

**GALZ**  
AN ASSOCIATION OF LGBTI PEOPLE IN ZIMBABWE

# PERCEPTIONS PERSPECTIVES

Access to facility-based health services for LGBT  
people in Harare & Bulawayo, Zimbabwe

# PERCEPTIONS | PERSPECTIVES

## Access to facility-based health services for LGBT people in Harare and Bulawayo, Zimbabwe A Situational Analysis

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KP Connect is a multi-country programme of The International HIV and AIDS Alliance (IHAA), managed on behalf of the IHAA by Positive Vibes.

KP Connect works with Alliance Linking Organisations and their respective community-based Implementing Partners across ten countries – Botswana, Burundi, Côte d'Ivoire, Senegal, South Africa, Zambia, Kenya, Uganda, Tanzania, and Zimbabwe – to create a more enabling environment for effective HIV, health and rights programming in relation to key populations – LGBT persons, persons engaged in sex work and people who use drugs.

The project aims to improve the technical capacity of Linking Organisations to promote access to HIV, health and rights services for key populations; to increase the engagement of national policy makers with Key Populations issues; and to improve processes for regional knowledge sharing and learning between Linking Organisations.

Since 2015, KP Connect has collaborated with The Alliance Centre for Health and Rights of Key Populations based in Cape Town to develop practice guidance and methodology, and generate evidence, to strengthen the influencing capacity of Linking Organisations at national level.

The Alliance Centre provided technical support to the Situational Analysis Process, in partnership with GALZ.

# Acronyms

ART Antiretroviral Therapy

ARV Antiretroviral

DHIS District Health Information System

GALZ Gays and Lesbians of Zimbabwe

GB(T) Gay and bisexual men (and trans-women)

HIV Human immunodeficiency virus

KP Key Populations

LB(T) Lesbian and bisexual women (and trans-men) LGBT(Q) Lesbian, gay, bisexual

and transgender (queer) MSM Men who have sex with men

PEP Post-Exposure Prophylaxis

PREP Pre-Exposure Prophylaxis

PSI Population Services International

SGBV Sexual and Gender based Violence

SRH Sexual and Reproductive Health

STI Sexually Transmissible Infections

SW Sex workers

TB Tuberculosis

TG Transgender

TW Trans women

WSW Women who have sex with women

# Contents

Background	5
Method	6
Headline Messages	8
Perceptions   Perspectives	18
Availability	19
Accessibility	22
Affordability	24
Acceptability	26
Accountability	31
Opportunities for Response	34

# Background

Since 2016, KP Connect has collaborated with The Alliance Centre within Positive Vibes to expand activities related to its second outcome area: advocacy. Through this collaboration, thought and practice have developed around approaches that strengthen the influencing capacity of Alliance Linking Organisations and their associated Key Populations-led organisations, linked to programming for and with these populations themselves.

In other country settings (eg. Zambia; Uganda), this capacity-strengthening support has centred around cultivating a vision for influence, developing a strategy, and exploring the collaborative relationship between Linking Organisations and their respective KP-led organisational partners in each respective country. In Zimbabwe, GALZ invited support to design and conduct a Situational Analysis of health services for LGBT people in Zimbabwe, through mixed-methods research of three health facilities in Harare and Bulawayo and their respective service-user populations. The light study aimed to analyse health service provision and identify enablers and barriers to access and uptake that may exist for key populations. Findings from the study would frame – amongst other outcomes – recommendations and guidelines to health facilities for more inclusive service provision.

Intelligence generated from the Situational Analysis exercise would potentially inform the development of an influencing strategy and formulation of specific thematic policy briefs by GALZ, together with its in-country legal resources.

Established in 1990, GALZ is one of the oldest membership-based LGBT rights organisations in Southern Africa, delivering a range of programmes to and on behalf of its constituency: direct service-provision; education, information and training; advocacy and political influencing; regional engagement on policy and LGBT health and rights strategy; sensitisation of community leaders, public duty-bearers and service providers; and facilitation of access to health and justice.

Not unlike many Southern African countries, accessing reliable, quality healthcare in Zimbabwe continues to be a complex challenge for the majority of that country's residents, a compound function of socioeconomic, political and sociocultural factors. A fragile economy,

the instability of which leads to frequent crippling shortages in currency and commodities. An unemployment rate reportedly as high as 90%<sup>1</sup>. An HIV prevalence of approximately 13% in the general population, but concentrated in disproportionately high numbers in key populations (eg. HIV prevalence in sex workers is approximately 50%; no data is reported for men who have sex with men)<sup>2</sup>, many of whom are socially stigmatised and legally criminalised so as to further limit their freedoms and confidence to access care. An overburdened public health system, where low wages, uncertain payroll cycles, drug shortages and stock-outs all contribute to low motivation and poor staff morale.

And if reliable, quality care is a challenge to the general population, it is exponentially more challenging to LGBT people, who are targets of punitive law, and social and religious discrimination and stigma.

Against this backdrop, GALZ has sought to facilitate increased access to decent care for its LGBT constituency by entering into partnership with three health facilities in the period 2016/2017, formalised through Memoranda of Understanding. Under this partnership, GALZ has responsibility for demand creation, mobilising its membership by encouraging LGBT people to access services provided by the partner facilities. Several GALZ members have been trained through PSI – and attract a nominal remuneration – to serve as Peer Mobilisers, an interface between the membership community and the facilities. GALZ has also offered sensitisation training to each of the facilities at the inception of the partnership. The Health Facilities, in turn, offer sexual and reproductive health services to the LGBT community, through referrals from GALZ, with the aim that those services are user-friendly within an environment that is safe and secure. Further, walk-in clients at the facilities are referred to GALZ for psychosocial support and counselling.

Wilkins is an Infectious Diseases Hospital in Harare, a public health facility under the administration of the City of Harare. The hospital operates a Sexual and Gender-based Violence (SGBV) unit that facilitates the provision of SRH services to key populations.

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1 According to Zimbabwe's Congress of Trade Unions, 2017

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2 UNAIDS 2016 Country Fact Sheet

*PSI is an international non-governmental organisation. Through the partnership with GALZ, two PSI New Start Centres – Africa House and Bambanani – offer a broad range of SRH services to key populations, in Harare and Bulawayo respectively. PSI differs from Wilkins in several respects: it is not a public sector facility; it is not a general hospital – its service offering and strategy expand from HIV-related prevention and treatment interventions that are entry-points into other SRH services, or where specific SRH services are entry-points into HIV testing and treatment.*

## Method

The Situational Analysis applied a qualitative approach to explore perspectives and perceptions about health service provision to members of key populations, based in the experiences of both service users and service providers. Components of that process included:

1. Informal, iterative, recursive conversation with members of the senior management and programme staff of GALZ to better understand the context for facility-based healthcare provision facilitated through GALZ to its LGBT constituency. Additionally, at least one member of the GALZ team accompanied each stage of the data collection process for transparency, ownership and insight, and for process accountability.
2. Brief conversations with the Director and Programme Manager of the Sexual Rights Centre (SRC), a collaborating partner with GALZ, based in Bulawayo, to deepen insight into the health and rights ecology for LGBT people in Zimbabwe.
3. Unstructured interviews with the Facility Managers of PSI New Start clinics in Harare (Africa House) and Bulawayo (Bambanani), and with the KP Mobiliser at PSI Bulawayo. These discussions gave insight into the scope of services provided by the facilities, and to technical and strategic direction that informed their service offer to key populations.
4. Separate semi-structured focus group conversations, spanning 60-120 minutes each, lightly facilitated with a variety of representative stakeholders:

a. In Harare: gay and bisexual men and other men who have sex with men (including male sex workers); lesbian and bisexual women and other women who have sex with women, with trans-men; trans- women; representatives of the clinical and management team of Wilkins Hospital; representatives of the clinical team of PSI Africa House.

b. In Bulawayo: gay and bisexual men and other men who have sex with men; lesbian and bisexual women and other women who have sex with women; trans-women and gender non-conforming person; representatives of the clinical team of PSI Bambanani.

LGBT representatives were members of GALZ, some of whom were engaged within the partnership with health facilities as Peer Mobilisers, each of whom were either service-users of one of the three health facilities or had been referred or recommended to the facility but elected not to present for treatment.

Group conversation with each focus group – service providers and service users alike – was guided by a simple process<sup>3</sup> that framed several simple learning questions:

- Each group was asked to consider its definition of “Good”: what qualities should reasonably characterise a good health service experience.

- A Mixing Desk analogy was used as a data-instrument to allow each group to talk about its experience of specific health facilities (and for health facilities to talk about themselves). The Mixing Desk (as depicted on the cover of this report) invited participants to assign a level-setting from 1-10 for each channel – Availability, Accessibility, Affordability, Acceptability and Accountability (the basic characteristics of “good”) – essentially a subjective grading/score, and to talk about reasons why they would have that opinion. Any ambiguity about the interpretation of those headings became a matter of discussion for the group so that common definitions were applied before conversation continued. The group process allowed participants to be in dialogue with each other to reconcile

the range of experiences and perspectives amongst individuals and come to some consensus about a score in each category that best reflected their collective experience.

- A third element was added to the exercise with Health Facility staff: asking them to simply define who they considered to be their “Key Population constituency”.

5. The Mixing Desk tool generated a series of comparable numeric values that could be analysed into graphs, showing the scores from each focus group for each category as they pertained to each of the three health-facilities.

6. Patterns were identified from the responses, prepared as “Headline Messages” (see below) and presented together with graphed analysis to a representative stakeholder meeting for reflection, to deepen dialogue and for validation. Participants included members of GALZ staff, representatives of the management and clinicians of Wilkins and PSI Health facilities, and representatives of MSM, WSW, and trans groups.

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*3 Methodology for this Situational Analysis was co-developed by a small regional Technical Working Group on Health Facility Monitoring, convened in Johannesburg through KP Connect approximately one week prior to the commencement of the Situational Analysis exercise in Zimbabwe. Contributors to that process represented experience in Key Populations health and rights programming from the AIDS*

*Legal Network (South Africa), Positive Vibes (Namibia), GALZ (Zimbabwe), SRC (Zimbabwe), BONELA (Botswana), FHI 360 and Friends of Rainka (Zambia).*



# Headline Messages



# Headline Messages

The Situational Analysis highlighted twelve (12) Headline Messages – observations, lessons learned, themes and insights – relevant to design and delivery of health services by service providers, to programming, to advocacy and policy-influence, and to the internal environment – structures, social dynamics, working culture – of GALZ itself.

## 1. Everyone agrees on a definition – a standard – of “GOOD”.

Each focus group discussion or interview throughout the Situational Analysis exercise began with the same simple question: “for you, personally, as a Zimbabwean citizen looking to access a good public health service, what does good look like?”

And across all groups – healthcare workers, health facility management, trans men and women, gay and bisexual men, lesbian and bisexual women, and sex workers – in both Bulawayo and Harare, respondents broadly described a similar set of standards and expectations:

- Good attitude; welcoming; received with a smile; comforting; non-judgemental; respectful; being treated like a human; non-discriminating; not being treated differently; no bias; non-stigmatising; people are treated with dignity; no strange looks from nurses; no negative questions; time to talk; space to express what I feel, honestly; being listened to; feel free and at ease; able to be open about why I came for services; feel that I'd want to come back again; compassionate; not being judged; not being brushed off; coming out of the place feeling good, and feeling good about going there; friendly;
- Effective; a service that meets my needs; drugs are available; there is continuity of care so that people can be referred for other services that may not be available in one facility.
- Efficient; I get what I need without waiting a long time; a short wait time; having enough staff; treating every case with urgency; quick; able to obtain the required medication from the same facility where it is prescribed; not need to go to a pharmacy; served on time
- Privacy; a service that is discrete; a good system for handover of cases between staff so I don't have to tell the same story over and over; confidential;
- Accessibility; easy to reach; not too far away
- Up to date with the knowledge and technology and equipment; well-sensitised so that staff have the right information to understand me, my sexual orientation; staff are able to

give me the right information about my individual health needs; the staff know what they are doing medically; staff are well-informed about sexual orientation and gender and other social issues; health workers are aware and educated on human sexuality; consultation and examinations are thorough and comprehensive, not like they're scared to look at me or just want to rush me through; health workers are knowledgeable, confident and composed in their delivery of services.

