; taken at face value, the language presents a promising policy document that is genuinely for the protection of Key Populations.

In April 2019, a small group of East and Southern African organisations working to promote health and human rights of sexual and gender minorities engaged with the strategy.

We see really good points in:

1. The strategy being developed through an extensive process of consultation with stakeholders that include key populations in the region;

2. An effort has been made to align the strategy to international and regional legal instruments such as CEDAW (in, for instance, its definition of gender), and strategies (for instance, UNAIDS’ priority on Key Populations).

We are, however, disappointed.

We would expect that in linking to regional and international instruments and strategies, SAARC would take into consideration the main concerns and setbacks that have repeatedly been raised around exclusion of sexual and gender minorities. We are disappointed, however, that the SAARC Regional Strategy seems yet another document that pays lip-service to inclusion but, in tone, preaches the familiar rhetoric of “preservation of standards of morality” and “African values and customs.” Like so many other frameworks before it, this one remains non-committal, with interpretation and implementation to be guided by national laws and the very cultural and religious contexts from which sexual and gender minorities need protection.

For example, in defining gender-based violence, CEDAW is the influence. We are disappointed, however, that when it comes to the definitions, the strategy is not clear. The strategy, however, is not clear about their sexual and reproductive health needs – only to be so fundamentally invalidated. We are disappointed by this typical example of how participation does not equal inclusion, and how easily Key Populations can be instrumentalised in order to check boxes for representation.

The framework is described to be about Sexual and Reproductive Health and Rights, and although those definitions are in line with global understanding, the integrity of those concepts breaks down in the way they are applied throughout the document. In language, and in the strategy that language represents, the SAARC Strategy does not even scratch the surface of “complete physical, mental and social well-being, and not merely the absence of disease or infirmity” ...

We are disappointed that, if anything, the definition is narrowed instead of expanding to reflect diversity. Sexual rights and reproductive rights are fused together, as are sexual and reproductive health with sexual and reproductive rights. Nor does the Strategy as a key guiding policy document describe and prescribe to Member States an acceptable universal minimum standard of health that should be attainable by Key Populations, leaving it instead at the discretion of the local context.

Invisible from this document are descriptions of freedom from discrimination on the basis of sexual orientation or gender; entitlement to privacy, to dignity, freedom for one to control one’s health and body. Instead a clear distinction is drawn between “vulnerable populations” (children and people with disabilities) and “key populations” (sex workers, men who have sex with men, etc.). This distinction echoes a stubborn position by SAARC Member States that the vulnerability of Key Populations is not innocent; it is a consequence of avoidable risky behaviour and poor sexual choices. That same distinction denies the claim of Key Population prioritisation, and reveals a resistance to the key vulnerability of Key Populations.

Labelling sexual and reproductive health issues of Key Populations as almost purely behavioural trivialises the real concerns of real people about their biology and their health, environment. That same attitude creates inappropriate interventions intended to correct and control people’s bodies. These half-hearted policies frame discriminatory attitudes, reinforce stigma and undermine attainment of the highest standard of physical and mental health.

We are disappointed that the strategy neither responds to global understandings – succumbs to subtle stigmatisation suggestions: instead of applying a lens that positions real and socioeconomic realities as barriers for Key Populations, the strategy leans that these barriers are, in fact, a result of Key Population behaviours.

Englobin; GALZ; SAT Zambia; TransBaantu Zambia; CHAI; NATH; Positive Vibes; MPOWER Trust; Voice of Hope Trust

This summary statement is drafted through collaboration of a small collective of East and Southern African organisations working for the health and rights of sexual and gender minorities, through the Positive Vibes “Bringing the Chain” project. Participating organisations include Galz; Sat Zambia; Trans Baantu Zambia; Chai; NATH; Positive Vibes; MPower Trust; Voice of Hope Trust.

For a more detailed review of the SAARC Strategy, please refer to the full Critical Analysis prepared by Positive from LovePositiveVibes.org.
It is evident that, whilst all LGBTIQ people and sex workers experience a degree of stigma and discrimination that limit their access to and uptake of health services, that experience is not universal across all identities.

