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Title: *Discriminatory practices in healthcare affecting Sexual and Gender Minorities in South Africa: implications for health and human rights*

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Discriminatory practices in healthcare affecting Sexual and Gender Minorities in South Africa: implications for health and human rights

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Abstract
Sexual and gender minority (SGM) populations - including but not limited to people who identify as lesbian, gay, bisexual, transgender, queer, intersex, and/or asexual – have been, under different contexts, historically discriminated against in housing, healthcare, and social security, not to mention the daily acts of macro- and microaggressions they often face. Discriminatory practices against SGM individuals, who might be already experiencing positions of rightlessness and vulnerability, further increase health inequities and might have larger implications for the protection of human rights and the reproduction of social injustice. In the African continent more specifically, many countries have a poor record when it comes to protecting and enforcing LGBT rights. In South Africa, on the other hand, despite relatively strong legislation on the rights of the LGBTQIA+ community, violence, and discrimination against SGM individuals still is a huge challenge. On that account, this research article aims to describe and analyse discriminatory practices in healthcare affecting sexual and gender minorities in South Africa in relation to access to and quality of care, alongside the implications for health management and human rights in particular. This is an exploratory research paper that addresses the situation of healthcare access and delivery to SGM populations in South Africa from a human rights-based and intersectional approach. The study challenges ongoing bias-motivated and discriminatory practices in healthcare settings and pinpoints how these practices can negatively affect the health and well-being of diverse populations, with a focus on sexual and gender diversity.

Keywords: South Africa, healthcare, discrimination, sexual and gender minority, human rights.

Introduction

Sexual and gender minority (SGM) is an umbrella term, usually used to describe the population who are members of the LGBTQIA+ (Lesbian, Gay, Bisexual, Trans, Queer, Intersex, and Asexual) community. Previous studies have acknowledged the persistence of discriminatory attitudes toward sexual and gender minorities (SGMs) in different healthcare settings (Ayhan et al., 2020), under a variety of circumstances. SGM patients often face stigma and mistreatment based on their sexual orientation and/or gender identity, and research shows that, across the globe, men who have sex with men (MSM) and transgender women are particularly vulnerable to experiencing HIV infection (Keuroghlian et al., 2021).

The barriers to accessing healthcare services encountered by SGM groups have been widely documented before in the literature on health and social services (Boehmer, 2018;

Erdley et al., 2014; Jennings et al., 2019; Marshall & Cahill, 2022). For instance, LGBTQIA+ individuals are more likely to report poorer health, low quality of services, and stigmatisation and prejudice from healthcare personnel. In the United States, for example, "nearly a sixth of LGBTQ adults have experienced discrimination at the doctor's office or in another health care setting, while a fifth say they have avoided seeking medical care out of fear of discrimination, according to a recent poll" (Powell, 2018, para. 1; see also Whitehead et al., 2016). Furthermore, research also indicates that experiencing discrimination can result in multiple negative health outcomes for SGM people (Alessi et al., 2013; Williams, 1999).

Although the research on LGBTQ healthcare and health inequities among SGM populations has considerably increased in recent years (Ramsey et al., 2022), the health needs of these individuals and their lived experiences of discrimination when seeking healthcare and social services are still understudied, especially in the African context. Because in many societies talking about sexual and gender diversity and pluralism still pretty much is a 'taboo' tied to so-called 'traditional values', discriminatory practices can easily be naturalised and left unchallenged (Msibi, 2011). Therefore, I argue that the notion of culturally sensitive practice in healthcare (Brooks et al., 2019), that is, the idea of acknowledging perceived cultural values or cultural factors in healthcare management and delivery, cannot be subverted to naturalise oppression and discrimination. Discriminatory practices against SGM individuals who might be already experiencing positions of rightlessness and vulnerability, based or not on socio-cultural values, further increase health inequities and might have larger implications in relation to human rights and social justice.

Therefore, in general, this study challenges ongoing bias-motivated and discriminatory practices in healthcare settings and pinpoints how these practices can negatively affect the health and well-being of diverse populations. This research article aims to describe and analyse, in particular, discriminatory practices in healthcare affecting SGM populations in South Africa concerning access to and quality of care, from a human rights-based and intersectional approach. General implications for health management and human rights protection are also discussed, alongside recommendations for change.

