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HYGIENE
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MEDICINE



**Claiming the right to health for women who have sex with women:
analysing South Africa's National Strategic Plans on HIV and STIs.**

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**Thesis submitted in accordance with the requirements for the degree of
Doctor of Public Health of the
University of London
2015**

Department of Global Health and Development

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No funding received

I, M. Felicity Daly, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

A handwritten signature in black ink, appearing to read 'M. L. J.' with a stylized flourish at the end.

Signed:

DEDICATION

This thesis is dedicated to the memory of my beloved parents

John K. Daly 1924-2011

Marie T. DeSonne Daly 1927-2012

ACKNOWLEDGEMENTS

I would like to thank my family, principally my beloved wife Feona for her significant support and encouragement throughout this degree and particularly the interest she has taken in this thesis. I am also grateful to my step sons, Louis whose interest in studying health developed during my years at the School and Albi who accepted my need to write even when it ate into time together.

I am deeply grateful to my informants, many of whom are the sheros and heros of the fight against HIV/AIDS in South Africa. I am grateful for their input and humbled that they took an interest in my research and I hope it will be of use to them in future policy processes.

I am grateful to Dr Neil Spicer for taking me on as a student, guiding me through this multi stage degree and for encouraging me to pursue a thesis topic that I am passionate about.

I am also grateful for the guidance and input of Dr Charlotte Watts and Dr Johanna Hanefeld and the encouragement of Dr Adam Bourne and Dr Susanna Mayhew.

Undertaking this thesis would have been impossible without the support of my friend Samantha Willan and her colleagues at HEARD. I am indebted to Samantha and Dr Andrew Gibbs for discussing the approach to the study, facilitating my access to many informants

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INTEGRATING STATEMENT

The Doctor of Public Health (DrPH) degree at the London School of Hygiene and Tropical Medicine (LSHTM) is structured to support the development of managers, leaders, advocates and influencers in the field of public health. In 2010 I choose to pursue the degree after working for a decade as a manager of policy and advocacy efforts of non-governmental organisations focused on global health and social development. As my MSc in Development Management from the London School of Economics and Political Science prepared me to analyse institutional development in low and middle income countries I sought a research degree which would allow me to acquire public health theory and provide insight into how to improve the performance of institutions mandated to address health problems in resource constrained settings. The degree has three aspects: a taught component; the Organisational and Policy Analysis Project and the thesis designed to enhance the analytical, management and research skills critical to leadership of public health agencies.

The taught component of the Dr PH consists of two compulsory modules: Evidence Based Public Health Policy (EBPHP) and Leadership, Management and Professional Development (LMPD). EBPHP provides students with key concepts in public health theory to be applied to the analysis of health sector organisations and their role in policy development and implementation. The LMPD module provides an overview of management and leadership theories and how they relate to organisations. Retreats undertaken within the module allowed for greater insight into: my own practice as a manager, how to enhance effective management, and consideration around my leadership style and the strengths I can develop and the weaknesses I must strive to overcome. In addition to the compulsory modules I audited MSc modules in: Economic Analysis for Health Policy; Global Mental Health; Introduction to Health Economics; Qualitative Methods; Reproductive Health Research and Sexual Health. These provided theoretical grounding on themes I had previously worked on, to pursue other interests and to build skills essential for the completion of the degree.

The Organisational and Policy Analysis (OPA) Project provides DrPH candidates with an opportunity to analyse the workings of an institution with a remit to improve health and apply public health and organisational and business management theories to consider how health policies are developed within institutional structures. In 2011 I conducted my OPA at the Secretariat of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). I sought to analyse how the Secretariat managed the implementation of two policies designed to help Global Fund grantees address social determinants of health: the Gender Equality Strategy and the Sexual Orientation and Gender Identity (SOGI) Strategy. My research question was: what are the leadership styles and management structures within the Global Fund to Fight AIDS, Tuberculosis and Malaria which support or limit the implementation of the Gender Equality (GE) Strategy and the Sexual Orientation and Gender Identities (SOGI) Strategy? I applied theories from the field of management studies including analysis of the role that gender plays in organisations as well as transformational and transactional leadership to review leadership styles and management skills in practice. The methods used were key informant interviews, participant observation and document analysis. The OPA was conducted in collaboration with an external evaluation conducted by Pangaea Global AIDS Foundation and recommendations from my research were included in their report to the Secretariat which was reviewed by the Portfolio and Implementation Committee of the Global Fund Board in December 2011.

