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'We can't help you here': The discursive erasure of sexual minorities in South African public sexual and reproductive health services

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Abstract

Worldwide, sexual and gender minorities struggle to access sexual and reproductive health (SRH) services. In South Africa, sexual prejudice is entrenched and pervasive in health systems and SRH services do not cater for a diverse range of people. Though health reform is underway, little attention has been given to how sexuality is being addressed in this process, particularly in the National Health Insurance scheme currently being piloted. We analyse interview data generated in an NHI pilot district, using discursive methodology, informed by a sexual and reproductive justice standpoint. We show how sexual and gender minorities are discursively in/visibilised in health settings and discuss these findings in relation to the social justice and solidarity aims of health systems reform.

Keywords: sexual minorities; LGBTQ; heterosexism; health system reform; sexual and reproductive health; universal health coverage

Equitable access to healthcare, and sexual and reproductive services in particular, continues to be a challenge for sexual minorities[i] worldwide (Skinner, 2015). South Africa is no exception. While officially tolerant of sexual minorities, in reality deep-seated heterosexism continues to thwart any real exercising of the impressive array of constitutionally guaranteed rights, including health rights (Stacey & Meadow, 2016). Deeply hetero-patriarchal cultures demand secrecy around non-normative gender and sexual practices and promote 'cultures of quiet acceptance' (Epprecht, 2012, p. 223) of sexual or romantic relationships between women or between men, 'secretive' bisexuality, and threats of homophobic violence in communities (Rispel, Metcalf, Cloete, Moorman, & Reddy, 2011; Rispel & Metcalf, 2009).

The current process of health system reform, which began after South Africa's first democratic elections, is driven by social justice principles, notably equity and social solidarity (Department of Health, n.d.). This is embodied in the nascent National Health Insurance (NHI) initiative, intended to enhance access to quality healthcare, with integrated comprehensive sexual and reproductive health (SRH) services, and improving health outcomes in particular for those in rural and previously disadvantaged areas and from 'the most vulnerable' populations (Naidoo, 2012). This initiative, being piloted by the national Department of Health, provides a crucial opportunity to address the needs of groups, including sexual minorities.

Expanding the package of SRH services and reaching a wider range of beneficiaries than the current heterosexual woman-focus allows is a key issue with regard to health sector reform (Braam, 2005; Lind, 2009). A recent evaluation of SRH services for the South African

Department of Health noted that the existing services are not oriented to meet the different needs of the diverse range of people, including ‘men, transgender people, people with disabilities, people living with HIV, adolescents and young people, women not of reproductive age, sex workers, or people with diverse sexual orientations’ (Klugman, Treger, Conco, & Moorman, 2011, p. 11). The task then is in ‘balancing general goals with particular needs’ (Skinner, 2015, p. 509). This is not merely a bland exercise in inclusivity, however; global research literature points to sexuality as an important social determinant of health, highlighting links between stigma, marginalisation, discrimination, and health outcomes (Müller & Hughes, 2016). Access barriers are intensified when it comes to SRH issues, owing to moral and value judgements associated with sex, reproduction, and intimacy (World Health Organisation, 2010).

Despite the importance of extending services to sexual minority people, very little attention, if any, has been given to whether or how sexuality has been considered in the process of health system reform, particularly in the rolling out of NHI. Likewise, despite prioritising maternal and reproductive health services in the NHI policy (Motsoaledi, 2012), no research has specifically evaluated how these services are being integrated into the system, or whether they are indeed being expanded to reach more diverse groups. Responding to this knowledge gap, we focus on accounts about sexual minorities’ experiences, perceptions, and utilisation of SRH services generated at a rural South African site in a district where the NHI is currently being piloted.

Our qualitative study builds on a small body of prior research that documents the obstacles faced by this population (discussed below). Taking a sexual and reproductive justice standpoint (explained further below), we explore accounts from sexual minority healthcare users, healthcare workers in public and private facilities, and key experts engaged with SRH services. Our work proceeds from the premise that in contexts of pervasive heteronormativity, like South Africa, queer[ii] persons are not constructed as citizen subjects requiring attention and care and, as a result, responses to their SRH needs are restricted (Logie, 2015). Our aim, therefore, is to investigate the discursive processes that position sexual minorities in particular ways, with implications for their entitlement and access to SRH services, particularly in light of health system reform and the need to transform these services towards greater equity. Our analysis attends to the ways that sexual minorities are made in/visible, appear and disappear, in relation to public health SRH services (Logie & Gibson, 2013).

This discursive approach provides a relatively novel, and necessary, perspective on the process of health system reform in South Africa. It is important to investigate the discursive context—that is, the widely available meanings in any particular sociocultural context—as it is these familiar meanings that connect to material inequities (Taylor & Littleton, 2006). Insights from such an investigation can assist in working towards truly inclusive universal healthcare.

Sexual minority experiences, perceptions, and utilisation of public SRH services

South (and Southern) African research on the SRH of sexual minorities is generally scarce. As in more developed locations, what research exists has a disproportionate focus on HIV and other sexually transmitted infections, is heavily skewed toward men, and tends to be conducted in urban, higher resourced locations (Logie, 2015; Müller & Hughes, 2016; Skinner, 2015). Existing findings resonate with North American research which identifies common healthcare access barriers, namely: (a) reluctance to disclose sexual or gender identity to health workers; (b) insufficient number of health workers competent to deal with sexual minorities and their specific health needs; (c) structural barriers that limit sexual minorities' decision-making and access to health insurance; and (d) a lack of culturally appropriate services (Müller & Hughes, 2016).