- Affordable; free medication
- Acceptable; in line with my culture; people are sensitive with the language they use and the assumptions they make; no unnecessary personal questions just because people are curious;
- Service-delivery comes with information so that I understand what is being done. • The services are safe; I can fully disclose my sexuality; service-providers accept me for who I am.

These common qualities and expectations are significant for at least three reasons:

- i. They describe a framework for acceptable standards of decent care and service-delivery for Key Populations (that are, in fact, no different from those standards that should be applied in a general population).
- ii. They demonstrate that the interests of service providers and service users are not contradictory or oppositional. Health providers can relate at a human level; there is greater capacity for empathy than might be assumed.
- iii. They illustrate what may seem to matter most to Key Populations in their experience of health services: an affirming environment; a dignified interpersonal interaction; and clinical competence.

## 2. The one quality not named by either service-users or service-providers as a standard of a good health service: “ACCOUNTABLE”

The set of qualities identified by healthcare-seekers to define a “good health service” is significant for one other reason – the conspicuous absence of one standard: accountability.

If healthcare were a product, a commodity, surely consumers might expect to have some say in the quality of that product? If healthcare were a service, surely users of that service might expect to have some say in how the service is delivered? In both cases, customers might expect to express dissatisfaction should that product or service be unsuitable. Arguably, healthcare is both product and service; and yet no respondents saw it as important that good public health required good public accountability.

Perhaps it is unsurprising in the political context of Zimbabwe where citizens are less free to exercise their rights and responsibilities to hold duty-bearers and public institutions answerable to the communities they serve. Still, this omission seems ironic amongst the constituency of a human-rights organisation such as GALZ – that service users might expect to have a right to transparency, inclusion, participation, engagement and answerability – and a telling oversight by service-providers.

As discussed later in this report, the absence of accountability – both the expectation of it by service users, and the discipline of it by service providers – is significant to an understanding of the health service experience by Key Populations:

- i. Despite the partnership between GALZ and the three health facilities to provide services to the Key Populations constituency, these populations have never met directly with the service providers to discuss their experiences and expectations. There remain considerably low levels of interpersonal engagement between those entities that might normalise relationship, build trust and openness, and equalise perceived power disparities.
- ii. Low to no feedback is given to populations on health outcomes, on performance standards, on statistical data. As a result, populations may have curiosity about what happens to all the data collected from them during facility visits, but have no ownership of it, or insight into it.
- iii. Service-users have low-levels of information about clinical practice or policy-driven motivations that have direct bearing on their experience of care at facilities. Many issues about which service users are dissatisfied are easily explicable by service-providers – eg. why HIV-testing is so strongly encouraged before STI treatment at, particularly, PSI facilities;

why it is that particular drugs are routinely unavailable; why seemingly unnecessary contact information is being asked for – but seem not to be explained.

iv. Nor is this absence of provider-supplied information met by high levels of enquiry from service-users. The situational analysis confirms that, frequently, service-users might feel uncomfortable, unclear or uneasy about a procedure or exchange at the facility, but seldom ask “why?” or feel confident to refuse or decline.

One reason identified for such reluctance is a low level of health rights literacy and general personal health awareness amongst the Key Population constituency, best expressed by one trans woman respondent:

*“How do we hold people accountable when we ourselves don’t know what to hold them to account about...and when we feel like they’re doing us a favour by even treating us at all?”*

## 3. All health facilities agree that priority “KP-services” are provided to the same defined Key Population client groups...except one: women who have sex with women (WSW).

The same three key-populations are unanimously identified as “targets” or “client groups” by facility managers and service-providers in each of the three health facilities: men who have sex with men (MSM); sex workers (SWs) and transgender people (TG).

Managers and service-providers, however, are not unanimous in identifying one population as a client group: lesbian and bisexual women, and other women who

have sex with women (WSW). In fact, in at least two facilities, a different understanding was expressed between management and service-providers within the same facility. There is consistent ambiguity across the health facilities about whether this group is recognised as a Key Population target group at all and, in fact, uncertainty about whether the population even exists in substantive numbers to require specific services. It is clear from the Situational Analysis exercise that health workers perceive women who have sex with women as exotic; they are an unfamiliar population around whom health workers have very little exposure or experience.

*“We’ve not seen that community. They’re not really much there. Like they’re invisible to us.”*

*“Women who have sex with women can come to access the services, but when they do, they don’t come out as lesbians. They live a double life, so they present to us at the facility as heterosexual women. We don’t have those protective barriers available for WSW because it’s not seen as a felt need. At least from a facility level, we don’t think we’ve felt that need from them.”*

*“They need to come out of the closet and say what they need.”*

*“We don’t get a lot of them, or they don’t own up. We don’t have experience in serving them. They should also access cervical cancer screening, but it may be that it is uncomfortable or painful for them.”*

*“When we think of GALZ, people associate them with gays or bisexual men. Women who have sex with women have been very silent. I wish they could engage us more; we might need to have a sensitisation so we understand them more.”*

*“We’re not really attending to all the groups of KPs. We see that we’re favouring gays and bisexuals. We have lubricants and condoms for males, but not for women who have sex with women.”*

#### 4. Perceptions about service-delivery and service-quality vary significantly between (a) populations of service-users and (b) service-users and service-providers.

As a perception survey, the Situational Analysis reinforces the fact that Key Populations

are not homogenous. And that in the absence of transparent, inclusive, accountable engagement between service-users and service-providers, differences in perception lead to lower demand, delivery and uptake of services.

The uncertainty and ambiguity about women who have sex with women, evident in responses from health workers, is consistent with the experience of the populations themselves. A remarkably stark difference exists in user-experience and perception of health services between men who have sex with men (MSM) and other populations: trans people and women who have sex with women.

Whilst all key population groups agree that their user-experience and quality of care and service could be markedly better, men who have sex with men have a significantly better experience with service-providers than do women and trans people, and consistently so across facilities and cities. And arguably, in some ways, cis-gendered lesbian and bisexual women are even less catered for than trans people.

This marked disparity can be attributed to a number of reasons:

- From a public health perspective where HIV is being managed and controlled through a determined “Test and Treat | Treat All” strategy, men who have sex with men are a popular and promoted target group for services, as may be trans people in certain environments. These perceived high-risk groups are sought out for services, and receive priority attention and access to protective barrier methods, testing, counselling, treatment and other interventions such as PREP. From that HIV- management perspective, however, women who have sex with women are – inaccurately – perceived by health programmers to be at significantly lesser risk of transmission of HIV.

- Women who have sex with women are exotic to service providers; little is known about them. The situational analysis suggests that the visibility of populations is proportional to service-provider perception of need/demand: in other words, seeing the population is evidence they exist, and a foundation on which to build clinical experience; not seeing them suggests they aren’t there.

Naturally, there is something problematic about that logic: there are a number of complex social reasons why women who have sex with women

might wish to remain as discrete and anonymous as possible; placing the burden on this population to 'out itself' to justify access to decent, equitable care seems unreasonable and unethical; a health system that behaves as though the population does not exist and does not know what to do with them or how to serve their unique health needs does not strongly incentivize the population to become visible.

- In the data-collection systems of these health facilities, no provision is made to capture lesbian or bisexual women who may be referred for services. They are instead captured as 'sex workers'. The data-collection tools that are consistent with the District Health Information System (DHIS) recognise "MSM" and "Sex Workers".

Even within the LGBT community, patriarchy subsists, making available better care to those who are men, or who have sex with men, a bias that is consistently evident in the perceptions of different populations towards the availability, accessibility, affordability and acceptability of health services within the same facilities.

If the Situational Analysis reveals these varied levels of experience between the Key Populations groups, it also shows a vast difference in perception between the service-providers and the groups they serve. Consistently, service-providers assume their services to Key Populations are considerably better received than is reflected in the experience of their clients.

This discrepancy can be attributed to a number of reasons discussed throughout this report, but including:

- KP clients perceive that service-providers have an inadequate clinical knowledge of their specific sexual or reproductive health needs (eg. trans health; hormone interaction; the health risks associated with breast binding; anal health; STIs that may present in the anus or throat; STIs and other physiological conditions that may present in women who have sex with women) and are ill-equipped to give appropriate health advice.
- Service providers and facilities perpetuate a heteronormative, cis- gendered environment. While it is recognised that there are serious socio-political challenges that make it difficult for providers to publicly demonstrate their commitment to care for key populations, no materials or publications in the facility provide health information in a way that represents individuals or relationships other than traditional heterosexual realities. Questionnaires and protocols designed to guide health workers through taking a clinical history presume heterosexual relationships: "Are you sexually active?"; "If yes, when was the last time you had sex with a

man?".

*'How do people feel welcomed and included when they do not see themselves represented in a space?'*

In the unique ecology of institutional health service provision to key populations in Zimbabwe, both sides – service providers and service users – have a steep gradient to overcome to reasonably reconcile their respective expectations, obligations and aspirations, but engaging openly with each other to surface and express those expectations will have a considerable levelling effect.

## 5. Consistently low availability of a limited set of high-demand services is sufficient to significantly compromise accessibility, utilisation and uptake of many other services available to Key Populations at health facilities.

In a context where social norms, political positions and legal provisions malign and criminalise members of key populations, such groups – men who have sex with men, women who have sex with women, trans people – become isolated and reluctant to seek care and services, fearful of harassment, stigma, discrimination, persecution that may come with exposure in public facilities. These conditions only increase the vulnerability of already vulnerable populations whose access and uptake of essential services are limited by structural and institutional barriers.

Against this backdrop, the services made available through the partnerships with PSI in Bulawayo and Harare, and with Wilkins Hospital in Harare offer key populations access to a range of interconnected services that are unlikely to be accessed elsewhere: HIV counselling and testing; STI treatment; access to PREP; enrolment on ART; family planning; cervical cancer screening; TB-screening and treatment; management of chronic, non-communicable conditions.

But, the potential benefits and impact of this comprehensive set of services and interventions are not realised, owing to consistently low availability of a small number of high-demand services. The absence of this small set of services has a

deterring effect on key populations users, who lose confidence in the facility, and are less likely to return for other services.

Four areas define this “small set of high-demand services”:

- i. Services that acknowledge and affirm the sexual and reproductive health needs of women who have sex with women: availability of protective barrier methods (eg. finger cots; dental dams); appropriate cervical cancer screening methods (eg. sensitivity to and caution in the use of speculums); ability to have private, non-group, pre-HIV test couples counselling; consulting questionnaires that use inclusive language.
- ii. Trans-specific healthcare, including protective barriers that provide for lesbian or bisexual women and trans men (dental dams, finger cots, female condoms, gloves); availability of hormones and knowledge about the interactions of hormones with other drugs such as ARVs; provisions for psychosocial support and mental health that include gender, sexuality and partner counselling; binders and knowledge about their effects on breast cancer; information about gender-affirming surgery for which the government makes provision for intersex people, but not for trans people.
- iii. Drug shortages most relevant to the treatment of sexually transmitted infections, specifically benzathine penicillin and Podophyllin indicated in the treatment of genital warts.
- iv. Access to STI management and treatment as a stand-alone programme, not as a secondary/referral service following HIV-related testing and treatment.

## 6. Good sexual and reproductive health are indivisible from good sexual and reproductive rights.

It is clear from what has already been discussed, and from what will be discussed in other sections of this report that where sexual identities and diversity are affirmed in the design and delivery of services to key populations, demand, access, uptake and utilisation of services increase.

Identity – sexual orientation, gender identity, gender expression – is not incidental to seeking healthcare and services. Where identities and rights are suppressed, denied or invisibilised – where gay men do not feel confident to talk about an anal infection because it reveals their orientation; where a trans woman presents at a facility as a straight man in order to receive services free of fear and discrimination; where lesbian women lie about their domestic partner in response to a presumptively heterosexual series of questions – health outcomes suffer.

Identity matters, not only biology. Moreover, identity matters to biology. And this is relevant to health workers who aim to provide quality services. Service-users need to be able to speak freely about who they are to describe and discuss the symptoms, the behaviours, the concerns that lead them to seek care. Without that complete picture, service providers cannot make an accurate diagnosis that facilitates quality care.

Sexual rights are extensions of human rights and include the right to quality sexual health; to a safe and satisfying sexual life with a partner or partners of choice; to self-determinism, control and agency in matters of sexuality, reproduction, bodily integrity and gender identity; to access to services and information that make it possible to appropriate these rights. Achieving good sexual and reproductive health is indivisible from good sexual and reproductive rights.