Methods and analytical approach

The study employs a qualitative design and is brought forward as a conceptual paper. This is essentially an exploratory research paper based mostly on secondary data published in other studies about the same topic. It aims to increase the literature produced on issues affecting the

LGBTQIA+ community in the African continent, with a particular focus on human rights and healthcare in South Africa. It does so by reviewing the existing literature and making connections between existing theoretical frameworks and their implications for health management, policy, and practice.

Despite the increasing amount of literature on the topic of LGBTQIA+ health, research on healthcare and SGM populations is still dominantly about the experiences of countries in the global North, with little reference to practices in the global South. In Africa, where perceptions about sexuality and gender are still pretty much tied to so-called traditional and religious values across several countries, SGM people seem to be at a greater disadvantage and often face discriminatory practices when seeking care. Therefore, research about these topics - which are still understudied - can hopefully help increase levels of access and quality of care to service users as well as guide healthcare administrators and providers toward cultivating better practices and policies within different organisations in South Africa, and elsewhere.

Theoretical frameworks

Human rights-based approach to healthcare

The global history of human rights is quite an intricate one filled with controversies and unfulfilled promises, however, my goal is not to dive into the philosophical or historical background of human rights, instead, I propose a more practical exercise. I argue that framing the health (as well as other biopsychosocial) needs of SGM populations in South Africa from a human rights-based approach/perspective can help legitimise their struggle towards dignity and well-being, especially in the context of the public healthcare system and state responsibility/accountability. Other authors have utilised this same approach before in similar studies (Müller 2017; 2016; Quinn, 2006).

The relationship between human rights and health has been widely explored before and needs no repeating. Therefore, the emphasis here is given to a human rights-based approach (HRBA) to health and healthcare. I follow, for the most part, the conceptualisation offered by Bustreo and Doebbler (2020). According to them, an HRBA to health and care not only positions health as a fundamental human right but also focuses on how *indivisible* human rights principles make the case for health outcomes to be achieved in a way that is consistent with the foundational values of human rights (Bustreo & Doebbler, 2020). An HRBA to healthcare can be employed as a key strategy in implementing and evaluating health policy, guided by

principles of equality and non-discrimination, participation, transparency, and accountability (Bustreo & Doebbler, 2020). See Figure 1.

Figure 1. Foundations of a Human Rights-Based Approach to Healthcare.
Source: Elaborated by the author based on Bustreo and Doebbler (2020) and the World Health Organisation (2022).

Minding the importance and indivisibility of the above-cited principles, this study focuses on the question of equality and non-discrimination, and the principles of quality and accessibility in healthcare and their implications for the rights of SGM populations in South Africa. The benefits of employing this approach are innumerous. For instance, London (2008) argues that the utilisation of ethical codes to guide the practice of health professionals may be improved by incorporating human rights guidelines, especially in instances where there is a conflict of interest between the well-being of clients or communities and their human rights. Additionally, it is crucial to establish institutional responsibility for safeguarding human rights to prevent health professionals from bearing the entire burden of responsibility (London, 2008). Adopting a human rights perspective may involve enforcing accountability among states and other relevant stakeholders, establishing policies and programs that align with human rights principles, and facilitating redress for those who have suffered from breaches of their right to health, as well as other rights, while seeking healthcare and/or medical attention (London, 2008).

These principles and responsibilities are also well integrated into the African human rights system, in the African Charter on Human and Peoples' Rights of 1981, in the African Women's Protocol of 2005, and in the African Youth Charter of 2009, as well as in other relevant legal and normative instruments within the African regional system for human rights protection (Durojaye, 2021). Therefore, these concepts are neither alien nor simple imports from the West; they have been interpreted and adapted by African nations in their efforts to promote human rights protection and accountability across the continent on their own terms. These frameworks and principles can and should be used to advocate for the rights of SGM individuals in South Africa.