Considerations around the topic for this thesis emerged from themes explored in the OPA. I initially sought to identify a country wherein I could trace the influence of the Global Fund Gender Equality and/or SOGI strategies on HIV programming. I took South Africa as a starting point because I knew that both women's rights and LGBT organisations had been involved in the HIV response there. Though I could not find strong correlation between the portfolio of GFATM grants to South Africa and the initial implementation of the Strategies I began to take a closer look at the space South African policy processes had afforded the LGBT community and women's rights organisations. Thus the focus of my research project emerged. Empowered with new skills and deeper perspectives gained through the course work I was able to design and conduct this research project then analyse the findings herein. Undertaking the study has helped to develop my qualitative policy analysis research skills and strengthen confidence in managing or commissioning such projects in the future.

This review of how WSW sexual health issues first emerged onto the NSP and how attention depreciated over time could be useful within processes for revising the NSP expected in 2016. It is hoped that this analysis might help better situate these issues within subsequent policy processes and may also provide analysis of the functionality of several SANAC civil society sectors. I presented initial findings at the University of Cape Town Colloquium: Heteronormativity and Health in Education and Practice 15-16 August 2014. I have been invited to publish an article based on the findings in the 2015 edition of The LGBTQ Policy Journal of Harvard University's Kennedy School of Government. I am also planning to present some of the results, with collaborators in South Africa, at the 7th South African AIDS Conference in June 2015. I hope to identify other opportunities to share the findings with advocates so that they can be more effective in representing the concerns of WSW within the response to HIV and STIs.

The DrPH degree has supported me to develop a set of analytical skills, particularly in application of qualitative methods to examine institutional strategy implementation and health policy processes. It has also allowed me to reflect on how to continue to develop my own management practice and leadership skills. I feel highly capacitated to secure leadership roles in global health and succeed in them as a manager grounded in health evidence.

ABSTRACT

Introduction:

Evidence has emerged that women who have sex with women (WSW) in South Africa face multiple vulnerabilities to sexually transmitted infections (STIs) including HIV. This health policy analysis seeks to understand why and how interventions to improve sexual health of WSW were initially proposed in the HIV & AIDS and STI Strategic Plan for South Africa 2007-2011, what was implemented and how issues were reframed in the National Strategic Plan (NSP) on HIV, STIs and TB 2012-2016.

Methodology:

Qualitative methods were used to analyse changes over time in policy discourse around WSW sexual health. A conceptual framework considered four factors determining political priority setting for WSW issues in NSP development processes: actor power, ideas, political context and issue characteristics. 25 semi-structured key informant interviews were conducted in South Africa in 2013 and findings were triangulated through document analysis.

Results:

Breakthrough in participation in policy making on HIV/AIDS in 2007 enabled the women's sector of the South African National AIDS Council (SANAC) to present testimony from WSW affected by HIV. Policy content of the 2007-2011 NSP included WSW issues but no activities were implemented in the public health system. Policy actors were mandated to redevelop an evidence based NSP for 2012-2016 and discourse on key populations vulnerable to HIV, including men who have sex with men (MSM), shaped policy content. Data on HIV and STIs among WSW existed but resources to disseminate or undertake further research were limited. The SANAC LGBTI sector, created to represent community interests, became preoccupied with MSM programming. Focus on WSW was not maintained in the 2012-2016 NSP due to limited health metrics, limits on participation and growing social conservatism.

Conclusion:

In the future advocates must reiterate rights based arguments on the vulnerabilities of WSW and call for a revised research agenda on the epidemiology of WSW sexual health.

ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	African National Congress
ARV	Antiretrovirals
ART	Antiretroviral Therapy
DoH	Department of Health
GBV	Gender based violence
HIV	Human Immunodeficiency Virus
HIV+	HIV positive
HPV	Human Papilloma Virus
HSV	Herpes Simplex Virus
IPV	Intimate partner violence
LGBT/I/Q	Lesbian, gay, bisexual, transgender / intersex / queer
MoH	Minister of Health
MSM	Men who have sex with men
NSP	National Strategic Plan
OSISA	Open Society Initiative for Southern Africa
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PrEP	Pre-Exposure Prophylaxis
SANAC	South African National AIDS Council
SOGI	Sexual orientation and gender identity
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
TAC	Treatment Action Campaign
TB	Tuberculosis
UN	United Nations
UNDP	United Nations Development Programme
UNAIDS	Joint United Nations Programme on HIV/AIDS
VAW	Violence against women
WSW	Women who have sex with women