While this formulation suggests that advancing human rights in a suppressive and oppressive society is necessary to facilitate better health outcomes, the reverse is also true: that better rights might be achieved, across the universal spectrum of rights, in the course of conscientiously strengthening delivery of sexual and reproductive health programmes and services.

In oppressive socio-political environments, where certain citizens are victimised by having their sexual identities invisibilised, invalidated, delegitimised or criminalised, it is especially important that health service-providers not reinforce that institutionalised culture of violation. If “good” public health services, in general, are where people feel respected and treated with dignity, then it is essential that health-providers trying to reach key populations – an already marginalised and suppressed community in society – observe other fundamental rights in the way services are delivered:

## 7. In social and political environments where sexual rights are denied, other rights require greater recognition!

- the right to privacy;
- the right to information;

- the right to consent;
- the right to bodily integrity – to decide what happens to your own body.
- the right to confidentiality;
- the right to dignity;
- the right to non-discrimination

Health workers should exercise special caution that they do not inadvertently compromise or violate these rights through well-intentioned service provision, often in the pursuit of noble aims or targets. Such violation may be easier to commit than health workers realise amongst populations with lesser power to choose, or to question, or to decline because their available options are limited.

Under such conditions, there is a fine line between “strongly encouraging HIV testing, even when there is resistance”, between “persuading them convincingly with counselling to do contact-tracing”, and coercion. It may not be acceptable to increase demand for services amongst other potential clients in communities by mobilising their LGBT peers to identify them to a health facility. It may not be appropriate to ask a client for the contact details of sexual partners or family members as part of service delivery without explaining why that information is necessary or how it will be used.

Service-users should not have to endure indignity in order to receive services. They should not have to choose between privacy and good health. They should not feel obliged to take an HIV-test before they are eligible for other services to treat the condition with which they first present to a facility.

And since experience so strongly shapes perception, only a small number of uneasy, distressing, uncomfortable experiences are necessary to dissuade clients from returning to a facility where they have felt compromised – and prompt them to share that perception with others.

Those responsible for delivering services that facilitate access to the right to health do so in the context of a system of other rights – indivisible, interdependent, interrelated. Respecting, upholding and fulfilling those other rights in the course of providing health services ensures a service that is respectful, dignified, appropriate and acceptable, even amongst people whose sexual rights are improperly limited.

## 8. Visibility equals vulnerability; and increased vulnerability is a major deterrent to accessing health services for populations already vulnerable and at-risk.

For members of Key Populations in social and political contexts such as Zimbabwe, visibility equals vulnerability.

In an environment that is not safe, that does not feel safe, that does not feel private, people feel more vulnerable the longer they are exposed to the public. And, in fact, this is more than perception: gay men, trans men and trans women especially report that prolonged exposure and visibility subjects them to a greater sense of self-consciousness and stigma, to harassment, to abuse.

This principle is a powerful determining factor in the experience of key populations accessing health services through the facilities in Harare and Bulawayo, and plays out in multiple ways throughout the experience: walking from home, waiting at a bus stop or taxi rank, taking public transport, walking through town to the facility, passing security, engaging with the receptionist and identifying the reason for the visit, waiting in a waiting area, standing in line to see a nurse or doctor, moving between departments, personnel and services within the facility, waiting in line to collect medications, and the journey home.

Service-users report feeling stared at throughout that experience, feeling judged, being subtly or openly mocked, feeling afraid or threatened. They recount stories of physical harassment en route to a facility. They recall the anxiety of waiting in line expecting to be recognised by someone they know from home.

This is an important consideration for health facilities that relates directly to how managing patient flow and adapting the physical layout of the facility might reduce wait time, might limit the exposure of key populations to the public, might increase privacy, and increase a sense of safety for insecure populations.

*Ironically, at the same time, no visibility (as in the case of undisclosed lesbian or bisexual women) leads to low availability of services because that population is thought to be non-existent, or demand seems low, also leading to increased vulnerability.*

## 9. Comprehensive health services are not the same as Integrated health services, but both are necessary to deliver good services to key populations, and to promote uptake of services.

The PSI New Start facilities, in particular, describe their services as “integrated”, but this may be a misnomer. Whilst there is a logical flow to the sequence of services, from entry-point issues (HIV; family planning; cancer screening) to other programmes (ART; PREP; contact tracing; STI treatment), it may be more accurate instead to describe the package of diverse services as ‘comprehensive’.

But why not convincingly “integrated”? Most notably at these facilities, the range of services are presently provided in compartmentalised ways, organised by ‘specialisation’ into departments between which clients are transferred. Clients may meet with an initial nurse or counsellor in a consulting or examination room. HIV counselling and HIV testing take place in a separate section of the facility, staffed by different nurses. Family Planning is a separate department. TB-screening is a separate department. area. Each area may have its own queue or waiting area.

Given that “visibility equals vulnerability”, and the realities of a busy, congested, high-traffic facility, this is a less than ideal design for an integrated service, especially one that is intended to be KP-sensitive. Amongst other effects:

- i. It increases wait-time and through-time in the facility.
- ii. It increases the level of visibility and exposure for key populations to staff and other service-users; there is a higher chance of a KP-client leaving midway through the visit, or avoiding seeking services entirely.
- iii. It requires a client to repeat a history several times, depending on how many service providers he or she is required to see.

More appropriately, an integrated service might mean that a client sees as few health workers as possible in a single visit, and that, ideally, one health worker is qualified to provide a range of services: to do HIV counselling and testing; to examine and treat STIs; to take TB samples; etc. For the service-user, integration means:

- an experience that is as seamless, smooth and easy to navigate as possible.
- that services are coordinated and organised to reduce the stages in a visit (ideally a single point of care) and the number of separate visits required.

- good systems for communication and handover between service- providers

*“We don’t want to have to keep explaining our situation over and over and over again to different people when we are referred between departments.”*

Whilst comprehensive services provide the scope of clinical and health-related services, integration facilitates the continuity of care where systems and services are organised, primarily, to meet the patient need. And, in the context of key populations especially, those needs are discretion, privacy, dignity, limited exposure, and efficient patient flow and facility throughput.

Improving integration is a technical, systems and culture issue, and one of practical design. It requires a different way of thinking about how health workers are trained, how the health system operates within the environment of the facility, and how the physical layout of the clinic is organised to facilitate smooth and efficient movement of clients from entry to exit. It presents a programming opportunity for modelling thoughtful design of a KP-friendly health facility.

## 10. A health facility cannot claim to offer a “KP-friendly service” where STI care, treatment and management are not offered as a stand-alone programme or service.

Two interrelated issues were prolific in conversation with the key populations focus groups in both Harare and Bulawayo: sex, and sexually transmitted infections. People are having sex – not infrequently and, by choice or circumstance, not always safely – and they are contracting infections. Infections other than HIV.

In a public health landscape where sexual and reproductive health discourse is still dominated by HIV prevention and treatment targets, STIs receive relatively little profile. And yet, they constitute an equally voracious parallel epidemic of frequently atypical or asymptomatic presentation, with significant negative health consequences, and damaging psychosocial impacts that compound stigma. More, the presence of an STI multiplies the transmissibility of HIV and the risk of acquiring it.

The ability of a sexually active key population community -- whose risk and vulnerability are increased by structural discrimination, social stigma, punitive law, insecurity, economic and political marginalisation, psychological distress, substance abuse and violence – to have non-HIV STIs examined, diagnosed, treated and managed is paramount.

Too often, however, the Situational Analysis exercise surfaced experiences from service-users who presented to facilities with an active STI, treatment of which was conditional upon being tested for HIV (or was perceived to be conditional) – and subsequently referred for either ART (if positive), or PREP (if negative). Consistently throughout the conversations, service-users reflected how negatively this affected their perception of the availability, accessibility and appropriateness of the service: that HIV-treatment was not the service they were seeking; that they should not be pressured into procedures they have not come for; that entering the HIV-test-and-treat “channel” unnecessarily prolonged the time they needed to spend at the facility; that it deterred them from seeking treatment for the STI.

*“They tell you you have to test for HIV before they will treat you for STI. So, you end up just going home with your STI.”*

Of the three health facilities, this tension seems most evident in the PSI New Start Centres in both Bulawayo and Harare. As a donor-funded NGO intervention, the PSI Centres are not general hospitals or, in fact, public primary health facilities. They exist as, primarily, HIV Counselling, Testing and Treatment Centres around which a host of complementary services are wrapped to provide a continuum of care. HIV is the entry-point through which many other services – STI screening and treatment, cervical cancer screening and treatment, family planning – might be accessed, and through which such services are subsidized.

Service providers and managers vary in their framing of the conditionality of HIV- services to STI-treatment, within and between the two Centres:

*“We strongly encourage HIV treatment. If you don’t want to the first time, it’s okay. But you can’t keep coming back without testing.”*

*“Consent is our primary issue here. Even when there is resistance, we try by all means to make people understand. It is important for them to know their status because it helps us in treatment of other issues and conditions. But we don’t coerce them.”*

*“If someone comes with an STI it means they are having unprotected sex, so we screen for HIV.”*

The PSI facilities have no stand-alone STI programme at present, although this was not always the case. Funded through a project, this stand-alone service came to an end in March 2017. Subsequently, STI services are delivered as a value-added service, not as an entry point programme into services in the way that HIV or Family Planning might be; those services are available to clients who come into the programme through other entry points that invariably finance the additional STI- services.

*“We have no funding for STI services at the moment; we give what we have, and if we don’t have we prescribe. We really need another funder for STI programmes, even if that is just available to the KP programme.”*

*“If clients are part of our HIV cohort, they get our STI services. If they don’t want to be tested for HIV, we can refer them to another centre, although that facility might not be KP-friendly or sensitised.”*

The availability and accessibility of on-demand, stand-alone STI treatment and management services for key populations constitute a significant advocacy and programming issue.

## 11. Sensitisation is a multifaceted effect, not an event.

“Sensitisation” was referenced in conversations throughout the situational analysis exercise, by both service-providers and GALZ programme team members, as having happened towards the start of the partnership.

Unsurprisingly, facility staff being exposed to a sensitisation workshop – a single, isolated awareness and information activity – does not immediately confer on them empathy, understanding or sensitivity, a fact that is repeatedly borne out in the experiences and perceptions of the key populations constituency. Nor might that effect, if successfully achieved several months previously, presently remain within the facility.

Health facilities are a complex and compound ecology. Sensitisation of this system cannot be achieved – to such effective measure where sensitivity and appropriateness are results within that system, not only an input – through a single, once-off workshop.



Insight from both service-users and service-providers suggests that, for sensitisation to be effective:

- The process should engage ALL facility-related personnel, not only clinical staff and managers, for at least two reasons:
  - Support staff (eg. security guards) are often an outsourced service, so are not included in sensitisations. LGBT service-users report that such 'gatekeeper' positions – security guards, receptionists, etc. – commonly present attitudes and dispositions that dissuade them from seeking further services. When this happens, clinicians and managers may never know of such incidents; clients may have voluntarily opted out.
  - Unless sensitivity is distributed across the facility, and consistent – if it is disproportionately concentrated in a small number of individuals – stigma is intensified, trust and confidence of LGBT service-users towards the facility decrease, and utilisation of services decreases.

*“The whole facility must be sensitive to LGBT people – it has to be a standard practice – not only a few individuals who are trained to deal with us, who then leave when there is staff turnover.”*

*“We already know when we get there, people look at us and call Mavis: ‘Mavis, your people are here for you.’”*

*“I went to the clinic, but Auntie Mavis wasn't there. So I went home.”*

- Processes need to be periodically REPEATED so that longer-serving staff are updated, and newer staff are oriented to the material. In the economic climate of Zimbabwe, health worker turnover is high; consequently, those service-providers who may have participated in an awareness workshop at one time may no longer be working at the facility. For example, GALZ delivered a sensitisation activity at PSI Africa House Harare in early 2017. By October 2017, up to 80% of the facility staff have changed.
- Processes aimed at health workers should address more than basic awareness and attitudes, although these remain necessary. Health workers require – and desire -- technical sensitisation as well, to have a better understanding of the clinical dimensions of care for particular groups within the key populations community (STIs; trans-health; women who have sex with women; etc.). A better understanding of the medicine and biology would create greater confidence and competence, and contribute to deepening shifts in attitude, perception and professional practice.