Intersectionality

Intersectionality is not necessarily a theory per se, it is a cross-cutting approach that can help us better understand different societal roles and identities of individuals and communities, and how they intersect in complex ways (see Figure 2). Despite its different interpretations and uses both as an academic concept and as a social justice movement (Al-Faham et al., 2019), I adopt the following definition from Professor Kimberlé Crenshaw, who popularised the term over thirty years ago. According to her, "it is basically a lens, a prism, for seeing the way in which various forms of inequality often operate together and exacerbate each other" (Crenshaw, 2020, para. 2). In the fields of health and social care more specifically, the lens of intersectionality can be particularly useful as it reveals, for example, how "people with multiple disadvantaged statuses often experience poorer health outcomes than those with a single disadvantaged status" (Vohra-Gupta et al., 2023, p. 90).

In the case of SGM populations, it helps us look beyond the question of sexual orientation and gender identity, to examine how those intersect with other identity markers including (but not limited to) race, class, ethnic background, and immigration status, among others (see Figure 2). For instance, in South Africa, transgender people are more likely to fear or experience discrimination than their cisgender counterparts (Luhur et al., 2021), and if they are poor or working class, they are less likely able to afford gender-affirming treatments and procedures (Luhur et al., 2021). Thus, from an intersectional standpoint, inquiries into the lived experiences of discrimination among SGM people should not assume they all experience prejudice, discrimination, and inequality in the same way. On that note, human rights and intersectionality are closely related because intersectionality helps us to understand how certain groups of people are disproportionately affected by rights violations as a result of multiple

systems of oppression. Going forward, I will discuss these and other issues affecting SGMs in South Africa, within the context of the public healthcare system.

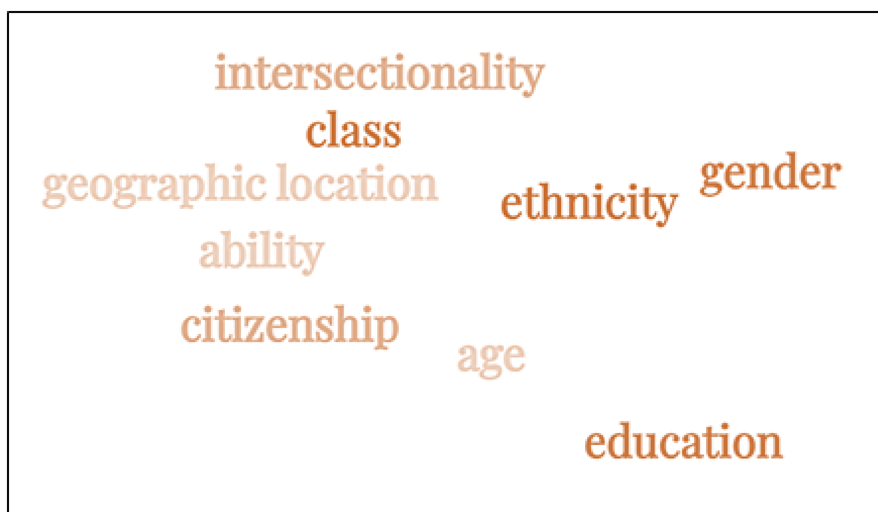

Figure 2. A few dimensions of intersectionality. Source: Elaborated by the author.

Healthcare and Sexual and Gender Minorities in South Africa

The case of South Africa is a very interesting one because it has perhaps one of the most progressive legislations aimed at protecting the rights and freedoms of the LGBTQIA+ community across the African continent. It definitely can serve as an inspiration to all African countries in terms of acknowledging the human dignity of SGM people and protecting their right to be who they are, free from violence and prejudice. Yet, the formal protections in the realm of the law do not always protect sexual and gender minorities in South Africa from encountering discrimination at the level of social relations and everyday interactions, especially in public spaces. According to Nyeck and Shepherd (2019, p. 3):

> Violence, particularly sexual violence, against LGBT South Africans is common. More than one in ten (11%) LGBT 16 to 24 year-olds who completed the recent OUT LGBT Well-being survey reported having experienced rape or other sexual abuse at school within the prior 24 months. Gender nonconforming adults, including those who are heterosexually-identified and those who are LGB-identified, were more likely to feel personally unsafe most days compared to gender conforming adults […], particularly when "walking alone in the dark" […].