South African research indicates that people from sexual minority groups commonly experience stigma, discriminatory behaviour, negative attitudes, and abuse in healthcare settings (Cele, Sibiya, & Sokhela, 2015; Cloete, Sanger, & Simbayi, 2011; Graziano, 2004; Matebeni, Reddy, Sandfort, & Southey-Swartz, 2013; Morison, Moolman & Reddy, 2015; Müller, 2013; Sandfort, Baumann, Matebeni, Reddy, & Southey-Swartz, 2013). As a result of negative experiences many people from these groups distrust and fear public health services, are reluctant to access services or engage with health workers; and often even avoid using services (Müller & Hughes, 2016; Padmanabhanunni & Edwards, 2013). For example, in a study with Black gay men and lesbians living in 'townships'[iii], Graziano (2004, p. 312) states that 'socioeconomic status affected participants' quality of healthcare. Despite a strong desire for more health and sexuality education, the lack of training and acceptance of gay men and lesbians at township clinics kept participants from visiting them'.

These barriers to SRH services are constructed and maintained by heterosexism: the normalisation of heterosexuality alongside the denigration and/or rendering invisible of other sexualities (Logie & Gibson, 2013). As a concept, heterosexism incorporates a range of processes and practices, from 'unreflective pervasive bias to deeply embedded normativity to unjust social privilege to cruel and deliberate social exclusion of sexual and gender minorities and to heterosexual bigotry of the most virulent and violent kind' (Callahan, Mann, & Ruddick, 2007, p. viii). For example, the negative experiences reported by participants in Morison et al.'s (2015) qualitative study ranged from less obvious behaviours—such as gossip, rudeness and humiliation—to overt acts of prejudice—like refusing treatment, providing expired medication and abusive behaviour. In this manner, sexual minorities' needs are rendered invisible in health systems both indirectly, due to a heterosexual bias, and through direct discrimination (Logie, 2015; Morison et al., 2015).

In addition to heterosexism, the marginalisation of sexual minorities is also shaped by other structural drivers of inequality. Social signifiers related to class, location, gender, race, for example, intersect with sexuality, creating multiple, interweaving lines of dis/advantage (Logie, 2015). As a result, sexual minorities 'may have less cultural, economic and social capital due to their intersecting identities and experiences with marginalisation, thus placing them in more vulnerable positions in regards to negotiating health systems' (Smith, 2015, p. 189). Of course, the intersection of identities also means that sexual minorities experience healthcare settings in unique ways, and have differing health concerns and needs (Müller & Hughes, 2016). In South Africa, where public health services tend to be used by uninsured, poorer or working class, largely Black,[iv] people (Shisana et al., 2013) marginalisation is shaped by 'the interlocking structural domination of race, class, gender, sexual preference, and spatial marginality' (Salo, Ribas, Lopes, & Zamboni, 2010, p. 299). The lack of access to public SRH services places an unfair, unaffordable burden and increased health risks on already marginalised people (Morison et al., 2015).

Improving access through health system reform

The goal of health system reform is to close ‘social, cultural, financial and/or physical distance between patients and the health system … [to make] healthcare more inclusive and equitable’ (Harris, Eyles, Penn-Kekana, Thomas, & Goudge, 2014). This is not simply a case of having available and affordable services, as the preceding discussion shows (Gilson, 2007; Thiede, Akweongo, & McIntyre, 2007). Access also entails enhancing physical and information accessibility and, significant to our study, ensuring that services are non-discriminatory, acceptable to patients, and responsive to their needs and expectations (Harris et al., 2014).

Improving service access has become a priority in the African region, spurred by the Millennium Development Goals and other global health imperatives. In the last decade, several low- and lower-middle-income countries have launched initiatives to ensure universal health coverage (Lagomarsino, Garabrant, Atikah, Richard, & Otoo, 2012). Following international trends in health system reform, in 2012 South Africa launched the NHI with a mandate to improve both access and quality of services (Hongoro, 2014). The NHI will create a single, publicly owned and administered fund to purchase health services on behalf of the total population from accredited and contracted providers (Hongoro, 2014). The South African Department of Health’s introduction to the scheme, cited below, underscores its grounding in the principle of social solidarity.

> National Health Insurance [the health department asserts] is a way of providing good healthcare for all by sharing the money available for healthcare among all our people. The health benefits that you receive will depend on how sick you are, not on how wealthy you are. Hospitals, clinics, doctors, specialists, dentists, nurses and all other health workers will also be available much more equally. *It all depends on our willingness to SHARE as ONE NATION. […] NHI will create fairness in the sharing of healthcare finance and other resources*, including skilled health professionals. […] [This] means you will receive healthcare for free at the time you require it (Department of Health, n.d., p. 2, emphasis added).

The NHI is thus clearly rooted in the social justice principles that characterise other South African health policies and the overall process of health system reform, particularly those of equity and the right to healthcare (Naidoo, 2012).

The NHI system is being implemented gradually in three phases over a 14-year period, starting with a pilot phase. The pilot, now in its fifth and final year, has included strengthening the service delivery platform and overall improvement of quality in the public health sector (Matsoso & Fryatt, 2013). Key elements of the NHI are being tested in ten districts, including the district where our study was conducted. In the following section, we provide contextual details about this geographical area, before outlining the methods used for data generation and analysis.

Study location

The study was conducted in an NHI pilot site in the Mpumalanga Province, a rural province with high levels of deprivation and insufficient resources. Like the rest of the province, the district is predominantly rural and under-developed, despite being a centre for agriculture and industry, with high youth unemployment and most households dependent on social grants (Morison & Janse van Vuuren, 2015; Rural Health Advocacy Project, 2013). The district's border location, relatively mobile population (of migrants and truckers), along with active mining and sex work industries create the perfect storm for the spread of sexually transmitted infections and HIV/AIDS (Phungula, 2016; Visser, Bhana, & Monticelli, 2012).