- Sensitisation need not only be instructive. The effect is deepened when linked to accountability and engagement: the person-to-person interface between health providers and health service users. Both groups agree that better engagement would lead to improved relationship and higher quality of service.

*“Let's work together more; we bring in what we have; talk together about what will work best for this community....”*  
*(facility manager)*

*“There's a need for better interaction with clients about their perceptions and expectations.”*  
*(facility manager)*

*“People have these attitudes. Maybe we can say they shouldn't have them because they are health workers, but in reality they still have those attitudes. They don't have the opportunity to understand the person they're serving. These are new things for our people. I mean, most people in Zimbabwe have never even heard of a trans person.”*  
*(facility manager)*

*“More engagement would help. It would help us. We want to engage with them more, on a personal level and a managerial level. We could arrange a half day or a whole day workshop so we can become more aware of their needs. We want to know them. We want to engage them. Our engagement is not enough. And to get feedback from them if we are not doing enough.”*  
*(facility manager)*

The process should extend to the LGBT community as well. Sensitisation need not only be applied as a strategy to better inform facilities. Awareness, information and skills are also needed amongst key population service users, who need to be more conversant around health issues, rights literacy in general, and health rights in particular.

## 12. Achieving inclusive, representative, accountable good practice on the outside requires inclusive, representative, accountable good practice on the inside.

The Situational Analysis highlighted several areas for attention within the internal institutional and management environment of GALZ itself that mirror some of the feelings of under-representation and marginalisation expressed by members of the constituency when they speak about the health facilities:

*“We need a survey of health needs and concerns for women only. Not together with the men.”*

*“Even programming in GALZ focusses on MSM. If there are, for instance, 10 projects, maybe 8 of them are for MSM. Where are the programmes for women?”*

*“Who is managing the GALZ offices? The men. I think more than three quarters of the office is men. How can we expect the public to take us seriously as women who have sex with women when we can’t even sort it out between us in our own organisation?”*

*“Our name says ‘Gays and Lesbians of Zimbabwe’. But we don’t act like that. GALZ is a boys-club.”*

*“I am a peer educator. I’m also a WSW. I spend most of my time promoting services and programmes for MSMs, when there is nothing for women like me.”*  
*“We don’t know who is speaking for us to these health facilities, or what is being agreed on our behalf. Are the men speaking up for us strongly enough as WSW?”*

*“We feel like we are being palmed off as members of GALZ to these facilities, now that GALZ is not so much of a service provider anymore. But we are not satisfied with just being bundled off to Wilkins. And now not getting services at these places.”*

These are matters of internal accountability and stakeholder engagement; they are matters of gender equity and representation within the complex diversity of the LGBT community and constituency, engagement with which is necessary to prevent disillusionment, disenfranchisement and fragmentation in a sector that cannot afford division.

They also speak to resource mobilisation: where is the financing for women’s sexual and reproductive health programming, what is being funded, and who might be making those resources available? In the absence of clear answers, this may be an issue for research and advocacy.



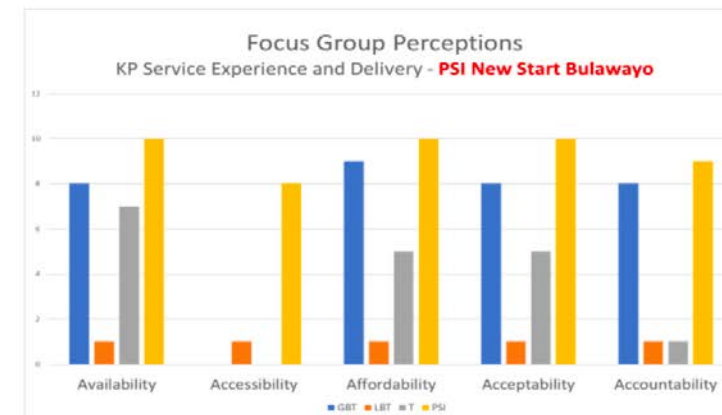
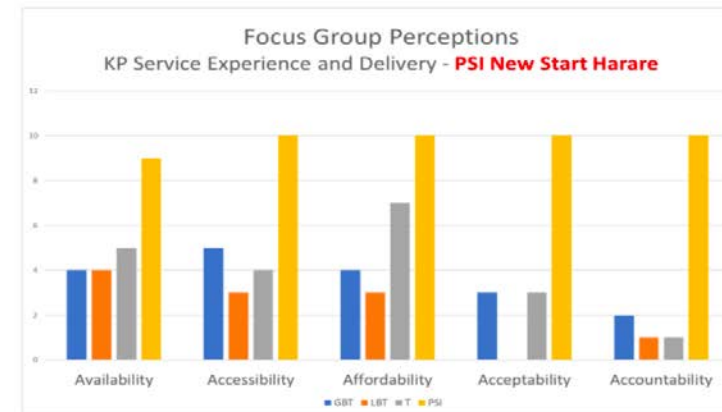
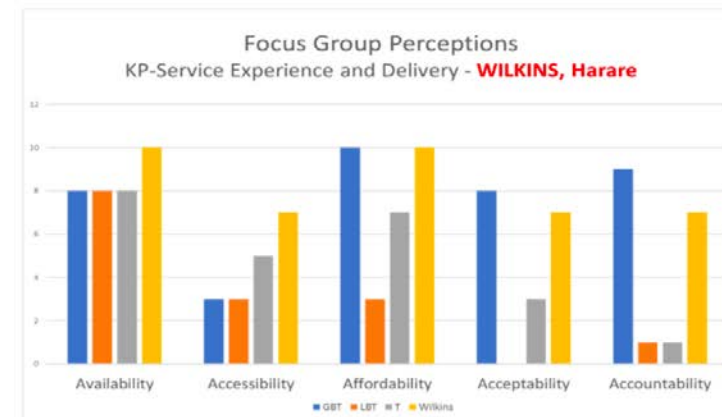
# Perceptions | Perspectives

# Perceptions | Perspectives

The Situational Analysis exercise illustrated that the various components of the system for health – service providers and service users; health facilities and communities – agree on the standards that should constitute “good” public health service. Focus group discussions with each group, however – with gay and bisexual men (GBT), with lesbian and bisexual women (and trans men; LBT), with transgendered men and women (predominantly a trans-women constituency; T), with facility management and clinical staff – reveal that:

- These groups have significantly varied perspectives on the extent to which these standards are met.
- Direct personal experience of health services strongly shapes perception of those services by users, as does second-hand reported experience transmitted across the community.
- Experience is, at least in part, a function of identity. Service providers generally perceive their services to be significantly more acceptable than do service users. Gay and bisexual men generally have a more favourable experience than do lesbian and bisexual women.
- Perception is subjective, and not necessarily based in fact. Nevertheless, it is strong enough to inform opinion and perspective by individual service users, and to be either an incentive or deterrent to continuing in care, both for those users and for peers in the community to whom that perspective might be transferred. Amongst members of key populations, sustained demand for services that translates into consistent utilisation is predicated on positive perception: that services are deemed appropriate and acceptable.

For the situational analysis process, groups reflected on their experience with at least one of the three partner health facilities, with reference to five standards: AVAILABILITY, ACCESSIBILITY, AFFORDABILITY, ACCEPTABILITY and ACCOUNTABILITY. Discussion around QUALITY, including the extent to which services were sexuality and gender AFFIRMING, was implicit. Each facility reflected similarly on itself. Using the Mixing Desk tool to guide discussion, respondents graded each standard by setting a level from 0 – 10, and discussing the perception that informed that score.





Availability

# Availability

Wilkins HRE	GBT 8	LBT 8	TW 8	Facility 10
PSI HRE	GBT 4	4LBT 4	TW 5	Facility 9
PSI BYO	GBT 8	LBT 1	TW 7	Facility 10

Service Providers across all three facilities express a high degree of confidence in the availability of services to key populations:

*“We are open 24/7; services are available. Anyone who comes can access the service.” (Wilkins)*

*“Lots of services are available: HIV testing, family planning, TB screening, cervical cancer screening, ARV treatment, HIV counselling, ultrasound and X-ray, viral load testing.” (PSI-Harare)*

*“We are different to public health facilities in that we give a preference to services for KPs. And all KPs who are referred to us through GALZ are seen by the doctor.” (PSI-H)*

*“KPs are allowed to be here. There is no service that we say, ‘this is not for you’. If you are a KP, everything is available for you here”. (PSI-Bulawayo)*

*“We are running an integrated service, so all services are available here.” (PSI-B)*

Facilities are, however, conscious of two limitations: virtually no availability of protective barrier methods for women who have sex with women (WSW); and irregular availability of medication for the treatment of STIs, specifically Podophyllin and Benzathine Penicillin. During these stock-outs, facilities issue prescriptions that patients fill at personal cost at a retail pharmacy.

This perception of good availability is not universally shared by key populations users. With respect to Wilkins Hospital in Harare, users appreciate the generally “comprehensive service and a fully stocked pharmacy”.

*“...medications are available. I find all the services I need there” “...they have the services; you can go for a lot of stuff...”*

And yet, availability is not consistent:

*“Wilkins says their Sexual and Gender-based Violence (SGBV) clinic is 24/7, but it’s not there on weekends. I had broken teeth and a swollen face after I was beat up on the weekend. I was actually shaking. I went to the SGBV clinic, but could not be helped. There was literally no one there at the 24-hour clinic.” (male sex-worker)*

*“Services at Wilkins are available. But high availability also means there is a high demand for services from a lot of people. There’s a long wait time. The staff go on lunch and patients wait.”*

*“A small group of us arrived at the clinic at 08h00. We wanted to be tested for HIV. And this was the time that was advertised. But the nurses were in a meeting and no one was available. We waited until 10h00, and then we left.” (LB woman)*

*“There are many services available, but they couldn’t explain to me why I needed the services they were talking about. Like coming to have my viral load tested. I didn’t know what was a viral load, or why I must test it.” (LB woman)*

*“The doctor is mostly not available for us; usually occupied in other sections.” (trans woman)*

*“We visited once to ask for gloves. We waited for about an hour and ended up leaving.”*

In general, Wilkins’ challenges may be illustrative of a high-demand, high-traffic public health service experiencing severe human resource constraints. Whilst services are available, the system is not agile enough for them to be consistently efficiently administered.

Trans-women, however, identify a more specific limitation, bridging the gap between availability of services, acceptability and accessibility:

*“Services are good – the basics, the general services. But, there is no service package for trans health. No gender counselling, for instance. And they don’t understand trans people.”*

*“They are not sensitised. We get strange looks at reception. We are pointed out between the nurses: ‘...those are the LGBTI...’”*

*“Sensitivity has to start from the gate...”*

*“They really need to get sensitised, starting from the guard at the gate.”*

It is PSI, however, in both Harare and Bulawayo that attracts consistently unfavourable feedback. As respondents reflect, they cannot avoid considering a set of interrelated factors that may present legitimate barriers and limitations to availability and how it is perceived.

Poor availability of medication is a recurring theme, across all populations that access PSI in both Harare and Bulawayo:

*“Frequently, there are no meds available, and you’ve been waiting there a long time.”*

*“The supply of medications is less available. They are not reliable.”*

*“You might find they don’t have all the necessary medications, like for STIs. When it comes to medications, they write prescriptions and you have to buy at a pharmacy. This costs us money we don’t have. And you have to face more judgements at the pharmacy.”*

Congested, over-burdened facilities and a long wait-time are experienced as a limitation on the availability of good services.

*“Services are available, yes. But it takes a long time to be treated. You need to set the whole day aside, and then the examination is very quick, not thorough. It’s a rush job. They don’t take the time with you. And we somehow have this expectation here that when we go to a hospital we don’t just want to be diagnosed in two minutes. We want someone to look.”*

*“Services are there but the quality of care is poor.”*

*“Services are slow; maybe there are too many people. You can stay in the queue for more than an hour.”*

*“I came at 09h00 with four friends who wanted to be tested, but we waited there until 17h00”*

*“It takes at least two hours or more if I want to be treated.”*

*“There’s usually a queue at reception, and you wait over 20 minutes there. Then you wait until Auntie Mavis is free to see you. She comes to get you and there’s a consultation with her. She tells you to go for testing. There’s a queue there for another 30 minutes. Then you have to wait 30 minutes for your results. Then back to Mavis. Then you need to see a doctor. More queueing. Then you get a prescription, but have to get it stamped at reception. Then another queue there for that stamp. Then to the dispensary and more waiting. It can easily take 4-5 hours.”*

Availability of drugs and efficiency of services are two relatively generic systemic issues in many health facilities. Two other factors material to availability, however, relate to PSI’s specific location of its work within an HIV-epidemiological framework. Unlike Wilkins, PSI’s New Start Centres are not general hospitals. They are primarily HIV-service facilities, with a mandate to increase testing and treatment of HIV. This institutional priority is recognised by key population users; it has a marked effect on their perception of service availability.