These daunting findings reveal a significant disconnection between a progressive legal landscape for SGMs and actual lived experiences of violence, prejudice, and discrimination. In the same study, Nyeck and Shepherd (2019, p. 3) highlight that “nearly half (48%) of health sector workers who completed the 2015/2016 SASAS endorsed statements that they ‘think it is disgusting when men dress like women and women dress like men,’ and 42% indicated that they ‘think gay men [and lesbians] are disgusting’”. If almost half of the South African healthcare workers interviewed openly share these discriminatory and biased beliefs, how can we expect SGM people to be treated fairly and equitably when seeking medical attention and healthcare services?

On top of the lack of healthcare workers who are equipped to adequately deal with health issues affecting SGM populations, there are systemic barriers of different natures (social, economic, and political), including the exclusion of SGM people from the medical system, especially those experiencing increased socioeconomic vulnerability. As a result of the invisibilisation of LGBTQIA+ communities in South Africa, no specific health information is gathered in medical facilities (Luvuno et al., 2019). SGM patients often face discriminatory practices as well when seeking care, especially when they are open about their gender/sexuality. According to Müller (2016), SGM individuals often experience complex and intersecting discrimination and marginalisation in health care, which undermines the legal protections meant to protect them from these in the first place. Taking this context into consideration, this section explores the situation of SGM populations concerning the public healthcare system in South Africa by addressing the question of access, the quality of care, and the impacts of discrimination.

The question of access

Access to healthcare services and facilities is an essential component of the human right to health, enshrined both in the South African constitution as well as in international law. In South Africa, according to Rensburg (2021), there is an essentially two-tiered healthcare system: the state-funded public healthcare system, which serves the majority of the population (around 71% of the people), and the private one which is funded largely through individual contributions or health insurance (which caters to around 27% of the population) (Rensburg, 2021). There is also an alternative Indigenous healing system that will not be the focus of this paper (for that, see Cumes, 2013). Given the severe underfunding of public health and the public healthcare system (Malakoane et al., 2020), there is a strong contrast between the two dominating systems.

Levels of access and the quality of care are still pretty much determined by how much a person can pay (Rensburg, 2021); this situation reinforces the pervasive legacies of apartheid as much as it is a reflection of stark income inequality in the country (Ewinyu & Mampane, n.d.). Therefore, systemic barriers related to access to healthcare are faced by the majority of the population: "South Africa faces healthcare challenges in three major areas: the growing quadruple disease burden […]; systemic and structural challenges in service delivery; and societal challenges associated with poverty and unemployment" (de Villiers, 2021, p. 3)

However, in the context of income, wealth, and health inequities in South Africa, SGM populations are at a particular disadvantage. Research shows that SGM individuals are less likely to be employed than gender-conforming heterosexual individuals, and they are also the least likely to be participating in the formal labour market (Nyeck & Shepherd, 2019). When employed, their monthly income earnings are, on average, lower than that of gender-conforming heterosexual individuals (Nyeck & Shepherd, 2019). In addition to that, SGM populations in South Africa face higher suicide rates than the general population, higher HIV prevalence (especially among transgender women), and are more vulnerable to violence and discrimination (Nyeck & Shepherd, 2019). By looking at this through both a human rights viewpoint and intersectionality lens, it is possible to acknowledge how SGM populations, in the South African context, are subject to multiple and intersecting inequalities that not only marginalise them but live them at greater risk of rights violations and limited access to health and social care.

When trying to access healthcare services and facilities, SGM people encounter many challenges. Barriers to accessibility can be quite straightforward such as the refusal of services to individuals who openly identify as LGTBQIA+ (Müller, 2017), or more subtle ones tied to discriminatory practices reproduced throughout the system (Müller, 2017). Access is also diminished when discrimination based on sexual orientation and gender identity intersects with other discriminations such as ableism and mentalism (Müller, 2017). There is also the problem of *avoidance* in seeking services. As a result of the stigma, neglect, and harassment often encountered by SGM populations in these spaces, they will often "[…] *avoid healthcare facilities because they perceive health spaces as unsafe*" (Luvuno et al., 2019, p. 2, my italics). Therefore, despite the promises of the South African Bill of Rights, Section 27, which states that everyone has the right to access healthcare, SGM populations are constantly denied care or provided with inferior treatment as a result of their sexual orientation and/or gender identity (Luvuno et al., 2019; Müller, 2017), which likely amounts to a gross violation of fundamental human rights including the right to health and rights of equality and non-discrimination.