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Chapter 1: INTRODUCTION

1.1 Background

HIV/AIDS is considered to present long term implications not just for individuals, families and communities but to societies and importantly to economies and governments (Barnett and Whiteside, 2006). The need for effective policies to respond to the challenges presented by HIV/AIDS is particularly compelling in South Africa as the burden of disease in the country is considered to be among the highest in the global pandemic. By 2013 16% of all new infections globally and 23% of all new infections in sub-Saharan Africa occurred in South Africa (Joint United Nations Programme on HIV/AIDS, 2014). HIV/AIDS has also provided a poignant focal point for realising the human right to health and considering the human rights implications of health policy (Wolff, 2012).

South African policy actors seeking to halt and reverse the spread of HIV/AIDS face complexities grounded in their particular country context. As the epidemic took hold South Africa was struggling to emerge from apartheid, establish a democratic Government and overcome a uniquely politicised battle around the science of HIV/AIDS which set the response back many years. While National Strategic Plans for HIV and AIDS (NSPs) have been a vehicle to coordinate national responses in other settings for over two decades (Morah and Ihalainen, 2009) it was only in 2007 that South Africa undertook a planning process influenced by normative guidance.

The development of the *HIV and AIDS and STI Strategic Plan for South Africa 2007-2011* (Republic of South Africa, 2007) was coordinated by the South African National AIDS Council (SANAC), which was at that time a programme of the Department of Health (DoH). The development of the plan was considered to have been a “broad consultative process” (Kehler, 2007b:7) which sought input from a wide range of civil society sectors. For the first time in the country’s HIV/AIDS planning advocates from the lesbian, gay, bisexual and transgender (LGBT) rights movement were able to influence policy discourse. The concerns these advocates raised helped to expand perceptions of a generalised epidemic driven by heterosexual sex to consider a range of other dynamics. As a result SANAC included ‘higher risk populations’ to target in HIV prevention interventions including: men who have sex with men (MSM); transsexuals (transgender people) and lesbians (women who have sex

with women) among other vulnerable groups and committed to address barriers these populations face in accessing non-discriminatory health services.

Women who have sex with women (WSW), who have same-sex partners whether or not they identify as lesbian or bisexual, have been under-analysed in both high income countries and low and middle income countries for a range of sexual and reproductive health concerns including risk of HIV transmission. Rarely are WSW highlighted for targeted public health interventions and the inclusion of WSW in a national HIV/AIDS response is uncommon. South African researchers have argued that the exclusion of WSW in domestic HIV research, prevention interventions and initiatives to enhance health services can no longer be justified by assertions that WSW face ‘no risk’ or ‘low risk’ of STI or HIV infection. A few recent studies demonstrate a burden of STIs including HIV among South African WSW including data shown in Table 1.1.

Table 1.1: Recent sexual health data on South African WSW

Authors, Year	Sample	Findings
(Cloete et al., 2011)	641 HIV+ women	76% of HIV+ WSW recently had an STI
(Sandfort et al., 2013)	591 WSW South Africa and region	9.6% of all WSW are HIV + of whom 31.7% had an infection route other than ‘traditional’ risk factors. “Female-to-female transmission might be the cause.”
(Matebeni et al., 2013)	24 WSW South Africa and region	20% of HIV+ WSW self-reported that they believe they were infected through their female partner.

WSW in South Africa face sexual health risks within their same-sex relationships as well as through partnering with men, including for transactional sex, and through forced sexual experiences (Sandfort et al., 2013). It has been established that gender-based violence (GBV) is a significant driver of women’s vulnerability to HIV (Stockman et al., 2013) and that South Africa has extremely high rates of GBV (Abrahams et al., 2014). Moreover there are numerous cases of lesbian and bisexual women raped because of their sexuality a phenomenon termed ‘corrective rape’ perpetrated to ‘cure’ a woman of same-sex desire (Holland-Muter, 2012) resulting in trauma including increased risk of HIV transmission.