On one level, the menu of services available at PSI are predicated on HIV as an entry-point.

*“If I want to be treated for an STI, I’m forced to get tested for HIV. I should have a right to choose, not be forced.”*

*“I’m like a peer counsellor. I recently referred someone to PSI for STI treatment. They were told they must test for HIV before they could get other services and treatment. If they tested positive, they would go for ART. If they tested negative, they would go on PREP.”*

*“Someone came from Mutare all the way for the service in Harare, but was forced to go through these other HIV testing channels first before getting other services.”*

*“One of our members, a sex worker, went for an antibiotic, but was being forced to be tested. She knew her status, and didn’t want to go through all those other processes again just to get antibiotics.”*

On another level, gay and bisexual men and other men who have sex with men are perceived to be a priority since, for an HIV-focussed facility, they are viewed as a particularly vulnerable target population. By contrast, women who have sex with women are perceived to be low-risk.

*“Services, equipment and personnel are available. They can do all the HIV-related services: blood tests, STI screening, HIV testing. But nothing trans-specific.”*

*“I have a (trans) sister who went there for PREP. They gave us the impression that they don’t recognise us when we come in. Their systems don’t recognise us, unless we come in as gay men.”*

*“In Zimbabwe, trans is invisible, non-existent. It’s a whole day spectacle when you go there needing to explain everything. Why you don’t need to see a gynaecologist. Why you might need to be referred to a urologist. They start asking you questions as if you are the doctor. They don’t know, so you need to educate them first yourself.”*

*“Basic Services’ are there, but no trans-specific health package. No protective barriers for lesbian or bisexual women and trans women - dental dams, finger cots, female condoms, gloves. No hormones. No gender counselling/sexuality counselling/partner counselling and identity counselling. Things that take your mental health into account. No binders, and knowledge about their effects in case we want information about breast cancer. And gender-affirming or re-assignment surgery is legally available to intersex people, but no provisions are there for trans- people.”*

*“You can get generic services there for women. But not as ‘WSW’. Not without discrimination. So, if I’m seeking services, I have to appear heterosexual.”*

*“For some certain groups, there are really excellent services. I got really great services when I went once. But there is favouritism when they deal with LGBT people. They’re more with the gay and bisexual men and trans”.*

*“As LB women, there are no barrier methods for us. No finger cots. No dental dams. They also need to be sensitised to what WSW need. These methods are*

*not available. They are ignorant about them; don’t know what those are.”*

*“No one really takes much time to understand lesbians, so there is very poor information available for us. We are women. We give birth. We engage with men sometimes. And we are in our same-sex relationships and vulnerable to HIV as well. Services are available, but only if you are a heterosexual woman.”*

*“PSI focusses on MSM only. Even lesbians who are peer educators distribute condoms and lubes for MSM when there is nothing for them. The questionnaires we administer are for MSMs. The data for DHIS that we collect can be entered specifically for MSM and heterosexual women, and sex workers. They think we are not affected as LB women, but HIV does affect us.”*

*“Some MSM get access to PREP, but they are married. They are in heterosexual relationships with women at home. Bisexual women and lesbians are also in heterosexual relationships with men sometimes. But those same services are not there for us. We don’t feel left behind. We are left behind.”*

Perceptions are subjective, and vary between service providers and service users. It is unlikely that PSI will recognise, acknowledge or agree that any client is “forced” into HIV testing. Or that services are so profoundly prejudiced towards men who have sex with men so as to ignore and exclude other sexual and gender identities from care. Perceptions are powerful, however, and have crystallised strongly in the minds of service users





# Accessibility

# Accessibility

Wilkins HRE	GBT 3	LBT 3	TW 5	Facility 7
PSI HRE	GBT 5	LBT 3	TW 4	Facility 10
PSI BYO	GBT 0	LBT 1	TW 0	Facility 8

Focus group respondents helpfully defined accessibility – services are there (available), but are they easy to get? – and expanded the criteria by which accessibility might be measured to include physical accessibility, a conducive space where services can be accessed safely and comfortably, an environment that is confidential and private.

As the graphs and table show, in as much as key population service users recognised the availability of a range of services from health facilities, they did not think those services were easy to appropriate, naming several barriers to access, many of which are recurring themes across the analysis of availability, acceptability, affordability and accountability.

Amongst these limitations to accessibility:

## 1. Physical distance

“PSI in Harare is physically more central than Wilkins. But they are both either in town or in the suburb where our community doesn’t live. There are clinics that are closer to where people live, and with shorter queues and wait-times, but they have not been sensitised to be LGBT friendly.”

“Wilkins is the only LGBT friendly clinic across many provinces, far removed from people who are not based in Harare.”

PSI in both Harare and Bulawayo, however, offer off-site services to key populations as an outreach programme.

“We’re centrally located in the CBD. Every Jack and Jill comes here, so stigma is likely to be low; discrimination is likely to be low. Everyone who has a need comes here. And if people want the services but don’t want to come to the facility, we visit in their places to offer services.”

## 2. Operating Hours

“In Harare, PSI is more reliable than Wilkins. We know they are open Monday to Friday. Wilkins is not available on weekends or public holidays, although they say they are open.”

“PSI works with an appointment system. But the services are slow. I booked at 09h30 but only got the service at 12h00. It takes a long time. Even if you make an appointment. I spend a lot of my day there. The wait is long.

“Services are slow at PSI. I first went at 15h00 on Wednesday and I was told they were closed. The next day I came at 09h00 and got the services I needed by 14h00. No one was in the lab, so I couldn’t get the service when I arrived and had to wait.”

## 3. A lack of confidence in the clinical competence of service providers and the rigour of their examination. In this context, clinical competence includes promoting and fulfilling the patient’s right to access information, and their rights to give consent based on comprehensive information.

“At PSI, we present with an issue. We are scared because of that issue. It is worrying us by the time we come to the facility. But they don’t even look at you properly to examine you fully. Like they’re scared to touch it.”

“There is low access to information. Information is often written in a language people can’t understand or its technical. When you try and find out, there’s a barrier. People get frustrated when you ask for information; they look at the line waiting for them behind you.”

“When a trans man went to Africa House [PSI Harare] they didn’t give him any information. No definitions. No descriptions. No instructions. No information on risks. They insert this metal thing inside, and it really hurt that person.”

#### 4. Poor knowledge of and provision for the health needs of women who have sex with women.

“A lot of our association with Wilkins and PSI is about HIV and TB. But we ourselves as WSWs don’t have a full understanding of other STIs that might affect us. And then they themselves – the nurses – at the clinic are not well informed about WSW health, and they don’t have a lot of information to share either if we’re looking for advice.”

“Protective barriers for lesbian and bisexual women are not accessible at clinics. They don’t cater for that. Condoms are, but male condoms. There is nothing available for women who have sex with women, not even at pharmacies. The assumption is that we are not a health risk for HIV, so they are not catered for.”

“Basic care – the essentials – should be accessible to women, even without having to go through all the ‘procedures’ they make you go through. Like, we need a police report to prove we’ve been violated or assaulted before we get access to treatment. A friend got drunk one night and woke up in bed with a man. She knew she needed to access PEP and that she wouldn’t be able to do that without a police report. So she went to the police station, but those victim-friendly officers were not around to file a report for PEP. They told my friend that the officers had gone to Harare. When she went to Bambanani [PSI Bulawayo] and explained the situation they told her ‘there’s nothing we can do. Go to the public hospital.’ How can we go to a public hospital when this one that is KP-friendly can’t help us? And then what? Get cross- questioned? Get arrested? And we needed those pills in less than 72 hours. But if you go as an MSM, you get those pills to protect yourself and each other.”

#### 5. In as much as facility staff have been through sensitisation workshops, negative attitudes persist, deepening the professionalised stigma experienced by KP-service users at facilities.

“Another trans man went to the facility for cervical cancer screening and was shouted at by a nurse in public. ‘Why are you sitting there? We don’t allow men to sit there. This line is for women.’ He ended up leaving and told me ‘I’d rather die than go back there.’”

“Some people in the facilities are really good to us. But that is not the same across the whole

facility. And it creates stigma. When we arrive at PSI, people literally call out ‘Aunty Mavis, your people are here’”.

“Maybe the managers at PSI think things are different to the way they really are. They have a different impression of how effective the sensitisations have been, and how deep that has penetrated the facility. Managers are the ones who go to the LGBT workshops, but I don’t think they share with their staff afterwards, like with the receptionists, for instance.”

“The staff may have been sensitised once, and worked hard to not discriminate. But now there are new staff members who have come in since then and are not all up to date.”

“In Bulawayo, from the time you walk in the door as a trans person you have to pass many people – the security, the receptionist, etc. – until you find the person you want to see. You already feel not welcome. Judged. Health workers calling others to come look.”

#### 6. Available services and the way in which they are delivered are not affirming of sexual and gender identities, especially of women who have sex with women and trans people.

“The services are fine. They’re available. And accessible to you as long as you present as a heterosexual.”

“At the end of the day you don’t feel comfortable asking or answering questions.”

“We can talk about accessibility, but what do we access if it’s not available for us? All of the services you can have, all of it is perfect, as long as you pretend to be something else.”

“Access to PEP is not given to males. It’s given to raped women. I’m a trans woman. When I was forcefully assaulted by a guy, I couldn’t access PEP because they saw me as a male. And no one believes a man can be raped. Or that if you had unprotected sex – even if you say it was forced – that it’s the same as rape. Besides, who is going to report that to the police?”

The background features a complex pattern of overlapping, wavy lines in shades of purple and pink, creating a sense of depth and movement. A solid white horizontal bar is positioned at the bottom of the image.

Affordability

# Affordability

Wilkins HRE	GBT 10	LBT 3	TW 7	Facility 10
PSI HRE	GBT 4	LBT 3	TW 7	Facility 10
PSI BYO	GBT 9	LBT 1	TW 5	Facility 10

Health Facilities are unanimous. Services are affordable in that they are offered free. Unlike Wilkins, PSI is ordinarily not a free service – clients typically pay a \$1 (USD) administration fee – but key population clients who are referred through GALZ are exempted from paying through a coupon system. Medication is supplied at no cost to key population clients and, even without the coupon, clients receive the services they need should they be unable to pay for them. Community members agree that the health facilities are significantly more affordable than other options that are otherwise inaccessible to most.

“Services are affordable compared to consultations at a private clinic where it’s anywhere from \$10 to \$50.”

“Compared to other places where services cost \$5 to \$10, the services are affordable. You can get testing, treatment, counselling and medication for \$1.”

For service-users, however, the analysis of affordability is not as simple. It is a more complicated issue – not only about the direct cost of specific services – described by KP-respondents through a systems-approach that bridges questions of affordability into issues of accessibility and, more broadly, social and economic justice, and livelihoods.

“Most LGBT people don’t go to work. They are marginalised in this country. We live in ghettos. Services at a facility might be free, but health is not affordable.”

“Services are free. And sometimes even medication is free. But medications need food and nutrition. People need to be able to eat to take the medications.”

“Prep is free, so that’s very affordable. But you need to eat to be on PREP, and that’s why I pulled out of PREP.”

Wilkins and PSI are three select facilities, unlike most in the public health system, where members of key populations can access services in a comparably safe environment. This means, however, that those essential services are not available to community members in close proximity to their homes. Travel is necessary to reach the facilities; and travel has significant implications for affordability in both Harare and Bulawayo.

“At Wilkins, you never have to pay, the service is free; but the challenge is when you don’t have transport money to get there.”

“In Zimbabwe, most people live on less than \$1 per day. 85% of people are unemployed. And amongst some of us who are gay or trans, we have even less employment. Most of us will need to take two kombis to get to Wilkins from where we live. That’s already \$2 just for transport one way. And \$2 back.”

“People who need the services can’t afford to live in that area where the clinics are. So they have to have transport to get there. And transport costs money.”