The quality of care

Despite its importance, access alone does not guarantee 'the right to the highest attainable standard of health'. The quality of healthcare interventions and services is yet another crucial part of the larger engine that is the healthcare system. The main argument here is that discriminatory practices within health places and facilities considerably reduce the quality of care, which can amount to violations of the fundamental human right to health, among other rights as well. In South Africa, there are many factors and challenges that negatively impact the quality of healthcare, including the shortage of or inadequate human resources, poor infrastructure, and insufficient disease control and prevention efforts (Maphumulo & Bhengu, 2019). Discrimination based on race and socioeconomic status has also been identified as an important variable (Maphumulo & Bhengu, 2019), however, not a lot of focus has been given to discrimination based on sexual orientation and/or gender identity and how it impacts the overall quality of healthcare.

When it comes to the perception of quality from the point of view of SGM populations, the lack of knowledge among healthcare providers and personnel about sexual and gender minorities alongside LGBT-specific health needs was the main source of concern in the study by Müller (2017). This is the result of not only bias against the LGBTQIA+ community but also a lack of training on how to work with these populations. Luvuno et al (2019) have demonstrated a failure to include SGM health as part of the training of healthcare workers in South Africa, and Müller (2017) points out that the South African Department of Health did not issue treatment guidelines for several health concerns affecting SGM people. In sum, "there is no nationally agreed-upon standard of care" (Müller, 2017, p. 6) concerning sexual and gender minorities in South Africa, which, among other things, undermines the quality of care that they receive. In a more recent survey, "[…] interviewees frequently raised the problem of pervasive heteronormativity and stigma experienced by LGBT people as a barrier to accessing public healthcare" (Müller et al., 2020, p. 32). Therefore, discriminatory beliefs and practices shared amongst healthcare providers, in addition to the lack of adequate training and resources, seem to be the major forces driving down the quality of the care delivered to SGM people, when they are not refused access to begin with.

Equality and discrimination

Discrimination against SGM populations can have negative impacts on their health and psychosocial well-being. It can lead to mental health issues such as depression, anxiety, and post-traumatic stress disorder (PTSD) (Bostwick et al., 2014), in addition to physical health issues such as heart disease, diabetes, and obesity (Pereira & Costa, 2016; Jackson et al., 2019). In countries such as South Africa, where SGM individuals are more likely to be discriminated against throughout their lifespan, discrimination in healthcare access and utilisation turns into an aggravation, leading to marginalisation and even exclusion from the public healthcare system.

From a strictly legal viewpoint, the South African Constitution (Section 9) protects people from discrimination of all natures and promises equal protection under the law. So does the African Charter on Human and Peoples' Rights, and several other human rights diplomas at local, regional, and global levels (see Figure 3). However, despite the importance of legal mechanisms and the role of judicial advocacy in seeking remedies for human rights violations, legal action alone is not likely going to change society's perceptions and treatment of SGM populations. When applying an intersectional approach, we need to acknowledge that access to legal aid and judicial proceedings is a lengthy and costly endeavor that not everybody can afford, especially when we consider the state of socioeconomic disadvantage that SGM people in South Africa are usually in. Therefore, when talking about issues of equality and discrimination, one needs to be aware of the limitations of a rights-based approach as it does not necessarily account for the shifts in societal views and beliefs that need to happen so that SGM individuals can fully enjoy equality at all levels of society, in and outside the healthcare system.