Health programmes that deliver sexual and reproductive health services – or, more accurately, “KP-services” – are almost universally dominated by a focus on men who have sex with men (MSM), to the exclusion of queer women who have sex with women and (female-bodied) trans men.

This exclusion only adds to the marginalisation, exclusion, invisibilisation and vulnerability of queer women and trans men.

Epidemiologically, queer women and trans men are perceived to be at negligible risk of contracting or transmitting HIV. But little research exists to understand their experiences, behaviours or interactions.

Sociologically, in patriarchal societies, the sexuality, safety and pleasure of female-bodied persons may be easily dismissed when these are not functions of an associated cisgender, heterosexual male sexual experience.

Queer women and trans men are mysterious and exotic to healthcare workers, who have little understanding of their relationships, and can offer little by way of sexual information or health education on safety, protection, prevention or risk; or by way of commodities including dental dams or finger cots.

Trans men, irrespective of their presentation, still require access to sexual health and reproductive health services, including cervical cancer screening and breast cancer screening. Many may not readily present for services due to personal experiences of dysmorphia, unless service-environments and health personnel are welcoming, hospitable, enabling and affirming.

Despite many policy and strategy documents citing the paucity of data available on transgender persons, public health information systems around the region show no evidence of adaptation to register, reflect, or disaggregate trans people who present for services. It is difficult to plan for, strategise around, and budget towards health services for a population that, statistically, does not exist.
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<tr>
<th>Hotspot</th>
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<tr>
<td>Spaghetti Bar</td>
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<td>Equatoria</td>
<td>3-5, 5-7</td>
<td>Fri-Sat, Sun-Sun</td>
<td>3-7pm, 6-10pm, 10am-4am, 10pm-11pm</td>
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<td>Max Meny</td>
<td>4-10, 5-10</td>
<td>Wed-Sun, Sun-Sun</td>
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<td>Lagos Club</td>
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<td>Donanza</td>
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Across the four countries participating in Setting The Levels, participants’ first analysis of “accessibility” – whether by community members or healthcare workers – was almost always identical: geographical. The physical location of the health facility, and its distance from home.

That initial impulse, however, rapidly cascaded outwards, expanding as participants realised the many associated factors that made accessibility complex:

- The implications of distance on transport options, travel time, transport cost and the degree of travel convenience.
- The internal environment of the health facility: its level of congestion; the degree of privacy and exposure and visibility; the waiting-time and the cost of that time; the hospitality or hostility of support staff such as cleaners, receptionists, security guards; the attitudes and behaviours of healthcare workers.
- The external environment: physical, psychological and emotional safety from community members who live or work around the health facility.

There is a layered and delicate intricacy to accessibility of healthcare, especially for minorities who are marginalised, socially vilified, economically excluded and frequently denied the protection of law. Despite so many programmes and projects purporting to focus on increasing access, inadequate attention may be paid to analysing and understanding the concept in order to better isolate its constituent components.

Accessibility cannot be achieved by focussing almost exclusively on the health facility. It is inherently socioecological. It requires a reconceptualization of health and healthcare provision, a different way of thinking. That accessibility may be a function of both the internal environment of the facility and its external environment in the physical neighbourhood that surrounds it. That achieving public health may require perceiving health as relational, not simply medical. That service-seekers and service-providers are co-participants in a single, shared local system for health, the vitality of which is a predictor of accessibility.
Conversations with LBTIQ people and sex workers in four countries were replete with experiences of abuse, humiliation, discrimination, offence and presumption by health workers towards clients who they had taken a professional oath to serve. Moreover, health workers in the public service represent the State’s constitutional undertaking to promote, protect, defend and fulfil the rights of its citizens to, amongst other rights, dignity, privacy and non-discrimination.

Whilst many healthcare workers have good intentions and do not intend to be harmful, common approaches, behaviours and practices, nevertheless, do damage. Consciously – as an exercise in prejudice or power or entitlement – or inadvertently – in ignorance; through unthinking privilege; by clinical protocol – many healthcare workers are guilty of remarkable insensitivity, intrusiveness and invasiveness. They stigmatise with their questioning. They judge with their moralising. They shame with their unsolicited counsel.