“To get to Wilkins, it needs two vehicles, and the transport cost that comes with that.”

“Transport costs you \$1, and then you have to be there all day.”

“We are told that PSI will give you \$2 for transport money. It happened the first time I went that I asked about it, and was told ‘There is no money’”.

*For trans people, using public transport to reach the health facility is not only an issue of money; it’s also an issue of visibility. And with visibility come stigma and harassment.*

*“If I needed to go to PSI with public transport, I’d never go.” “That is why the trans community is dying.”*

During the Situational Analysis exercise, two trans women shared their traumatic experience of harassment in Harare when their car was surrounded by a mob of some forty men, who climbed over the vehicle, shook it violently, and tried to pull them out before they were able to drive away.

In as much as health facilities claim that a free service is made available to key populations, and that a coupon system provides for a waiving of PSI’s service fee

for clients referred through a GALZ peer counsellor, KP-respondents speak repeatedly about the \$1 fee they are required to pay, with or without a coupon. This issue surfaces so frequently during the Situational Analysis amongst so many different respondents in different groups from different cities, that it is impossible to believe the experience is isolated, misunderstood or misrepresented.

“They say services are free, and drugs are free. But the clinics charge us a \$1 “handling fee”. Without paying that fee we can’t access our “free treatment”. And we still have to get transport there and back.”

“The dollar sounds so little, but when you add transport and medication – especially if you have to get medicines from a pharmacy with a prescription – you need about \$5 or \$6.”

“You come and pay at reception before you get the services. And if you don’t have that dollar – if I don’t have that dollar – I will die. They will turn you away. And that’s life threatening if you don’t get some drugs like ARVs. And they want that dollar to give you a 3-month supply. If they don’t get that dollar you can’t access drugs or services.”

“When we as peer counsellors give our clients a coupon, they’re not supposed to pay. But some are paying even with the coupon.”

“We come with the coupon, but they tell us ‘...never mind that coupon...\$1.’”

“At PSI, you get CD4 testing for \$1. But you have to wake up and be there very early. If you get there late, they don’t do anything for latecomers. They only take 8-10 people per day. At Wilkins, they do 100 people on Tuesdays only. You can get there at 4AM and stay until 4PM.”

“If you get a coupon from GALZ and a Peer Educator, you don’t pay. But without that coupon, it’s a dollar for the service. And without that dollar, there’s no service.”

“If you don’t have money, they don’t treat you; if there’s an emergency, you’re told to go to the police to get an affidavit stating that you can’t pay and why.”

The issue of payment for services is sensitive and contentious, with several contrasting narratives that may only be reconciled and resolved through engagement and dialogue between health facility staff and community members. It may be that certain constituencies

within the GALZ membership are not recognised by the clinic when they present (eg. lesbians or bisexual women) with a coupon, or perhaps do not present with a coupon by choice so as not to be identified, and subsequently are not afforded the free service. It may well be that receptionists are not uniformly informed about the policy to waive service-fees for referred KPs, and that these incidents never reach the attention of facility managers or clinical staff who operate under the assumption that no GALZ referral pays for services.

Three other interrelated issues surfaced during the analysis of affordability that are more broadly discussed under other sections of this report:

1. An over-burdened health facility increases waiting time for clients with at least two effects: increased visibility and exposure, and time lost for generating income. As one respondent reflects: “Transport costs money. And being at the clinic all day takes time when people could be earning money.”

2. The perception of affordability is generally much higher for gay and bisexual men, and for transwomen (who often present at facilities as men in order to be less visible) than for lesbian and bisexual women. The gender-advantage for men is repeatedly made visible. Perhaps this is because men are more vocal, more likely to complain. Perhaps it is because of the public-health/HIV-emphasis on reaching “MSM” that gay men’s access to services – including affordability – is more deliberately facilitated by the health service. And by their own admission, lesbian women are more reluctant to be visibly identifiable, conscious of being stigmatised.

“The services are affordable, yes! But for who? For MSMs. They access everything, we assume.” (LB woman, Bulawayo)

“That coupon stigmatises us. As soon as they see that coupon, they know these ones are from GALZ and they are KP.” (LB woman, Harare)

3. Whilst HIV-negative clients who are exposed to reasonable risk are encouraged to initiate PREP at no cost, post exposure prophylaxis (PEP) is complicated and expensive to access, but often felt to be necessary for members of key populations.

“If you go for PEP, they say ‘we don’t have’. There’s a long process to get it and it’s not easy. There’s a preference for rape victims – and the assumption is that men can’t be raped, so you can’t report that as a gay man, or as a trans woman. And to get it from a pharmacy is \$54.”



Acceptability

## Acceptability

Wilkins HRE	GBT 10	LBT 3	TW 7	Facility 10
PSI HRE	GBT 4	LBT 3	TW 7	Facility 10
PSI BYO	GBT 9	LBT 1	TW 5	Facility 10

As a standard for “good health services”, acceptability speaks to the appropriateness of the service to the service user; to fit. It is a measure of the extent to which services are sensitive to the unique identities, cultures and preferences of those who might access them, and the degree to which service users feel comfortable with the services and how they are delivered. Given the stigma and discrimination attached to Key Populations, the risks that are weighed in every decision to seek healthcare, and the potential for compromised privacy and dignity, acceptability features prominently as a determining factor to either encourage or deter uptake of services by LGBT people.

PSI centres in both Harare and Bulawayo are confident in their self-assessment of the acceptability of their services to Key Populations.

“We offer a range of services; people can receive the particular services they need.”

“We treat every individual as unique.”

“Some may not even need to wait in the waiting area, but can go straight to the counsellor; there is flexibility.”

“We are working to reduce stigma and discrimination so that no one knows the reason why anyone is seeking services.”

“HIV is a priority for us. It’s not a prerequisite to obtaining services, but we strongly offer it as an advantage, as part of a package of services to Key Populations.”

“Contact tracing is very important in the service. But always with consent; we can’t force; we don’t coerce; we respect autonomy of the clients. But it is also a new intervention - maybe a provider gets it wrong and pushes too strongly; thinks they are doing the right thing but doesn’t realise it is too harsh.”

“We are non-judgemental. Non-discriminatory. We treat everyone as individuals who are there for the services they require.”

The team at Wilkins has a somewhat more moderate self-assessment, acknowledging that LGBT clients may not consistently feel comfortable – that services are a good match for them – and claiming responsibility for those gaps.

“Everyone from the security to ground staff to nurses has been sensitised. But, we as health care workers, even though we have been sensitised, maybe we also need more workshops, to be trained, for instance, on STIs [presentation, diagnosis, treatment] for LGBT people.”<sup>4</sup>

“Maybe our clients mistake us when we give health education. Maybe they mistake our tone of voice for judgement. Maybe sometimes it is judgement.”

Several community respondents recognise that incremental progress is being made towards more acceptable, appropriate services; notably, these appreciative insights are exclusively offered by gay or bisexual men.

“It’s easy for me as an LGBT person to go there [PSI-Bulawayo] and to see the KP officer; someone who understands issues better than anyone else.”

“PSI is still new to our community, being sensitised on how to handle our community. It’s important that we go there; it’s our way to demonstrate ‘we are here’. That the MSMs are not only one white person.”

“They are still growing up; taking a step. Unlike way back when you’d try and explain, and they don’t understand.”

*4 It is significant to the note that, across the system for health (including facilities and GALZ staff), people talk about sensitisation as an event, and then as an assumed result of that event. It is tacitly assumed that a sensitisation workshop equates to significant shifts in behaviour or practice, but there is*

*no evidence of anyone verifying that outcome over time to determine whether sensitisation as a process is bearing fruit.*



“They give space; they listen; you can be honest. As opposed to a government facility where you get arrested.”

“These people have improved. They are offering a service at a stage where they are still being sensitised.”

“Long time back it was very difficult. These people are starting to know us. There’s space now to disclose more openly, although that’s not how it is with all the counsellors. They used to say things, ask awkward questions, insist on us bringing our partners. Now it’s different; it’s at least better.”

This perspective on acceptability amongst gay and bisexual men, although encouraging, is markedly different from the experience of lesbian and bisexual women, or trans people. Reflections across these populations were notably similar whether in Bulawayo or in Harare. One fundamental issue lay at the core of the acceptability analysis by women and trans people: affirmation; that their sexuality and gender identities were recognised and validated. Too often, however, these populations felt they were misunderstood, misgendered, misclassified (trans women considered as gay men; non- heterosexual women captured statistically as sex workers), their sexualities and gender invisibilised or delegitimised within a system of care still biased towards heteronormativity and maleness. And within that analysis, the intersections between acceptability and availability of services for women and trans people are powerfully highlighted.

### Amongst lesbian and bisexual women (and trans men):

“I can get many other services – many other general services that are available for other women – but not specific to my needs as a lesbian woman. Like partner treatment and counselling. I can’t bring my lesbian partner. Or my partner if I am a trans man. Then all the questions start, and we can’t be counselled together. We have to be in separate rooms because we’re not recognised as a couple.”

“Full disclosure is not an option; I can’t say everything about myself. I fear the discrimination and judgement. We have to create a back-story or lie about how we got a condition; find some way to explain it with a hetero- narrative.”

“We can’t talk openly. We can’t ask for advice or a correct diagnosis that is specific to us. We can’t ask for information about transmission of infections between women having sex with other women. They start preaching. They act as pastors. They lecture us.”

“As WSWs our statistics are not included in their data. If we come there as women who are ‘KPs’ we are automatically entered as sex workers. They can classify only as ‘MSM’ or ‘SW male’ or ‘SW female’. They never talk about ‘WSW’”.

“When we went [to PSI Bulawayo] we realised there’s a questionnaire you fill in. But it’s discriminatory. It just makes the assumption that you are in a heterosexual relationship.”

“Pre-test counselling [at PSI] is usually done in a group. So when you come as a couple there’s a lack of privacy to talk about things as a couple. They call it counselling, but it’s mostly just education before you take the test. There’s nothing for psychosocial support. But coming to test as a couple needs that kind of support. A lesbian couple usually comes for testing because there’s been an issue of trust, like if one of them has been cheating with a man. This needs support.”

“No one has really taken the time to understand in what way we are affected by HIV. We as women. How do we protect our woman partners from HIV? Women are the group most affected by HIV, but as lesbian or bisexual women we have no means to protect our partners. People assume there is no transmission between two women. Why then do we get STIs?”

“As soon as you mention your sexuality, the health workers start scratching each other’s arms to get their attention. Rolling their eyes in our direction. Like to say ‘these are those ones’”.

“For me, a good health service means being listened to. So, when I go for treatment for an STI and I’m asked ‘where’s your partner?’ They ask for that because I am a woman; they end up blaming you for having that STI. And they assume your partner is a man. It’s like that in the questionnaire.”

As has been noted earlier in this report, some of these reflections may or may not be factually accurate, or they may be; most likely a combination of both. It may well be that health care providers are especially stigmatising of women, consciously or not. Or it may be that service users are not well-enough informed about why certain questions are being asked in the course of taking a patient history, so they experience them as being arbitrary and invasive.

Either way, this is an issue to be addressed in the delivery of services so that patients feel both safe from judgement and stigma, and informed in order to make choices about their own health and care.

### Amongst trans women:

“Health services are very generic, or they have a clear priority on “MSM” from that perceived HIV-risk angle. But nothing for trans health. Screening for cancer, for instance, is available for biologically born females only.”

“They have no knowledge of trans people. We are virtually invisible. But we’re the most vulnerable, especially transwomen. If you go to the facility, you’re discriminated. If you get raped it’s hard to report when you’re seen as a man, and the belief is men don’t get raped. It’s hard to go back to the facility. You’ll sit in your house, rot, die.”

“At PSI, if we send a transman to the clinics, they record “female”. And when we ask for protective barriers for transwomen, we’re told ‘you are covered under MSM’. They didn’t know I was a transwoman. I was told to sit in a queue with ladies going for a pap smear. I got to the counsellor and had to explain why I couldn’t get a pap smear. A trans man went for cervical cancer screening; told he could not be at the women section and was made to leave.”

“Doctors assume gays get anal warts and prescribe [Podophyllin]. This can be painful to apply. One of our members – a trans person – went to the clinic complaining of a condition and, without confirmation, was given that medication. It was just assumed she was a gay man, so she must have anal warts. She applied it for a month, but there was no change. She went back to the clinic, and they told her she had been misdiagnosed.”