With among the highest rates of HIV infections in the country, and generally poor healthcare facilities, the study district was an ideal site for the NHI pilot, which targets rural and previously disadvantaged areas. Currently, local facilities experience medicine and supplies shortages, are under-staffed and over-crowded, with long waiting times and clinic queues forming hours prior to opening (Department of Health, 2012; Phungula, 2016). Mobile clinics operate weekly in farming communities, but this is not frequent enough to relieve the situation (Phungula, 2016). The majority of people who attend these public health facilities are from a relatively low socio-economic stratum, with the large majority being female, unemployed, and reliant on social grants (Morison & Lynch, 2016).

There are few alternatives to the public health services that offer SRH care. Overall, there are very few non-governmental organisations (NGOs) in the province that deal with sexual and reproductive health rights (SRHR) issues, and even fewer lesbian, gay, bisexual, transgender and intersex (LGBTI) focused programmes or facilities that are inclusive and affirming of sexual minorities (Hivos, n.d.). One exception was a recently completed two-year project focused on improving sexual health of gay and bisexual men and other men who have sex with men (MSM); increasing NGO capacity; and promoting acceptance of sexual minority men. Some positive outcomes have been noted from this project, but in contrast sexual minority women and transgender persons are particularly underrepresented in community-based organisations and civil society (Hivos, n.d.; Lane et al., 2014).

Participants

We invited healthcare workers and facility managers from three sites (an urban hospital, and a rural and urban clinic) in the district to participate in the research. We also invited lesbian, gay and bisexual (LGB) persons who are healthcare service users in the district, identified through existing civil society networks in the province. These persons were all Black and from poor and working class positions. In addition to these interviews, we also conducted expert interviews with key informants. These participants—from middle class positions and racially diverse (two Black and three White participants)—were from organisations across South Africa that: (a) offer direct psycho-social and sexual health services to sexual minorities; (b) provide LGB focused training to health service providers; (c) deliver services to survivors of sexual violence; and/or (d) advocate for comprehensive SRHR. The combination of purposive and convenience sampling resulted in a total of 34 participants. Table 1 provides a summary of the research sites and provides some significant participant characteristics.

Table 1: Summary of participants' characteristics

Research sites and participants		**n**
District public healthcare facilities *(facility manager and two healthcare workers at each facility)*	Urban clinic	3
	Urban hospital	3
	Rural clinic	3
District NGO / community based organisations (CBO) and facilities	Sexual violence-related service provider	1
	HIV-focused NGO	1
	Youth-focused NGO 1	1
	Youth-focused NGO 2	1
	Gender-based violence and HIV-focused NGO	1
	LGBTI-focused CBO	1
	Women's rights-focused NGO	1
	MSM-focused service provider	1
LGBTI healthcare users in the district	Healthcare users self-identifying as lesbian women	3
	Healthcare users self-identifying as gay men	6
	Healthcare users self-identifying as bisexual men	3
Key informants in SRHR sector	Nationally active LGBTI organisation	1
	National HIV/AIDS Council, LGBTI sector	1
	Nationally active MSM-focused organisation	1
	Nationally active sex work-focused organisation	1
	SRHR research specialist and activist	1
Total participants		**34**

Generating data with different kinds of participants was intended to create a richer data set. Also, noting that service providers' and users' narratives are shaped by differing expectations and experiences (Harris et al., 2014), we wished to allow for potential converging and diverging perspectives from multiple points in the health system (Thurmond, 2001).

Ethics

Before commencing with data collection, our ethics protocol including all research materials were approved by the Human Sciences Research Council's *Research Ethics Committee*. The study was conducted according to standard ethical guidelines for research with human participants, including special attention to communicating the aims of the study, the rights of those participating in the research, obtaining informed consent and ensuring confidentiality. In accordance with these guidelines, actual names and locations are not disclosed in this article.

Data generation

Data were generated in one-on-one, in-depth, semi-structured interviews, exploring the following domains: access and quality of SRH services in public and non-government healthcare facilities; availability of services oriented to sexual minorities; and SRHR advocacy to improve access and quality. In order to refine the interview guides, pilot interviews were conducted in a neighbouring area prior to the commencement of the main study. Thereafter, interviews were conducted with the selected participants in the language of their choice, by Black field researchers conversant in local languages. Data were transcribed and, where needed, translated in English by a transcriber proficient in local languages and checked by the field researchers for the veracity of the translation.

Data analysis

The transcribed interview material was analysed by the first and second authors: White, cisgender, queer women. We used thematic analysis, guided by Braun and Clarke's (2012) six phases, namely: (1) familiarisation with the data set through repeated readings; (2) initial code generation; (3) construction of preliminary themes; (4) refinement of themes through comparison with coded extracts and the entire dataset; (5) naming and defining themes; and (6) reporting the findings. We approached the analysis from a deductive, critical, and constructionist standpoint (Braun & Clarke, 2012). After coding and classifying the data according to themes, we used a sexual and reproductive justice standpoint to interpret the resulting thematic structures.

A sexual and reproductive justice standpoint has its basis in Black feminist theory on intersectionality, which explores how 'one's manifold social identities (e.g. race, gender, sexual orientation, and class) converge to create distinct experiences of both oppression (e.g. stigma) and opportunity (e.g. solidarity)' (Logie, 2015, p. 528). Using this framework, scholars locate 'reproductive rights in a political context of intersecting race, gender, and class oppressions' (Roberts, 2015, p. 79) and show how interlocking inequities shape people's SRH experiences and needs, as well as the obstacles and challenges that they face in exercising their sexual and reproductive health rights (Gilliam, Neustadt, & Gordon, 2009; Morison, 2013).