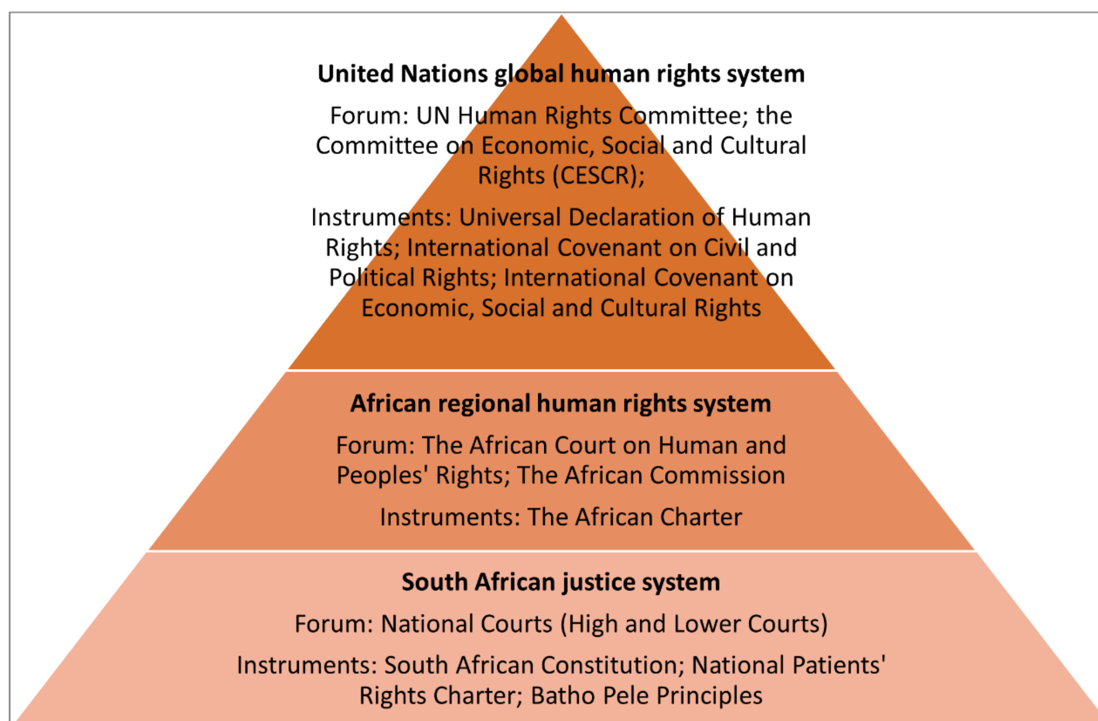

Figure 3. The advocacy pyramid, indicating the forums and instruments for rights adjudication at different levels. Source: Elaborated by the author based on Müller (2016) and da Luz Scherf et al (2022).

Non-judicial remedies to discrimination in healthcare may include (but is not limited to) building community-led healthcare delivery (Müller et al., 2020), as well as training and advocacy concerning the health and social needs of SGM populations (Müller et al., 2020; Luvuno et al., 2019). For instance, Müller et al (2020) highlight the role of LGBTQIA+ non-governmental organisations in South Africa in improving access to sexual and reproductive health. According to them, these organisations provide certain healthcare services themselves which are tailormade for SGM individuals and free of discrimination (Müller et al., 2020), in addition to participating in the education and training of healthcare providers as well as in wider health policy developments (Müller et al., 2020). The only reservation I have with this scenario is that, in the long term, it might lead to an NGO-isation of essential public services and subsequent outsourcing of state responsibilities, nonetheless, it does seem to be a viable short-term solution to the lack of specialised health services and care for SGM populations across the country. Alternative models that focus on the well-being and safety of SGM individuals are always welcome, however, the state should be the first one responsible for ensuring that LGBTQIA+ people are treated with respect and that their rights to health, equality, and non-discrimination are upheld in reality as much as on paper.

Concluding remarks

The main goal of this research article was to describe and analyse discriminatory practices in healthcare affecting SGM populations in South Africa concerning access to and quality of care, from a human rights-based and intersectional approach. The main findings were that SGM individuals when seeking medical attention or health care in public healthcare facilities in South Africa are faced with several challenges. The first one would be a complete denial of care. LGBTQIA+ individuals who are open about their sexual orientation or gender identity, or both, run the risk of being denied access to treatment and other health-related services. Secondly, even when access is indeed secured, many SGM people experience stigmatisation, prejudice, and derogatory treatment from healthcare workers, which clearly undermines the quality of care they receive. This is the result of bias and discrimination, alongside the lack of training concerning SGM health needs, among other things. The lack of training guidelines and quality standards related to gender-affirming care is another significant factor that prevents SGM populations in South Africa from realising their fundamental human right to the highest attainable standard of health.