“In Zimbabwe, trans people who are on hormones often obtain those hormones from the black market. If we need to go on ART, we are presented the choice by nurses to either stop the hormones, or not take ARVs.”

“Being a gender non-conforming person I’m already confusing to even the LGBT community. If I go there to the facility and explain I don’t want to be recorded under any gender binary! It’s easier to just go as a cis-woman, but it’s not who I am.”

“Someone might understand who you are, or they’re trying to understand. But you still see “that look” and you withdraw from giving your information. Most of the time I go there as someone else. The services they offer me are not appropriate to me as a transwoman. I go as a man. And then not even a gay man. A straight man.”

“Hormonal therapy is only available to cis women. I went to the clinic and asked for an injection, but the nurses can’t prescribe anything there, and they’re in any case only available at special facilities.”

Sexuality and gender-affirming health services are a critical enabler of service uptake by members of key populations. And, in as much as gay and bisexual men present a more favourable perspective on the acceptability of the health facilities, they are also subject to pressure to comply with a heteronormative standard.

“At one point when I was being interviewed by the counsellor, I was asked ‘when was the last time you had sex...with a girl’”.

“Within our political environment, with the situation here as it is, I still don’t feel completely safe to fully disclose everything. The questions can be too personal, especially about your partners. So, you lie. You want treatment and services, so you lie. You say your partner is not around. Or you tell them you have a wife who works out of town.”

“They still use that standardised questionnaire with us. But it should be more open-ended, not so heterosexual.”

In the analysis of acceptability, five other themes emerge, more universal and systems-related in nature, and not specific to a sexual orientation or gender identity:

1. Sensitisation is no substitute for representation. Cisgender, heterosexual health providers – however sensitive and empathetic – are not as relatable as members of the community. Reducing stigma as a barrier to accessing care requires a more visibly diverse and inclusive facility environment.

*“There are no trans people on the staff to speak to, someone who can really relate to me. It would be so nice to be able to see a trans person at the clinic as a counsellor. Because even a very sensitive and sensitised person would not be able to understand fully certain things. They just don’t share your experience.”*

*I've been there, and at the end of the day, I fail to say all I want to say because it's a male."*

*"We understand the situation we are in in the country. And that organisations can't be too obvious about supporting our community or they could be deregistered. But, all the posters and information in the facilities are heterosexual. They don't represent me, or other men who are gay or bisexual. I don't see myself there."*

*"The facilities should employ people who are MSM and can understand their peers. If you want to catch a thief, use a thief."*

Service users desire identity-affirming attitudes and clinical competence in service providers, so that key populations are not further stigmatised when health workers are unsure how to examine, diagnose or treat them.

"Wilkins is okay, they're doing okay. But at PSI the people who examine you have book knowledge, but it's not practical for people like us. They expect to see infections in a certain way. But we don't only get STIs in the front; we also get them at the back."

"The thing is not about acceptance. I don't need health workers to accept me. The thing is about making people better. To deliver services that make people better. When I come to seek services, but I have to start teaching the nurse before I am helped, I lose confidence. They might be qualified, but they don't understand the issues of LGBTQ people."

"Nurses and staff need to be better educated to know about us. Last time we had a workshop with them. They were interested in knowing about the STIs that affect gay men. They've never actually seen a nicely decorated anus before. The assumption from them is that you can't do sex with an anus, so they are not sure how to treat it. It's a mentality they have. When you go there they tell you about the elasticity of the vagina that is not like an anus. They get afraid. But they need to know that the anus has now been upgraded. It's not only an exit point."

2. Most specific to PSI, the leveraging of sexual and reproductive health services off of HIV testing and treatment is unacceptable to LGBT service users. In as much as PSI suggests that services – especially STI treatment – are not conditional upon uptake of HIV-services, service users hold a strongly contrary perception.

"When I want STI screening only, but not HIV, they tell me it's not an STI clinic. If we are not there for HIV things, they should still accommodate us."

"I referred someone there but they were told they can't do STI screening. But if that person goes to another clinic that does offer that service, there are too many questions asked."

First you need to have an HIV test. It's required. I was told that 'first you need to be one of our patients before we can give you services. And if you don't have an HIV test, we can't register you as a client.' If you decline, you need to go somewhere else."

"I went for STI screening with my partner. They required that we had to register before we got that service. So we ended up not doing it."

3. The right to privacy is not academic in this environment. Privacy means security, safety from exposure, protection from potential violence. The absence of privacy increases fear and stigma. In the way that respondents discussed privacy with respect to PSI, this issue is a function of congestion, of facility layout, and of systems-design in the way particular elements of each health service are offered. These may be less significant for a general, heterosexual population, but are of primary importance to a highly stigmatised, highly marginalised population.

"There's no privacy. Everyone is sitting there. You get your pills at the pharmacy in front of everyone. If you want PREP you're mixed in there with those people on ARVs. So, our people feel afraid to collect drugs."

"They just tell you 'get in that line'. You fear seeing someone you know. So people avoid the facilities because they're afraid. Can a Peer Educator not collect the drugs for patients, or have them delivered to our homes or our meeting spaces?"

"I don't want to be seen in that environment, in that line, seen by people that I'm going to get tested."

"Once I went with my boyfriend to test, and we wanted to test as a couple. So I came with my boyfriend, but we got counselled in public, in that group-counselling, together."

"The facility is congested and crowded. We have to move about between one department

and another, so there's very little privacy. We are already out as trans people; we can't hide. People can see you even if you are not out. Being in that facility makes us feel looked at and stared at.”

4. Human resource capacity has an effect on the acceptability and appropriateness of services to key populations. In as much as facilities claim that the entire facility has been sensitised, certain staff members are designated and recognised as “KP-specialists”. Their expertise and sensitivity are not universally distributed across the staff complement. As a result, when these unofficial specialists are not available, clients avoid seeking care from other members of staff. At the same time, these specialists are not exclusively dedicated to KP-services; they occupy other roles within the facility, with the general population of service-users, and are not always available on demand to key populations clients.

“At Wilkins, there are special people to give us services. But because that's not spread across the whole institution, services for us are understaffed. They have to call staff from the main clinic to see us and this increases the time we have to wait there.”<sup>5</sup>

“At PSI (Bulawayo), the KP-Officer is available, but not all the time. That person is also a general counsellor giving services to a lot of other people, not only LGBT people.”

“[for PSI Harare] People are reluctant to approach other staff members because the quality of care is poor. If Aunty Mavis is not there, we go home with our STIs.”

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5 “Wait time” is not only about the inconvenience of waiting. It is also about increased duration of public visibility and increased exposure to stigmatising behaviour. It becomes a deterrent to staying, and a deterrent to returning for follow-up care.



# Accountability

# Accountability

Wilkins HRE	GBT 9	LBT 1	TW 7	Facility 7
PSI HRE	GBT 2	LBT 1	TW 7	Facility 10
PSI BYO	GBT 8	LBT 1	TW 5	Facility 9

Of the many standards that might constitute good health services, “accountability” – the idea that healthcare providers could be held answerable for the quality of care and overall user-experience; or that service-users should have access to information collected about them – was the least developed in the minds of respondents during the Situational Analysis, whether service provider or LGBT service user.

Accountability as a standard and value in health service provision may be one of the more significant, albeit subtle, metrics for effective, efficient, acceptable programming to Key Populations within a healthy system for health: it becomes a measure of conversation and dialogue between providers and users; it speaks to the rights of users to access to information, to informed consent, to autonomy that is governed by their ability to make informed choices about what is good for them, to dignity because they are recognised as stakeholders with equity in the system; it indicates the level of community engagement and ownership within the health system – both necessary to reconcile and integrate health systems strengthening and community systems strengthening into a responsive system for health. Accountability, responsibly exercised, and non-defensively received, makes systems better. It increases trust, relationship, human agency and voice and applies them to quality assurance. It becomes obvious how this effect is desirable and effective to increase access and uptake of services by Key Populations. Achieving these gains with those populations holds benefit for all users of the system, irrespective of sexuality or gender.

Health care providers agree that accountability is important, and implicit for professional staff in that sector.

“We are professionals who have taken an oath, and the Patient Charter is always applicable. Whoever offers a service is accountable.” (PSI-H)

“We have standard operating procedures and protocols and templates to exhaust every

possibility.” (PSI-H)

“Clients have a right to see the management and report any unsatisfactory incidents.” (PSI-B) Health facilities confirm that certain institutional mechanisms are in place to invite accountability – complaints boxes, suggestions boxes, PSI has a system that makes it possible to identify which service provider interacted with a client who may complain about a negative experience after the fact – although it is acknowledged that these are not actively promoted or effectively utilised. Users who may benefit from such structures are not sufficiently informed of how to access those mechanisms. Nor is there sufficient interaction between health staff and communities to encourage that kind of exchange and signal it is safe.

“At Wilkins, we have a complaints and compliments box. We do monthly reviews amongst the staff where we talk about any incidents. We have occasional exit interviews to check client satisfaction. And we maintain an open-door policy for feedback. We’ve had three meetings recently with GALZ, community representatives and Wilkins management which is a good sign. But still there are gaps and little interaction, so accountability is not routine or systematic.”

“We [PSI-B] have suggestion boxes for concerns in two locations around the facility, although...who opens that box? And is there a report back to the community? Are people informed of the mechanisms? Only if they ask about it.”

It is interesting to note that, with reference to Wilkins and PSI in Bulawayo, gay and bisexual men have had positive experiences with feedback to health providers:

“At Wilkins, we had issues with them about long wait time and we complained. They actually called us in to explain, and to try and understand our experience and how best they could improve their services. They invited feedback from the community. They have an open-door policy to see the director, and to report any bad experiences with staff.”

“These guys at the facility are still growing and we’re creating a relationship with them. But they do come back to us and ask if we are satisfied. They try to understand us.”

These experiences are encouraging and demonstrate that accountability is possible. That perspective, however, is not consistent, nor is it universal across the populations. Community

members, unsurprisingly, feel significantly more disenfranchised as stakeholders in the system for health than health providers might assume, with little agency to realistically exercise accountability.

“If we complain, then we can be told ‘these are the policies of the clinic’. Or ‘these are the policies of the government’”.

“At PSI, there is an “us” and “them”. They gang up to protect each other if you complain. And then what? If you complain, then you must know you still have to come back and deal with that staff member when you want to come and access the service. We don’t have other options if we don’t like this one.”

“If you complain they say ‘go and complain to the government; we haven’t been paid. We are understaffed.’”

“They think they are doing us a favour; they’re not accountable to us. It’s like charity, like they’re feeding the hungry children.”

“There are supposed to be these Health Committees in wards. These are structures that are named in a number of documents like the national adolescent SRH strategy and guidelines. But these committees are generally not operational. And where they do operate, it’s really unlikely they will be trans-friendly.”

Few opportunities, if any, exist for service users to interact directly with service providers, to face each other to surface concerns, appreciate each other’s perspectives and, through dialogue and joint agreement, resolve conflict. Often, GALZ acts as an intermediary on behalf of the community to the facility, the benefit of which is questionable.

“As for PSI (Harare), we can’t approach them directly; we have to go through GALZ. They need to engage more with us in the community, not only with their development partners.”

“There is a relationship between representatives of GALZ and representatives of the facilities. But we don’t have an opportunity to engage with the providers directly.”

“We never get to confront the service providers ourselves. It’s not the first time we talk about these issues. We don’t have a say. We feel like a project.”

Community members express a sense of frustration and futility, that there may be little point in exercising accountability, as there is little follow-up or feedback from service providers. This is not limited to responses to complaint; it also extends to sharing information about statistics, data collected and health outcomes.

“The government releases the DHIS reports annually, but the categories are ‘male’, ‘female’, ‘MSM’ and ‘sex worker’. There is no recognition or visibility of trans health in that information that is released. But we are also using those facilities.”

“Reports come out that cover population information; they are there for national statistics. But they are also in technical language that is not accessible to us ordinary people.”

“I’ve only seen evaluations and feedback in hotels. And maybe at some NGO workshops. But not for PSI.”

“They have a suggestion box like all public institutions. But we don’t know who looks at them, who tends to complaints, what they do with it.”

“You put your complaints, but there’s no feedback. We get told about ‘the situation in the country’ or that ‘we are working on it’ or ‘we are rectifying it’, but there’s no feedback on what is being done or what is supposed to change.”