In order to explore this empirically, positioning analysis usefully allows for the examination of how speakers construct and use particular identities in their talk. Such an analysis connects the wider notions of discourses and dominant cultural narratives to the social construction of identities (Reynolds, Wetherell, & Taylor, 2007). Particular discourses allow for certain positions for social subjects to take up, resist, or modify as they variously position themselves or others within their talk. The discursive purpose of this positioning is usually to construct a positive social identity for individuals and/or the groups that they belong to. Following Davies and Harré (1990), positioning may be already conferred (e.g. race) allowing one to recite already existing racial discourses (e.g., White superiority) to consolidate one's position or to alter these. A position may also be reflexive and involve active self-positioning (e.g., being racist is an undesirable position that one can negotiate). Significantly, cohering with the sexual and reproductive justice standpoint, positioning analysis avoids simplistic analyses that reduce subjects to single, homogenous identity groupings and attends to the intersection of fragmentary subjectivities, emphasising their multiplicity and contingency (Taylor & Littleton, 2006). This method assisted with our research objective: exploring the positioning of sexual minorities by particular discursive practices and, specifically, the ways that sexual minorities are made in/visible, appear and disappear in talk about South African public health SRH services (Logie & Gibson, 2013).

Findings

Our aim in this paper is to further the scholarship in this area by exploring how, within health settings located in the pilot district, particular persons and their needs come to be overlooked, actively disregarded or, alternatively, marked as legitimate. As intimated in the introduction, we turn our attention to the discursive processes through which particular sexual minorities are rendered in/visible in public health settings. We attend also to silences, noting which subjectivities are absent in talk. In our analysis, we identified three main discourses evident across the dataset. In the sections that follow, we show how these discourses are drawn on and how sexual minorities are positioned within them. First, we demonstrate how a discourse of heterosexual complementarity serves to negatively construct sexual minorities as troubling hetero-gendered norms and contributes to their discursive erasure. Next, we turn to two ways of talking—drawing on a rights discourse and a public health discourse—that to some extent challenge or resist the in/visibility of sexual minorities, allowing for partial recognition of queer persons in health systems. We provide extracts that are illustrative of these discourses across the data set, indicating our own emphasis in bold font.

A discourse of heterosexual complementarity

This first discourse identified in the data supports ‘an understanding of gender as a fundamental and complementary *difference* between ‘man’ and ‘woman’’ (Folgerø, 2008, p. 136). Founded upon ‘the law of two sexes’, femininity and masculinity are seen both as polar opposites and as complementary. Each is defined in terms of what the other lacks so that genders are thought of as counterparts to one another. This extends to sexual desire so that the ‘natural’ object of desire for a ‘woman’ is masculine and for a ‘man’, feminine. The notion of bipolar, complementary gender categories establishes a necessary relationship between one’s gender and one’s body (or ‘sex’) that in turn invokes various gendered norms and expectations that are associated with designated bodies (Butler, 1990). This discourse is often supported by the view of gender difference as rooted in essential, biological differences which renders particular behaviours or practices natural (e.g. ‘opposite’ sex desire, procreative heterosex).

Participants’, and particularly healthcare workers’, knowledge and awareness of sexual minority SRH was often shaped and regulated by this ‘categorical approach to understanding gender … [which] encompass[es] dichotomous (male/female) understandings of biological differences, social norms, and gender roles’ (Logie, 2015, p. 533). This talk re/inscribes the familiar boundaries of recognition of social subjects: determining who comes into being through ‘regulatory grids of intelligibility’ (Butler, 1990, p. 166) and who is rendered unintelligible in health systems. We demonstrate how these distinctions hinge on conformity to (some) aspects of hetero-gendered norms.

To illustrate this, the extract below demonstrates how a discourse of heterosexual complementarity can, even in the presence of markers of difference, subsume queer persons into existing gendered and relational norms.

> *Extract 1*
> Interviewer: But are there any instances or stories you've heard, where treatment or attitude was positive from those people in health facilities, regarding LGBTI individuals?
> Zuko: Yes, there are, especially towards those gays who are out, the 'drag queens'. It's perhaps a little easier for them because they have a lot of female friends and so them and the female health workers will refer to each other by names like: *tjommie*[v], *mkhozi*[vi], friend. But with MSM it's really not easy. (Black gay male healthcare user)

In Zuko's account, 'drag queens' are provided cultural intelligibility and some measure of acceptance by conforming to a feminine gender role. In his rendition, access to care hinges on the maintenance of the norm of heterosexual complementarity. This echoes South African research findings showing that compliance with cultural gender norms promotes 'quiet' or 'qualified' acceptance of non-normative sexual practices (Epprecht, 2012; Sigamoney & Epprecht, 2013). Reid's (2013) study—conducted in the same district—has clear resonances. He notes tolerance of non-normative sexuality in relation to cross-dressing men who, similar to Zuko's account, are identified as 'gay' men, but referred to as 'ladies' or '*sis-Butis*'[vii] in local parlance. Rather than having sex with other gay men (tantamount to lesbianism in the local view) the 'ladies'' sexual partners are '*Injongas'* or 'gents'.[viii] These are men who maintain a traditional male social and sexual role and—since they do not have sex with other men, but rather with 'ladies'—are identified as straight, albeit 'somehow bended'.

Zuko's rendition suggests a similar symbolic or discursive (mis)recognition of 'drag queens' as feminine as they are hailed with feminine terms of close affiliation and affection ('*tjommie*' and *mkhozi*'). Despite being 'out', 'drag queens' are rendered culturally intelligible social subjects by conforming to a feminine gender role. In contrast, the identity associated with the public health label 'MSM' (*men* who have sex with men) is depicted as a troubled identity, implying that divergence from the discourse of heterosexual complementarity makes it difficult to access services.

In the extracts below other participants also describe experiences of being culturally unintelligible, which can be explained in terms of discursive erasure.