The policy content of the 2007-2011 NSP attempted to address this unique context but SANAC struggled to implement many objectives (Heywood, 2011a) and mainly focused on scaling up access to antiretroviral therapy, which has been the principal concern of South African HIV/AIDS activism (Mbali, 2013). When SANAC set out to develop the next five year plan in 2011 several contextual changes had occurred. SANAC became an autonomous body with strong ties to the DoH, many new policy actors were in place and some constituencies faced challenges in participating in the policy process. Notably, normative guidance around key populations at higher risk for exposure to HIV urged that focusing on MSM, transgender people, people who inject drugs and sex workers and their clients could lower incidence (Joint United Nations Programme on HIV/AIDS, 2010c). South Africa's *National Strategic Plan on HIV, STIs and TB 2012-2016* (Republic of South Africa, 2011) maintained policy content regarding the need to address MSM and transgender people's HIV prevention needs within an overall strategy to address a set of domestically identified key populations, which excluded WSW.

1.2 Study Approach, Aim, Objectives and Value

Study Approach

This health policy analysis incorporates the factors which Walt and Gilson (1994) consider to be in play when making health policy: context, content, process with actors: as individuals and as members of groups or organisations the centre of what they called a *model for health policy analysis* also known as the 'health policy analysis triangle'. I adapted Shiffman and Smith's framework (2007) on the generation of political priority for global health initiatives to analyse the categories of: actor power, ideas, political contexts and issue characteristics and their related factors which play a role in decisions about which health issues are integrated into policy. Within analysis of the factors I paid special attention to certain structural elements: problems, politics, policy windows and policy entrepreneurs which Kingdon (2003) proposed lead to a policy output.

Study Aim

This study aims to understand the policy process around the development of the current and immediate previous National Strategic Plans (NSP) on HIV and STIs in South Africa and

how interventions to improve sexual health and enhance prevention of HIV among WSW were initially proposed and how they changed over time.

Study Objectives

1. To analyse why and how initiatives targeted toward WSW as a population vulnerable to HIV and poor sexual health were included in the 2007-2011 NSP considering:
 - i. how the factors of actor power, ideas, political context and issue characteristics shaped the policy process, content and context; (Chapter 4)
 - ii. what the policy content of the 2007-2011 NSP indicated should be done to improve the sexual health of WSW; (Chapter 4)
 - iii. what implementation evidence exists for interventions targeting WSW.
(Chapter 4)
2. To understand why there was a change in focus on WSW in the 2012-2016 NSP through analysis of:
 - i. emerging evidence, political context, actor power and ideas (Chapter 5);
 - ii. the participatory process and how it shaped the content of that NSP (Chapter 5);
 - iii. how policy content on WSW differs in the 2012-2016 NSP. (Chapter 5)
3. To suggest relevant recommendations which may provide insight to policy actors, particularly within SANAC, concerned with developing policy to address the sexual health of WSW. (Chapter 6)

Value of the Study

The value of the study can be justified in several ways. The study fills a gap in knowledge regarding South Africa's NSP development and implementation. The study can be considered an analysis of an attempt to apply recommendations that urge policy makers in East and Southern Africa to meaningfully integrate a response to gender inequality and address GBV through NSPs (Gibbs et al., 2012a); (Gibbs et al., 2012b). It also provides insight into the policy process through which WSW issues emerged onto the policy content of South Africa's 2007-2011 and 2012-2016 NSPs which were critiqued in terms of HIV prevention, human rights and sexual and reproductive health content (Kehler, 2007b); (Kehler, 2007a); (Kehler, 2012). The study offers conceptual value for researchers

considering the application of Shiffman and Smith's framework (2007) particularly when analysing issue characteristics where health metrics are limited.

The public health value of the study is grounded in a human rights approach to health, particularly sexual and reproductive health, which considers the causal links between human rights violations and health and the ways that discrimination based on sexuality affects health (Miller, 2000). The study presents epidemiological arguments which can be employed for a focus on prevention of HIV and STI transmission among WSW, particularly in the hyper endemic setting of South Africa and the Southern Africa region. Public health arguments around WSW have been overlooked given that sexual transmission of HIV and other STIs is higher between heterosexual partners in generalised epidemics. Similarly WSW sexual health concerns are often subsumed within public health strategies targeting the LGBT community which focus on MSM and transgender women given that receptive anal sex carries a relatively higher risk of HIV and STI transmission (DeGruttola et al., 1989). Nevertheless South African policy actors have a duty to protect all individuals according to the 1996 Constitution which intended to cast off racial, gender and sexuality based inequalities. Thus there is an incentive to enhance the quality of care of WSW by ensuring non-discrimination and equality are core principles of the promotion of health (Fish and Bewley, 2010).