Interestingly, in as much as service providers have become the target for sensitisation by LGBT health and rights organisations, the constituency of those organisations have a low awareness of their rights, and a self-identified deficit of capacity to express their agency in defence of those rights.

“Our community lacks capacity and awareness and skills to know our rights. To know how to report. Or how to challenge. We don’t know the right channels. These people are at the clinic; they are trained. I go there with my grievance and they can overrule it with their jargon. Like, if I want to complain about that questionnaire they use and how it is offensive or too personal, they will explain to me why it has to be like that.”

“We don’t question even if we are violated. We think they are doing us a favour and we must be grateful, even if we are treated badly.”

“We feel like a nuisance and a disturbance, so we don't want to make any noise.”

The Patient Charter exists, but we don't know the document. We don't know what our rights are. We don't question.”

“When I got PREP at PSI, she never explained to me what the side effects would be. And how do you hold someone accountable when you don't know what to hold them accountable for?”

“It was also like that for me at PSI. When I went for PREP, they asked me to write down my partners name and details, and my next of kin. I didn't want to do that – I'm not out – but I wanted PREP, and I didn't ask why they wanted those details.”

It is evident, however, that the management of health facilities desire better engagement, more closely connected, more frequently. This represents an important opportunity to systematise and institutionalise accountability that facilitates clearer communication, better relationship and improved shared ownership of the system for health.

“We would like to work more with the gays, the lesbians, the trans people but we are not seeing as many as we would hope here at PSI. We would like to go there to them sometimes to offer testing and other services. Possibly they don't know they can come here for a stigma-free service.”

“More engagement would help. We want to engage with them more on a personal level and on a managerial level. We could even arrange a half day or a whole day workshop, so we become more aware of their needs.”

“We want to know them. We want to engage them. And right now our engagement is not enough.”

“We need their feedback. If we are not doing enough, we need to hear it.”





# Opportunities For Response

# Opportunities for Response

This Situational Analysis report resists the temptation to frame specific prescriptive recommendations that may be presumptive, premature or limiting in scope and scale of response. Instead, this section surfaces a selection of opportunities for response by GALZ, Positive Vibes and their respective constituencies and partners. Several other potential responses may be inferred or implied throughout the report. It is important that practical recommendations be framed through further participation and consultation by the community and service providers themselves as part of their collective forward planning.

## A. Opportunities for ENGAGEMENT

The Situational Analysis exercise demonstrated both the value of and interest in dialogue between service providers and service users, to foster relationship and connection, to expand accountability and shared ownership of the system for health, and to collaborate around improving quality that, in turn, increases demand, utilisation and efficacy of care. Several opportunities for engagement may be possible:

1. The Situational Analysis report itself presents an opportunity for immediate feedback. How might the report be used as a tool to draw together the constituency, to gather around the findings, to analyse and discuss, to interact, test, verify, validate? Whether the community – with or without the service providers, at first (although it will be important to include the latter at some point) – confirms or refutes the findings is less important; invariably, the conversation is more important, and the findings simply a platform from which to deepen reflection, analysis, dialogue and, potentially, programme design and operational planning.

2. GALZ should not lose the momentum or opportunity generated through this Situational Analysis exercise to engage with its specific sub- constituencies – in particular, lesbian and bisexual women and trans men and trans women – to discuss their feelings of marginalisation, exclusion and under-representation. Given the space they often occupy on the fringes of the system for health, it is important that the LGBT-organisation with which they associate themselves acts with proportionally greater effort to amplify their voices in order to afford them equity with their gay and bisexual male counterparts.

3. As was proposed by the Health Facilities themselves, the process and tool used for this Situational Analysis exercise – the simple Mixing Desk metaphor – might be applied as a routine monitoring and quality assurance activity, repeated on a quarterly or six-monthly basis to test for improvement, with the present findings set as baseline levels. This kind of activity would increase accountability using a standardised framework, and institutionalise community participation in health facility monitoring.

4. Were there interest in taking joint analysis and quality assurance even further, such subjective, qualitative reflection of the type surfaced through this exercise might be augmented by quantitative data, in an area of interest or priority to service users and service providers. For example, on a periodic basis (eg. once a month; once a quarter; etc.) service providers and community members might gather for a 'Technical Programme Review'. Each Review meeting might focus on a specific programme/ service offered through the facilities (eg. HIV-testing; cervical cancer screening; STI-treatment; contact tracing; TB-testing, treatment and cure rate; etc.). Service providers could prepare statistical data relevant to the KP community to present for reflection, analysis and discussion (eg. utilisation numbers; user demographics – whether gay, lesbian, trans; etc.) and have Key Populations and clinic staff engage together around what the data shows, what gaps exist, and how to adapt services to improve for each particular technical programme.

## B. Opportunities for INFLUENCING

There are at least three (and likely several other) policy-related influencing opportunities that present themselves, significant in that:

- a. They lead easily and legitimately to further evidence-gathering and 'research' work in order to strengthen an advocacy argument.
- b. They offer an opportunity to use a health and health services entry point to directly increase the profile of LGBT identities; in so doing, they advance a rights discourse, but from a safer, more accessible entry-point.
- c. They potentially create a way that GALZ and health providers (at the operational level) might collaborate in an influencing agenda, rather than have the providers be an advocacy target for GALZ.
- d. Making progress on any one of these issues (or several of them simultaneously, since they are conceivably interrelated) has a direct benefit on service-provision and health outcomes of LGBT people.

**1. Increasing the visibility and expanding the understanding of women who have sex with women as a vulnerable “Key Population”.** A recurring theme throughout the analysis: that HIV transmission and prevention programming has focussed on men who have sex with men, while women who have sex with women are virtually ignored. Whilst conventional HIV- messaging has made clear for decades that women carry a disproportionate burden of infection, this message seems to cease to apply when women are no longer heterosexual. Consequently, their sexual and reproductive health needs remain misunderstood and unmet. SRH-services for women are based around reproduction and fertility, and protective barrier methods are limited to male condoms and female condoms. The presumption of prevention programming for women is heteronormative. And the reported low visibility of women at facilities who identify openly as lesbian or bisexual supports the assumption that they don't exist and that they are not vulnerable to HIV, a narrative that should be challenged with evidence to reveal the story behind these identities: many are mothers, many have occasional or regular relationships with men, many have concurrent female partners. It is likely that more robust investigation and data would demonstrate considerably higher numbers of women who identify as lesbian, bisexual or WSW are vulnerable than are reflected in services provided for them.

**2. Provision of stand-alone STI services.** This issue is highlighted most prominently by the PSI New Start centres that are, primarily, HIV test and treat facilities. LGBT people or sex workers who present with an active, symptomatic STI simply want a walk-in service where that infection can be examined, diagnosed and treated. Having to access the desired services through an obligatory HIV-programme pathway is a deterrent to access for Key Populations. This seems to be an issue for policy-dialogue. While it makes sense that presenting with STIs may suggest exposure and risk for HIV, and that clients should be encouraged to access services for ART or PREP, it also makes sense that people presenting with an STI (and who may be HIV-negative) are also more susceptible to HIV, and efficient management of their present infection is preventative. From the feedback of the focus groups, not being able to access discrete STI- services on demand is limiting utilisation of the facility by Key Populations. That policy is not KP-friendly. It may be that health facilities will be keen to collaborate around influencing that policy position, so that resources are allocated that recognise STI-service availability as a characteristic of a KP-friendly health service.

**3. Drug stock outs.** At each of the three facilities, user perceptions about service

availability, accessibility and affordability are influenced by the non-availability of medication, an issue that results in their having to pay for prescribed medication from retail pharmacies. It would seem, however, that the same drugs seem to be in shortage: benzathine penicillin and Podophyllin, indicated in the treatment of genital warts. This may, conceivably, be a procurement, supply and distribution issue. Drugs are provided to facilities through the National Pharmacy. It is possible that the State through the Department of Health is not ordering sufficient quantities from that Pharmacy because it is unaware of the demand. Alternatively, it's possible that these drugs are distributed in equal proportion to all health facilities. Since they are for the treatment of warts and specific sexually transmitted infections, they may expire in most facilities that may not be treating clients who require those services. This gives the inaccurate impression of low general demand, and does not give sufficient evidence of high specific demand. Could it be possible that the stock-out issue might be remedied simply by recognising certain facilities require and are supplied with higher concentrations of these drugs (as in facilities with high demand for STI-management) to match demand?

Of the many possible issues for influencing, these may be easy entry-points into positive advocacy for Key Populations that shift both the quality of care and service, and the policy environment, but through a safer, accessible health lens that requires the specific needs and identities of these populations be acknowledged.

## C. Opportunities for COLLABORATION

1. Under the present configuration, GALZ is engaged with Wilkins Hospital and with PSI in Harare and Bulawayo to provide services to its constituency. Although the intended outcomes are identical, the partnerships with Wilkins and PSI are independent of each other. Through GALZ, however, Wilkins and PSI become thematically linked around Sexual and Reproductive Health to Key Populations. And in that link lies the potential for peer exchange. Each facility has experience, expertise and technical capacity from which the other might learn, in order to improve the quality of SRH service provision in both.

For example:

- Wilkins Hospital follows the general guidelines for management of STIs, but has no clinical guidelines specific to Key Populations that may, for instance, highlight infections that may present symptomatically in the mouth or throat or anus. PSI is a non-governmental organisation that has developed an electronic point of care system (EPOC), internal to PSI, with guidelines that include KP-specific treatment protocols consistent with national guidelines, and diagnostic questions that are designed to be, theoretically, non-heteronormative and appropriate for working with KPs.
- PSI claims to offer a service that is 'integrated', but is more accurately described as 'comprehensive'. Clients to PSI move between multiple 'specialist' departments for specific services, increasing wait time and contact time and exposure. By contrast, Wilkins works as much as possible through a single point of care, providing as many services as possible in one staff member trained to deliver multiple services.

There may be a role for GALZ to stimulate interest in this kind of technical collaboration, to facilitate an exploration of comparative advantage between the facilities, to support the convening of the facilities, etc.

2. Health Facilities are utilising or generating materials, tools, standards, procedures and protocols for training staff or as guidelines to staff for the delivery of care. Members of Key Populations would have valuable insight to contribute in the reviewing of materials to make recommendations around their accuracy, appropriateness and

viability.

## D. Opportunities for CONCEPTUALISATION

The Situational Analysis suggests a number of opportunities for innovation and thought leadership, for the articulation of concepts that may lead to design and practice-development:

1. The development of a framework to describe the components of "Good KP Health Service Provision", including the concept of a "system for health", models for "integrated" and "comprehensive" services, and designs for facility layout and patient flow.
2. The development of a comprehensive package/programme – content, process, tools and measurement – for localised sensitisation of health care service providers to sexual and gender identities, and to sexual and reproductive health for LGBT people.
3. The development of a more intensive initiative, possibly applied at multi-country level, for the capacity-building of health care providers around sexual and reproductive healthcare or LGBT people. Ideally, this initiative should address attitudinal, practice and behavioural, and clinical requirements of service providers; may build provider capacity to be SOGIE-literate, SOGIE-affirming and respectful of diversity; and provide an introduction to health-related rights and ethics. It may be possible that a similar stream be designed for LGBT people who are not clinicians, but have an interest in engaging with the system for health, or for increasing their rights literacy.
4. Development of a concept where LGBT lay-people might occupy supportive roles within health facilities, to complement clinical staff, and act as a familiar peer-link to care from within the facility, not only at community level. This concept would require thought around roles, appropriate task-shifting, skills-development, training, resourcing and supervision.
5. The Situational Analysis exercise in Zimbabwe has field-tested a simple methodology to stimulate participatory community monitoring of health facilities by members of Key Populations that leads to better engagement with service providers, quality improvement and opportunities for policy engagement around community-identified issues. Might this simple method be capable of application at scale through a multi-country process in a region such as Southern Africa? Such a process could focus on the use of public health monitoring where the right to stakeholder participation bridges health and rights, expands citizen action for public accountability, safely and responsibly increases the visibility of invisible populations to service-providers, opens a path for accessible interaction by community members with statistical health

outcomes data, and improves access to quality services. Strategically, that process would use the entry point of health to engage with Othering, the alienation of service-users who should be the subjects of the public health response, not the objects, and the creation of progressive, accountable, inclusive societies.

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