> *Extract 2*
> Interviewer: What did nurses say to you [when seeking care following a homophobic sexual assault]?
> Lindiwe: That we [lesbians] are **acting like men while we are women**.
> Interviewer: And what did you say?
> Lindiwe: I explained that it's not that I am acting like a man when I'm a woman, I also don't like to be treated the way I'm treated, but **this is the way I am** and I cannot change it. And I also told her that it doesn't mean people have the right to treat me like that and she ended up saying, 'No, I am not saying that they are right, but you

> also have to think for yourself'. So I just ended up leaving. (Black lesbian healthcare user)

> *Extract 3*
> Mbulelo: With me, people gossip a lot about me, especially girls. For example, let's say I am passing [by]; they would then ask themselves questions like, '**What is he?** Why is he not making moves on us? Is he gay?' ((Laughter)) Then they would start calling me names, but I am used to that. (Black bisexual male healthcare user)

Due to their divergence from hetero-gendered norms, both Lindiwe and Mbulelo are positioned as hyper visible—a woman 'acting like a man' and a man failing to perform the expected male heterosexual script of sexual conquest—and at the same unintelligible. This is indicated by Lindiwe's failed attempt to 'explain' and thus render her identity intelligible, as well as Mbulelo's report of female patients overtly asking, 'What is he?' The word 'what' suggests a process of categorisation. Both accounts can be understood as instances of misrecognition—moments in which subjects are cognised negatively—which compromises their status as full members of society and curtails their entitlement to rights (Fraser, 2005).

Discursive erasure was also evident in talk about sexual violence perpetrated against gay men. For example, the excerpts below demonstrate how gay men's deviation from normative notions of masculinity invisibilises them as survivors of sexual assault and discounts them from being seen as valid recipients of medico-legal services.

> *Extract 4*
> David: I once heard of someone who went into a police station to report a matter on assault and then police started asking him, '**So why didn't you hit him back, because you are also a man?**' (Black bisexual male healthcare user)

> *Extract 5*
> Jennifer: I think what it [the corrective rape narrative[ix]] has done is to also completely alienate gay men, for example. So I remember speaking to a gay man who went to a clinic […] after he was raped and was told flat-out '**but men can't get raped and we can't help you here**'. [Interviewer: No…] But it's the same problem, right? It's an incredibly narrow, heteronormative understanding of what sexual violence is and who can perpetrate it against whom. (Informant, white female SRHR activist)

These excerpts illustrate how gender insubordination results in discursive erasure of particular persons. The contravention of gender norms is related to gay men's passive positioning as victims of sexual violence—usually associated with women—as well as the convergence of the taboos of male rape and homosexuality, which both threaten dominant notions of masculinity (Gear, 2007). The service providers' responses in these accounts serve to silence and invisibilise these particular men. In this manner, 'hurt men are erased, desire is disqualified and violence endorsed' (Gear, 2007, p. 224). The result is that since the subject is not recognisable, he is seen as not in need of medical attention (Logie & Gibson, 2013), hence the verdict: 'we can't help you here'.

The discursive erasure of victims of homophobic sexual violence identified in our data echoes Logie and Gibson's (2013) findings. Drawing on Butler's view that violence becomes invisible in relation to subjects who are not considered credible, the authors note how such acts of erasure amount to ‘a ‘mark that is no mark’, recording neither violence nor ‘non-heterosexuality’ (p. 29). We have shown how the discourse of heterosexual complementarity is implicated in such erasure. This discourse largely constructs sexual minorities as culturally unintelligible, where transgression of hetero-gendered norms positions queer persons as outside of what is socially recognised as a credible citizen subject, as socially deviant ‘unsubjects’ (Butler, 1990, p. 20). In the following section, we focus on talk that challenges discursive erasure through appeals to a constitutional rights-bearing subject.

A human rights discourse

Rights-based talk is widely employed in post-apartheid South Africa, where sexual rights advocacy towards inclusion of sexual orientation in the Bill of Rights, and more recently in mobilising around the right to marry, relied on framing discrimination based on sexual orientation as similar to that based on other lines of difference, notably that of race (Van Zyl, 2009). Similarly, global activism has seen human rights discourse being powerfully employed to advance justice for LGBTI people (Kollman & Waites, 2009). In our data, expressions of resistance, and entitlement to equal treatment and comprehensive SRH, often drew on this discourse, with sexual minorities articulating their claims in relation to appeals to ‘equal rights’. As David (a Black bisexual male healthcare user) put it: ‘Everyone has their rights. I believe it is about rights. There are people who wish to be free’. This is also shown in the following quotations.

> *Extract 8*
> Vusi: LGBTI persons are **human beings** just like straight people, and as much as straight people have **rights**, the same rights applies to the LGBTI as well, people mustn’t be discriminated against on the basis of their sexual orientation and preferences. We live in a **democratic country** and we are all free to live the lives we are comfortable with. (Black gay male healthcare user)
>
> *Extract 9*
> Interviewer: What would your ideal space look like for you, in order to get information about sexual reproductive health? How do you wish for it to be? [….]
> Sipho: OK, I hear you. If there was anything that I could wish for in order for things to be alright, I would wish for them to stop discriminating against us. They should treat us as **human beings** because they already, they understand that this is our choice of life. So I would appreciate it, that when we get to the clinics, then they should also give us our attention. They should hear us out. Even in the community, if we want to say something they must give us that attention. Then, they can help us and say, ‘OK we hear what you guys are saying. Here is how we can help you’. They must give us services like everybody else. They should treat us **equally**. (Black gay male healthcare user)

These excerpts amount to calls for full recognition as citizen subjects. They demonstrate resistance to the discursive erasure of sexual minorities in heterosexist contexts through the mobilisation of a human rights discourse and appeals to democratic ideals of equality and fairness. Hence Sipho states: 'they should hear us out, even in our community', recalling Lindiwe's earlier claim to be recognised 'for who she is' (extract 2). Such rights-based talk constructs sexual minorities as equal citizens, accruing the same rights and responsibilities as heterosexual persons; it challenges the 'absence of entitlement' in relation to queer sexual and reproductive health and rights (Fine, 1988, p. 49; see also Richardson & Munro, 2014; Richardson, 2015).