Another justification for contributing a research output is linked to SANAC's processes as the 2012-2016 NSP is scheduled to be reviewed in 2015 for consideration of challenges SANAC faced in implementation before they develop a subsequent plan. Thus it is timely to present a review of the strengths and weaknesses of advocacy on WSW sexual health within policy formulation opportunities afforded by SANAC. Beyond the South African context, the study may be useful in analysing NSP development in other countries particularly Botswana, Namibia and Zimbabwe where data on WSW sexual health shows similar epidemiological concerns. Also the study could be useful in considering participation within National AIDS Councils and coordination of civil society inputs with particular regard to policy actors from the LGBT community.

Chapter 2: LITERATURE REVIEW

Introduction

This chapter provides an overview of South Africa's policy response to HIV/AIDS, how certain global health policies have shaped this response and some of the dynamics of the epidemic in the country relevant to the study's consideration of the position of women who have sex with women. It then discusses the global evidence base on sexually transmitted infections (STIs) including HIV and among women who have sex with women and contextualises this with data from South Africa and other countries Southern Africa. Finally, the chapter explores the concepts of health policy analysis which form the basis of the study's conceptual framework.

2.1 A brief review of HIV/AIDS and the policy response in South Africa

Since the first free election in 1994, the Republic of South Africa is a constitutional democracy with executive, judicial and legislative branches and three layers of government at local, regional and national levels in the legislature. South Africa is classified as a upper-middle income economy characterised by one of the highest inequality rates in the world, perpetuating inequality and exclusion based on race. (World Bank, 2015) The burden of HIV/AIDS in South Africa is considered to be among the highest in the global pandemic. The national average of adult HIV prevalence is continuing to rise and was estimated at 12.2% in 2012 (95% CI: 4-13.1) which is "statistically significantly different" ($p < 0.001$) from the 2008 national estimate of 10.6% (95% CI: 9.8-11.6) (Shishana, 2014). While HIV has affected all races black Africans have the highest HIV compared to all other races (ibid).

HIV first emerged in South Africa in 1982 when Apartheid, a racially segregationist and authoritarian political system which compounded inequalities in health service access and health outcomes along race and class lines (Petros et al., 2006) was still in place though robustly resisted. In 1988, the Department of Health (DoH) initiated an AIDS Unit which was supplanted by a National AIDS Programme in 1991 (McNeil, 2014). Civil society organisations responding to the burden of HIV/AIDS formed an advocacy network to draft the first National AIDS Plan in collaboration with Government in 1994 (Mbali, 2013).

Following the end of apartheid the transition to democracy was secured through the South African Constitution of 1996 which established socio-economic rights, stressing the importance of racial equality as well as gender equality and made homosexuality legal. Article 27 of the Constitution includes “the right to have access to health care services, including reproductive health care.” (Republic of South Africa, 1996) Revised AIDS plans were issued in 1995, reviewed in 1997 and finally in 2000, the year that the South African National AIDS Council (SANAC) was established, a plan was rearticulated for 2000-2005. Significant gaps in policy implementation beset each of these plans and the location of the AIDS response in the DoH undercut a multisectoral response (Wouters et al., 2010).

South Africa’s healthcare system is two-tiered with a private sector serving the wealthy minority, many of whom hold private medical insurance, while the public sector is poorly financed to serve 68% of the population, the majority black, a situation barely changed since the end of apartheid (Pillay and Skordis-Worrall, 2013). The response to HIV/AIDS was outpaced by the rapidly rising burden of disease. President Nelson Mandela was unable to marshal an effective response to the epidemic but following his one term in office Mandela became a galvanising force in AIDS activism and declared “AIDS is no longer a disease, it is a human rights issue.” (South Africa Info, 2015) This was in stark contrast to the position of his successor, Thabo Mbeki, who was influenced by discredited science that questioned the etiology of AIDS (Wouters et al., 2010). Mbeki appointed Dr Manto Tshabalala-Msimang as Minister of Health (MoH) and she became notorious for her resistance to provision of anti-retroviral therapy (Mayosi et al., 2012).

The Treatment Action Campaign (TAC), a civil society movement, ultimately proved that certain Constitutional rights were actionable, winning a landmark 2001 court case against the Government which forced the public health system to treat pregnant women with anti-retrovirals to prevent vertical transmission of HIV to newborns. (Mbali, 2013) This was a major turning point in an action on claiming the human right to health, and international development partners supported this struggle and following the court decision dedicated significant resources for HIV/AIDS services through global health initiatives, notably the Global Fund to Fight AIDS, TB and Malaria and the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR). (The Global Fund to Fight AIDS, 2014); (PEPFAR, 2013). Nevertheless critics

question why domestic financing of HIV/AIDS services in the public health system is not more robust given that South Africa is a middle income country and thus “has the resources, and the capability to rise to these challenges but has not been able to devote resources commensurate with the scale of the problem” (Abdool Karim et al., 2009).