There is one school of thought that sensitisation – education about sexual and gender minorities; exposure to LBTIQ people; discussion about prejudice and attitudes – is sufficient to overcome healthcare worker impropriety by dealing with their individual, subjective bias. This is no doubt effective, although possibly only partially so.

In some ways, the inappropriateness, abuse and violation by healthcare workers – as public servants and representatives of the State, bound by a professional code of conduct – reflects the separation of health from rights, and the low levels of awareness – amongst both healthcare workers and clients – of how accountability can and should be exercised. In settings where human rights are divorced from health, where clients are criminalised with little recourse to justice under the law and little social status or power, it is easier to provide services without thought for dignity and sensitivity. To treat people as objects for whom services are not a duty, but a favour.

Addressing the professional appropriateness of healthcare workers towards LBTIQ people and sex workers – a critical factor in expanding accessibility and uptake of services – requires that awareness of rights and structures for accountability be strengthened, not simply that attitudes be improved.
Men who have Sex with Men Job Aid

Sex Worker Job Aid

High Index of Suspicion

To Identify a Sex Worker in a Public Setting
- Dress code: Tight fitting clothes
- Eye contact: Often roll eyes or touch head
- Body language: Touch crotch area or use of colourless nail polish
- Genitalia: Maintain long nails or use of nail polish
- Make-up: Light make-up use

Confirmation Tips

Confirmation of Sex Worker

Female Sex Worker is counted under the KP program as one of the following one and more of the criterion are present:

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Male</th>
<th>Female</th>
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<tr>
<td>Physical</td>
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<td>Ice-breaker</td>
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Who to test

Tips to Identify the Right MSM to receive HIV Testing

1. Condom Use: History of STIs, offers condom free sex to clients
2. Client Referral: All men who present which STIs should be asked the above questions to determine if the one of more of sex partners is a sex worker
3. Index Testing: Trace known positive clients of sex workers and contact sex workers have been with 6 months prior to ART initiation
4. Weight Loss: Sex workers wearing oversized clothes could be a sign of TB infection and advanced HIV disease

New Sex Worker

HIV incidence and prevalence is highest in new industry entrants

Sex Code

Cheap and desperately dressed SW is sign of risky sexual behaviour

Testing

Regardless they do not consider sex work as their occupation

* Who to test

- History of STIs
- Client Referral
- Index Testing
- Weight Loss
- Sex Code
Civil society organisations and, in particular, LGBTIQ and sex work organisations, have invested in relationship-building and sensitisation of healthcare workers at specific facilities over many years. This has increased the awareness and sensitivity of healthcare workers, their understanding of sexual and gender diversity, their insight into human rights and civic freedoms; and improved the quality of relationship and clinical care provided to sexual and gender minorities.

Slowly, over time, through consistent engagement and cooperation between communities and health facilities, acceptability and appropriateness of the service-environment and user-experience can increase, leading to increased accessibility of the facility and greater uptake of services as trust and confidence develop. At times, inadvertently, champion healthcare workers emerge, celebrated by the community as true allies — reliable, dependable, caring. In Harare, Mavis. In Walvis Bay, Vera. In Lusaka, Thandiwe.

One systemic issue acts to the detriment of this steady increase in capacity and quality, a low stave in a barrel from which contents leak out and are lost: staff turnover. In the public healthcare system, staff turnover is frequent and constant. It is both intentional – as a strategy to distribute experience, transfer skills and for professional development; or through promotion; or through retirement – and unintentional, as healthcare professionals resign, or move into the private sector.

Whether planned or unplanned, there is an undeniable effect of the loss of sensitised healthcare workers to a local facility, who have rapport with the community, and may be replaced by someone new with no previous exposure to or experience with sexual and gender minorities and, potentially, a hostile disposition. Under these circumstances, staff turnover produces fatigue and frustration in the community at the thought of starting over; often loses to the community one of a limited number of trusted allies within the health facility; and erodes overall confidence in the health facility itself.