The rights discourse, however, potentially allows for the creation of a hierarchy of rights and the pitting of various rights against one another, as evidenced through the frequent clash between 'rights talk' and 'culture talk' in South Africa, as well as the invocation of religious freedoms (Van Zyl, 2009). In our data rights talk was resisted by appealing to culture or religion, as shown below, to construct sexual minority rights as secondary to other citizens' rights or as able to be ignored. In the extract below, the speaker (a clinic staff member) uses language reminiscent of conscientious objection citing 'religious values' as a reason to deny health rights to sexual minorities —similar to the so-called escape clause in the Civil Union Act allowing officiants to decline their services to sexual minorities for religious reasons.

> *Extract 10*
> Interviewer: What is the institutional support, or any form of support, for providing quality services to lesbians, gay men, bisexual persons, transgender persons and so on? Are there any training programmes or any formal or informal support [for staff in this facility]?
> Katlego: For lesbians and gays?
> Interviewer: Yes, does your institution support them so that they can get quality services?
> Katlego: There are no systems in place to support those people. Because of **our** religious values, I am less interested in helping those people.
> Interviewer: So there are no systems in place to help them regarding their health, due to religious values?
> Katlego: Yes, religious values, and apart from religion, **most of us disapprove although the government does grant them rights**, but personally I don't want to assist those people. (Black male healthcare worker, clinic)

Katlego's response is unusual in its frankness, but illustrates the resistance to assisting sexual minorities that many health workers feel. The fact that a healthcare worker felt able to express these views so candidly is indicative of broader widespread heterosexism within the country, which allows officials and service providers to ignore the constitutional rights of sexual minority persons, as well as a lack of accountability for this heterosexist behaviour. Indeed, the response is framed by the consensus of a large group of people—a persuasive majoritarian argument—that appeals to 'our religious values' and 'most of us' as disapproving (Ellis & Kitzinger, 2002). This also follows a recent trend in South African political rhetoric identified by Vincent (2011, p. 1), namely 'the (populist) equation of democracy with 'the will of the people'', which is mobilised in relation to controversial topics such as capital punishment or LGBTI rights.

It is clear, therefore, that rights discourse is politically limited. Appeals to equality and common humanity rely on the conferral of recognition as a full member of society. The human rights discourse remains mired in individualism (as seen by participants' references to 'preferences', in extract 8, and 'choice', in extract 9). This discourse, underpinned by the neo-liberal conception of personal responsibility and freedoms supports an 'ideology of self-interest [that] is fundamentally at odds with solidarity and social cohesion' (Siconolfi et al., 2015, p. 555). As the extract above shows, this discourse can easily be used to counter claims for equal treatment by allowing people to claim the right to 'personally' refrain from complying or by furnishing another set of competing rights (religion, culture) which may very well be seen as trumping sexual rights (Richardson & Munro, 2012). This is seen in the allusion in extract 11, below, to the widely employed argument of same-sex sexuality being new and, in particular, being 'un-African' (Epprecht, 2012) to account for community elders' resistance to young people asserting their sexual and reproductive health rights.

> *Extract 11*
> Sphiwe: Because the problem is with the elders, as we go to the clinic we get information from them, where they make comments to say that '**In our time**, these things [being gay] were not there. Why do you guys have to do this now? Why do you need help with such now?' (Black bisexual male healthcare user)

Talk that is resistant of appeals to rights-based discourse points to a disjuncture between political rhetoric and local contexts of meaning-making. The construction of the government granting rights to particular persons as being out of synch with popular sentiment and as tokenistic has been noted in other research (e.g., Dworkin, Colvin, Hatcher, & Peacock, 2012; Jowett, 2014). This resistance has more recently prompted African initiatives that adopt

> …a more subtle strategy to promote sexual rights and sexual health that steers between confrontation and closet. This 'interim' approach urges the careful use of euphemism or implicit language and embedding the rights and self-esteem agenda for sexual minorities within sexual health campaigns that are ostensibly aimed at the heterosexual majority (Epprecht, 2012, p. 225).

Indeed, we noted that a public health discourse was drawn on by those working in the NGO sector, as discussed in the following section.

A public health discourse

Public health discourse is primarily focused on health concerns and therefore characterised by the use of 'neutral' medical language, without recourse to notions of rights, identities, or eroticism (Epprecht, 2012; Young & Meyer, 2005). This discourse was evident in common references to 'MSM', a term which focuses on sexual behaviours, rather than identity (Young & Meyer, 2005). It was also evident in the relatively common 'key population' narrative in service providers' and civil society members' talk. This narrative originates in policy directives identifying MSM and transgender persons as groups 'who lack access to services, and for whom the risk of HIV infection and TB [tuberculosis] infection is also driven by inadequate protection of human rights, and by prejudice', resulting in their inclusion in focused efforts to prevent and treat HIV (SANAC, 2011, p. 25). This narrative holds traction among organisations that are able to identify MSM as an at-risk group in the HIV epidemic, requiring targeted interventions, as illustrated in extract 6 below.