Implications for human rights protection

Discriminatory practices in healthcare affecting sexual and gender minorities have implications not only for the biopsychosocial well-being of these populations; they also undermine or violate fundamental rights enshrined in local, regional, and global human rights instruments. The denial of healthcare services, harassment, and discrimination against SGM individuals can have severe consequences on their health, well-being, and overall quality of life. With that said, healthcare providers and facilities have a duty to provide non-discriminatory care to all individuals, regardless of their sexual orientation or gender identity. I also risk saying that oppressive practices in public services and degrading treatment of SGM people and other minorities undermine the overall quality of government. When certain groups or populations are seen or treated as less then, the fundamental values of democratic life (liberty, equality, justice, human rights, etc.) start to erode, compromising the very fabric of society and the social contract altogether.

Implications for health management and policy

Healthcare providers, healthcare managers, and policymakers in South Africa need to understand the larger impact that discrimination against SGM populations has on the quality of healthcare services, service delivery, and accountability. Healthcare managers and health policymakers can take several steps to ensure better services for SGM people, free from discrimination: 1. Provide education and training: healthcare providers and staff should receive education and training on the unique healthcare needs of SGM people, including the barriers and challenges they face when accessing healthcare. This can include training on cultural competency, sensitivity, and inclusion. 2. Create inclusive policies and procedures: healthcare organisations should have clear policies and procedures in place to ensure that SGM people are treated with respect and dignity. This includes policies around non-discrimination, patient privacy, and staff behaviour. 3. Implement data collection and analysis: healthcare facilities should collect data on sexual orientation and gender identity confidentially and sensitively, as this data can help identify disparities in healthcare access and outcomes for SGM people and inform policy and programmatic changes. 4. Create SGM-specific services: health spaces should provide specialized services to meet the unique needs of SGM people. This can include providing gender-affirming care, HIV prevention and treatment, mental health services, and support for survivors of violence. 5. Engage with the SGM community: healthcare providers and policymakers should actively engage with SGM community members to better understand their healthcare needs and perspectives. This can include partnering with community organizations and holding public forums to solicit feedback and input. By taking these steps, healthcare managers and policymakers can help ensure that SGM people receive high-quality, culturally competent healthcare that is free from discrimination.

Further recommendations

1. In light of possible human rights violations, healthcare providers should be investigated and punished in cases where discrimination, harassment, or negligence toward SGM individuals is proven to have taken place. In 2011, a South African Equality Court in the case of *Lallu v. Van Staden* found a neighbour's verbal abuse of a transgender woman to constitute harassment, hate speech, and unfair discrimination (Luhur et al., 2021). These, and other precedents (see also *September v Subramoney NO and Others*), can be used in favour of SGM people who are victims of discriminatory practices within healthcare facilities.

2. Measures should be taken by the South African government to include gender-equitable education and diversity modules in the school curricula nationwide, as early as in primary school. When education is emancipatory, it becomes a powerful tool to question normative speeches and fight prejudice and discrimination. This also involves training teachers on these issues, so they are capable of bringing up these topics in the classroom, exposing students to diverse socioeconomic and cultural groups and preparing them to become better members of their community, and ending the transmission of intergenerational bias and prejudice.
3. Guidelines on how to treat SGM populations in healthcare centers should be elaborated by the National Department of Health. It should also encourage the collection of data on specific issues affecting the health and well-being of the LGBTQIA+ community in South Africa, respecting the principles of privacy and confidentiality. The aforementioned guidelines concerning gender-affirming care should be enforced by the Health Professions Council of South Africa, to make sure that healthcare professionals comply with its determinations. Ultimately, ombudsperson services and procedures should be installed, to identify and correct bad behaviour. Accountability is key to providing better services, both for SGM people and for the general population.

In conclusion, this research article sheds light on the discriminatory practices faced by sexual and gender minorities in accessing and receiving quality healthcare in South Africa. Such practices not only impact the biopsychosocial well-being of SGM individuals but also violate their fundamental human rights enshrined in local, regional, and global human rights instruments. To improve the quality of healthcare services for SGM people, healthcare managers, policymakers, and providers in South Africa should undertake education and training, create inclusive policies and procedures, implement data collection and analysis, create SGM-specific services, and engage with the SGM community. These and other recommendations were made throughout the article. By taking these steps, I believe that South Africa can provide high-quality, culturally competent healthcare that is free from discrimination for SGM people, improving the overall quality of government and society.

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