Consideration to Human Resource Turnover may be worthwhile for three reasons:

1. High-quality healthcare workers in Harare and Walvis Bay retire within the next 12-month period. Community organisations may wish to interact with the process and selection of their replacements, and their subsequent orientation.

2. Turnover and retention are frequently issues of district management and national policy, levels at which tactical advocacy would be appropriate.

3. Anticipating high staff turnover could motivate community organisations to develop a more systematic, structured, regular process for facility sensitisation, delivered through a fixed agreement with that facility to compensate for loss of trained staff.
Two themes were consistent across the four countries participating in *Setting The Levels* during 2019, both of which were systemic and disturbing, both of which have severe implications for delivering effective, quality sexual and reproductive health to sexual and gender minorities.

One, as has already been discussed, is ethical: the widespread, standardised practices of health programmes and healthcare workers to target LGBTIQ people and sex workers in ways that violate their basic human rights to health, to dignity, to privacy, to confidentiality, choice and consent.

The second, is material: the frequency with which essential products – equipment, supplies, commodities and medication – are unavailable.

The unavailability of products necessary for basic SRH services is disturbing for at least three important reasons:

1. **The frequency** with which stock-outs take place. Shortage of supplies was recorded as the primary challenge to “availability” when monitoring or self-assessing health facilities, by community members and healthcare workers alike, in Botswana, Zambia, Zimbabwe and Namibia. Shortages are not occasional; they are sufficiently routine for health facilities to be characterised by them.

2. **The nature** of the unavailable supplies. Clients and healthcare workers are not concerned over luxury items; instead, clinical products that are disturbingly out of stock – varying from country to country – have literally life-threatening implications:
   a. Medication for the treatment of sexually transmitted infections
   b. HIV-test kits
   c. Antiretrovirals (HIV/ART)
   d. Male condoms

3. **The relative location** of the health facilities in their respective countries. For this round of *Setting The Levels*, none of the health facilities were in rural health districts. Harare and Lusaka are national capital cities. Francistown is the second-largest city in Botswana. Walvis Bay is the third-largest city in Namibia. If stock-outs of this type and frequency are affecting major centres in this way, it is alarming to imagine the reality for communities in remote locations.

There are important monitoring, accountability and advocacy questions to be asked. Are these systemic shortages matters of policy? Of procurement? Of inefficiency in planning and administration at a district management level? Are they matters of budget allocation, or corruption?
Sexually transmitted infections are a natural feature of any sexually active population. It should come as no surprise, then, that Sexual and Reproductive Health (SRH) Services include timely, effective treatment and care for STIs. Not only is this good healthcare practice, but it is epidemiologically significant to the management of HIV: untreated STIs increase the risk of contracting the virus.

Management of STIs is especially important to already vulnerable sexual and gender minorities. Through the Setting The Levels processes, STIs featured prominently in conversation as an issue raised by both community members and healthcare workers in every country. Healthcare workers report the high incidence of STIs with which LGBTIQ clients and sex workers present to facilities. Community members confirm that examination, testing and treatment of STIs is one of the leading causes for visiting a health facility. Quality care around STIs, is, potentially, a powerful entry-point into access and uptake of other SRH-related services.

And yet, STI treatment is frequently delayed, deferred or denied, a story that all too commonly ends with a client who “went home with [my] STI and never went back.”

Four aspects are worth consideration:

1. Several health facilities that offer targeted “KP/HIV” programmes make HIV-testing a mandatory requirement – a condition – for STI treatment. They, in effect, leverage cure of a common bacterial or fungal infection against HIV-testing and enrolment on treatment. Clients who decline HIV-testing services are denied other services. STI treatment is not a stand-alone service, unbundled from HIV.

2. Treatment is not readily available. Drugs are frequently out of stock. Or local healthcare workers are not equipped or trained for specific presentations and must refer, or wait for the periodic visit of a suitably capable rotational physician in the district.

3. Healthcare workers may diagnose an STI purely from a patient description of symptoms, but be reluctant to perform an examination owing to their own discomfort, especially when the patient is LGBTIQ.