> *Extract 6*
> Themba: In terms of addressing HIV and AIDS we need to focus on key populations. The reason they fall under key population is because they are far from services, they are far from information. So lesbians and gays also we have identified as a key population [….] I believe the [LGBTI] key population is not addressed and it needs to be addressed (Black male informant, local HIV-focused NGO)

This statement illustrates how the key population narrative, in conjunction with a biomedical discourse of risk, renders certain persons visible and recognisable as subjects requiring care. Drawing on this discourse may be effective in securing care for (some) sexual minorities in contexts marked by pervasive heterosexism and heteronormativity. Epprecht (2012) argues that 'strategies primarily focused on health concerns that simultaneously yet discreetly promote sexual rights are having some success in challenging prevalent homophobic or 'silencing' cultures and discourses' (p. 223). Indeed, as seen in the excerpt above, this framing of sexual minorities constructs them as unfairly excluded and marginalised ('they are far from services' and 'information') and compels a response to remedy this ('it needs to be addressed'). Conversely, Young and Meyer (2005) maintain that this is a risky strategy. Firstly, it is not guaranteed to stave off resistance and at the same time undermines analytical precision. Secondly, such an approach may inadvertently reinforce conservative opinions that minority sexualities are 'foreign' to particular settings and forestall local struggles over sexual meanings and rights.

The public health discourse also has a narrow focus and limits awareness to 'risk', most notably HIV risk related to men, as pointed out in research (Logie & Gibson, 2013; Logie, 2015; Müller & Macgregor, 2014). Despite the NGO representative in the above quote referring to lesbians in addition to gay men, our data largely indicate a silence around identities and practices outside of those of gay and bisexual men and other MSM. For instance, the term 'LGBTI' was predominantly used by participants to refer to gay men only. This is part of a broader trend in health systems where 'SRHR for women who have sex with women, lesbian women, transgender women, or women who are sex workers, are rarely addressed' (Müller & Macgregor, 2014, p. 19).

A public health discourse brings into visibility gay and bisexual men and other MSM, but as it stands, does not extend to other sexual and gender minorities. Drawing on a biomedical risk narrative to construct MSM as a priority in relation to HIV risk, results in other groups such as queer women not being regarded as ''risky' enough to justify inclusion in HIV prevention' (Logie, 2015, p. 535). As we noted in our description of the district, there are no dedicated health services for sexual minority women. Participants commented on their absence, for example, Lindiwe (a lesbian participant) stated: 'I really wish there was a place where lesbians only could get help'. Lesbian participants also reported a lack of necessary, targeted care—in particular a lack of HIV risk and transmission knowledge, assisted reproduction information and services, and unavailability of dental damns and other barrier methods—confirming other research in which healthcare users report that, beyond (heteronormative) pregnancy and maternal care, women's sexual health needs are not adequately catered to (Morison & Lynch, 2016; Morison et al., 2015). Thus, while some of the SRH needs of particular sexual minority persons are made visible in the public health discourse, it does not necessarily translate into broader awareness of and responsiveness to sexual and gender diversity.

Discussion

Our findings resonate with other local studies (e.g., Lynch & Clayton, 2014; Morison et al., 2015; Morison & Lynch, 2016; Matebeni, Reddy, Sandfort, & Southey-Swartz, 2013; Sandfort, Baumann, Matebeni, Reddy, & Southey-Swartz, 2013). Our participants reported similar challenges to accessing SRH services, rooted in pervasive heterosexism: unresponsiveness to the needs of various sexual minority persons; untrained health workers; and no tailored SRH information, treatment, and/or supplies. Participants also described misinformation and ignorance regarding sexual minority health as common and recounted instances of rudeness, suspicion, ridicule, privacy violations, and refusals of care. These findings Therefore add to the growing, and much-needed, qualitative evidence in South Africa.

Our discursive analysis, informed by a Sexual and Reproductive Justice standpoint, also makes a novel contribution by illuminating discursive processes of exclusion within the system, including spaces and practices intended to address access barriers. The analysis highlights the centrality of mis/recognition of personhood and accordingly of citizenship rights (Fraser, 2004), as it illuminates the various ways that the institutionalisation of heterosexism in health systems serve to ‘constitute some actors as inferior, excluded, wholly other or simply invisible’ (Fraser, 2005, p. 24). Building on previous studies that report on widespread heterosexism in health systems (Logie, 2015; Logie & Gibson, 2013; Rispel et al., 2011) we considered the ways that visibility is constrained within the South African public health setting, and outlined three prominent discourses which work together to render queer subjectivities and experiences in/visible in various ways.

The first discourse—of heterosexual gender complementarity—functions to paradoxically mark queer persons as different while at the same time erasing them in health settings (Lind, 2009). This can be understood according to Butler's (1990) notion of abjection, a process of Othering in which deviant subjectivities form the constitutive outside of acceptable gender, defining the boundaries of the dominant category of ‘normality’. To achieve this, the threatening spectre of failed gender performance must be simultaneously acknowledged and firmly designated ‘Other’. Hence, heterosexism regulates and disciplines identities which contravene dominant hetero-gendered norms (Butler, 1990). We showed, for instance, how contravention of particular understandings of gender were erased in order to maintain the normative category of heterosexual complementarity (Butler, 1990). Our research provides further evidence for the particular influence of gender-nonconformity in shaping this discursive process. Indeed, Logie (2015) argues that divergence from hetero-gendered norms underlies heterosexism and sexual prejudice.

The other two discourses potentially resist this discursive erasure. The rights discourse is drawn on to repair the invisibilising of sexual minorities and instead position them as deserving of equal treatment. Rights-based talk is considered ‘a powerful political tool in fighting for social change’ (Ellis & Kitzinger, 2002, p. 170). Our analysis shows, however, that this discourse is limited to the extent that it can be refuted in contexts where conferral of rights is contingent on regarding queer subjects as full citizens. Furthermore, rights-based talk remains tied to an individualising neo-liberal conception of personal responsibility, which is not in alignment with efforts to advance social solidarity (Siconolfi et al., 2015). Like

Jowett (2014), we do not argue for rights-based talk to be abandoned wholesale. Instead, we support the assertion that efforts to advance queer health rights amid widespread heterosexism might require having 'a more extensive toolkit of rhetorical resources, to suit the nuances of the local socio-political climate and respond adequately to counter-positions' (Jowett, 2014, p. 17). Further research is needed to explore counter-discourses and rhetoric that challenges the discursive erasure of sexual minorities.

The final discourse, the public health discourse, also only partially counters the discursive erasure of sexual minorities, in that it retains a narrow focus on risk and 'key populations', rendering only some persons (men) and some SRH concerns (HIV) visible while obscuring others. This leaves sexual minority women and transgender persons excluded. Further to this, a public health framing of risk, while making visible the (important) health concerns queer men face, potentially limits the attention paid to other pertinent risks, such as structural disparities that diminish SRH outcomes for queer persons (e.g. heterosexism, poverty, racial inequality, rurality and violence) (Ham & Gerard, 2014; Logie, 2015; Matthews, Smith, Brown, & Malebranche, 2016; Siconolfi et al., 2015). In this manner, a public health discourse potentially forecloses possibilities for achieving broader social justice for sexual minorities.

It is possible to see, therefore, that all three of the discourses outlined contribute in some measure to discursive erasure, through acts of non-recognition (e.g., disavowal or disregarding) and misrecognition (including negative or devaluing characterisations) (Fraser, 2005). These can be read as acts of symbolic violence, but which also have material effects. We contend, following Logie and Gibson (2013), that to be unrecognisable within health systems 'is to be seen as not needing attention' (p. 35); thus, the discursive erasure of queer identities 'hinders service providers' abilities to anticipate, validate, and meet [clients'] sexual health needs' (p. 34). This has implications for sexual minorities' entitlement to SRH; in contexts where the intelligibility of subjects remains closely tied to adherence to gender norms, 'those whose experiences and identifications remain unacknowledged in terms of citizenship norms are still figured as 'less than human'' (Sanger, 2008, p. 50). In addition, discursive erasure has implications for what services get funded (Logie & Gibson, 2013). Invisibility of sexual minorities can create and reinforce the impression that current services are sufficient, bolster the heterosexist bias of health systems, and leave an absence of care for persons not defined as falling within the ambit of HIV risk (Logie, 2015; Richardson & Munro, 2013).

Conclusion

Our analysis showed how resistance to the discursive erasure of sexual minorities, through rights and public health discourses, remains limited to certain subjectivities and health concerns, and is largely individualised. It relies on a neo-liberal subject who must exercise rights, but does not account for the relational nature of rights (recognition); the manner in which agency is constrained by identification (visibility); or the lack of enabling conditions for rights to be claimed.

Public health lenses aimed at advancing SRH of sexual minorities can benefit from interrogating how risk is conceptualised, to expand the focus on sexual risk to also consider the 'vulnerabilising contexts' that produce such risk, as well as expanding the identities included as requiring access to services (Ham & Gerard, 2014, p. 301). Healthcare reform, rooted in principles of social justice, can fall short of its objectives if solely reliant on the language of human rights and public health discourse. Our findings point to the value of supplementing these approaches with a language of justice that foregrounds the structures (such as heteronormative and heterosexist systems) that breed risk and vulnerability.

Infusing healthcare reform with the analytic concept of intersectionality—articulated in the language of sexual and reproductive justice—can assist to visibilise not only particular 'at-risk' groups but also to improve responsiveness to broader sexual and gender diversity. The inclusion of sexual minority women and transgender persons in health provision, for instance, benefits a range of persons currently marginalised in health systems and, ultimately ''shift[s] the curve' for all service users towards inclusive, comprehensive, appropriate, accessible SRH care' (Ewing & Van Rooyen, 2015, p. 6). A sexual and reproductive justice standpoint with its intersectional approach addresses structural drivers of health disparities and 'has the potential to not only benefit queer women, but also transgender persons and sexually diverse men—through reducing sexual and gender non-conformity stigma—and heterosexual women, by challenging sexism' (Logie, 2015, p. 535). This standpoint coheres with the social justice principles that guide South African health system reform and many civil society organisations working in the area of SRH and rights and is therefore a potentially rich perspective for advocacy, policy reform, and intervention.

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Notes

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[i] We use this term to be inclusive of the various local meanings of non-normative sexual and gender practices that may exist beyond the Western notions of 'homosexuality' (see Sigamoney & Epprecht, 2013).

[ii] Our usage of the term 'queer' corresponds roughly with that of 'sexual minority' and describes persons who do not adhere to the conventional heteronormative scripts.

[iii] An urban living area usually built on the periphery of towns and cities and formerly officially designated for Black occupation by apartheid legislation. These areas are still predominantly comprised of Black inhabitants and are often underdeveloped and over-crowded. While more established townships, like Soweto (near Johannesburg), tend to have areas with better amenities and housing, most townships lack basic services, have high crime rates, and are similar to the shanty towns, favelas, or slums in other poorer countries.

[iv] Racial categories are capitalised to indicate their constructed nature. Formal segregation along racial lines was abolished after the demise of apartheid South Africa, but racial categories continue to shape people's lives, particularly through a race-class nexus. We do not endorse racial terminologies but use them pragmatically to call attention to ongoing inequities and effects.

[v] This word, pronounced 'chommie', is borrowed from Afrikaans and is slang for friend or buddy (likely derived from 'chum').

[vi] The direct translation of this Zulu word is 'mother in-law' and includes anyone with the same clan name as your in-laws. Here it is used to mean friend, but also implies more than that; it denotes respect, acceptance and ties of familial connection.

[vii] Literally: sister-brothers

[viii] See also Reid (2006) for further detailed discussion of these terms.

[ix] Targeted homophobic rape is commonly referred to as 'corrective rape', a term that has been problematized by South African activists since it is risks reinforcing a rape myth—i.e., that the non-conformity of sexual minority women can be 'corrected' through sexual violence (Hames, 2011). We use the term, mindful of this critique, due to its familiarity.