4. In as much as HIV and SRH-R are commonly and widely discussed, the incidence and prevalence of STIs, and their prevention and treatment, receive comparatively little public or programmatic attention and, possibly as a result, comparatively low allocations of funding.
"That they give you choices to test or not is a lie. I will speak about my experience that I was forced to test in order to get STI treatment. I came for STI screening and they forced me to have an HIV test; told me ‘If you want STI, we first need to test you’. So I cancelled everything and went home.

I feel they violated me because what I came for is my STI and I might already know my status. It feels like all they want is my HIV and not the STI that I wanted to be treated.”

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"I have to test for HIV even if I only want STI screening and then drugs. Instead, I get enrolled on ART and PREP. You have to wait hours in those long lines for the HIV programmes. And then in the end, they don’t even look at your STI. Then they don’t have this or that.”

"It’s the silent ones who are usually the ones that are violated. We feel forced. I think we should give the people the option of choice. People shouldn’t feel coerced to have an HIV test or tricked to have one so that they can get what they actually came for.”

"Most KPs come here and want STI treatment and then have to buy drugs, because they are not always available. Mostly what they need is STI treatment, nothing else. They come here with STIs even more than anything else.”

"I have to test for HIV even if I only want STI screening and then drugs. Instead, I get enrolled on ART and PREP. You have to wait hours in those long lines for the HIV programmes. And then in the end, they don’t even look at your STI. Then they don’t have this or that.”

"It’s the silent ones who are usually the ones that are violated. We feel forced. I think we should give the people the option of choice. People shouldn’t feel coerced to have an HIV test or tricked to have one so that they can get what they actually came for.”
In several countries participating in the Setting The Levels process, “KP-programmes” operated by non-governmental organisations offer a limited range of specialist SRH services to sexual and gender minorities. Other public-sector health facilities, operated by the State, offer a broader range of primary healthcare services that may include, but are not limited to SRH services.

Facilities of each type are organised in one of two different ways. Some are organised by “special function”. A client presents at a health facility and joins a queue to wait to have his vitals taken – weight, temperature, blood pressure – by a nurse assigned to that function. Then, assuming he is at the clinic for STI treatment – and HIV testing is a condition before STI treatment – he joins the HIV queue, for testing, administered by the nurse assigned to that function. Finally, he joins the line outside a third exam room, to describe his symptoms, be examined and diagnosed by another nurse, who prescribes medication for which he joins the pharmacy line.

Some facilities are organised in a more integrated way. A client presents at a health facility and, from reception, is connected to a nurse trained to administer a number of services all at one time. The nurse takes his vitals, offers and administers an HIV test, should he want it, and examines him for an STI.

Overwhelmingly, LGBTIQ people and sex workers in communities across four countries prefer services that are comprehensive – broad primary healthcare services that go beyond HIV, sexual and reproductive health (in part, because they are fully-dimensional human beings whose health needs and interests are not exclusively sexual or HIV-related) – and integrated: a “one-stop shop”.

Integration is vitally important to high-quality, dignified care for several reasons:

1. It makes health service delivery more efficient (although it has up-front implications for how health workers are trained).
2. It focusses health service delivery on patients and care, not on specific disease and service-quota.
3. It reduces the breaches in confidentiality caused by having clients wait, visibly, for identifiable services: TB area; ARV area; HIV-testing room.
4. It reduces the fatigue, indignity and possible humiliation commonly experienced by clients who are required to relate a history and symptoms to multiple service providers during the course of one visit to a facility.

Integration of services (especially HIV, TB, STI and Family Planning) makes good sense for quality SRH-delivery. It is, however, not an established standard in many facilities.
GAP 2019 is a summary that draws its content and learning from source material generated through *Bridging The Chasm* during 2019.

For detailed information, reference should be made to:

- *Perceptions and Perspectives: Report on community-led monitoring of health facilities in Walvis Bay, Namibia* (September 2019)
- *Critical Analysis: SADC Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations, 2018* (March 2019)
- *NO/KNOW Rights, NO/KNOW Health: A Statement on the SADC Regional Strategy for HIV and SRH-R among Key Populations* (July 2019)