The breakthrough of the political stalemate around the response to HIV/AIDS created more opportunities for stakeholders in Government and civil society to work together to develop policy. In 2007 SANAC set out to develop a five year National Strategic Plan on HIV and STIs with input from a range of policy actors. National Strategic Plans for HIV and AIDS (NSPs) are considered to be a key vehicle in the coordination of national responses to HIV/AIDS (Morah and Ihalainen, 2009) and have “become a mainstay of the response in southern and eastern Africa, and widely supported by donor communities” (Gibbs et al., 2012a: 1121). The policy process around the development of South Africa’s 2007-2011 NSP will be explored in Chapter 4.

Jacob Zuma challenged Mbeki’s leadership of the ANC and assumed the Presidency in 2009. Zuma appointed Dr Barbara Hogan as MoH who served for a year and was considered to have initiated “several projects to deal with the disarray in the Department of Health” (Mayosi et al., 2012: 2029). In 2009 Dr Aaron Motsoaledi became MoH and serves in the post currently. He has reflected on the legacy of the politicised response to HIV/AIDS saying “the burden of disease is very high...because of our wrong approach in the beginning, the program started very late...We lost a decade, and that makes it very difficult to catch up” (Cohen, 2013:898). South Africa now has the largest antiretroviral programme in the world (Joint United Nations Programme on HIV/AIDS, 2014) but it has been argued that focusing on treatment alone will not turn the tide of the epidemic as it can “neglect the needs of the majority...not yet infected....not change the community and social contexts that led to the development of the epidemic...nor ...strengthen affected communities ...protect them from...future epidemics” (Campbell, 2003:19).

Jacob Zuma made his first World AIDS Day speech as President in 2009 and called on South Africans “to take responsibility for their health and well-being and that of their partners, their families and their communities...our people must be armed with information” (Joint

United Nations Programme on HIV/AIDS, 2010b: 11). Given his public statements demonstrating sexist and heterosexist views, including testimony during his 2005 trial for the rape of an HIV positive lesbian, Zuma is considered a problematic figure in relation to the response required to address structural drivers, such as gender inequality, driving South Africa's epidemic (Tallis, 2012).

2.2 Gender dynamics of South Africa's HIV/AIDS epidemic

Women's vulnerability to HIV transmission, compounded by persistent gender inequality, is well recognised and resulted in AIDS being the leading cause of death of women age 15-49 globally (World Health Organization, 2009). Among South African women HIV prevalence continues to increase "peaking at 30-34 years where prevalence reaches a record high of 36.0%" (Shishana O, 2014: 38). There are significant gender disparities in HIV prevalence, the burden in women age 20-24 are 12.3% higher than men their own age 11.1% higher in women age 25-29 (ibid). The high burden among young black African women is related to determinants including: early sexual debut; age disparate relationships; multiple and concurrent sexual partnerships and inconsistent condom use (ibid).

Given this high burden of disease there has been an increased emphasis on how to address the structural drivers of women's vulnerability to HIV (Campbell and Gibbs, 2010). Gender-based violence (GBV) has been established as contributing "significantly to a woman's risk for HIV infection" (Stockman et al., 2013: 832). South Africa is considered to be a deeply patriarchal society where women's position in society is subordinate to men and the country exemplifies "the dual epidemics of HIV and gender-based violence" (Jewkes and Morrell, 2010: 2). Almost half of all women in South Africa have a forced sexual debut (Watts and Zimmerman, 2002) and estimated prevalence of non-partner sexual violence is 12.2%, double the global rate (Abrahams et al., 2014). A study of women in South Africa aged 15-26 years found that women who had experienced intimate partner violence (IPV) were 50% more likely to have acquired HIV than women who had not experienced violence (Jewkes et al., 2010). These levels of violence remain "rampant, irrespective of human rights- focused laws passed by the government" (Mogale et al., 2012: 583).

Strategies to address such drivers of HIV incidence among women of reproductive age include technical guidance including from the Joint United Nations Programme on HIV/AIDS (UNAIDS) which encouraged countries to incorporate actions to enhance the rights of women and girls into National Strategic Plans (NSPs) on HIV/AIDS (Joint United Nations Programme on HIV/AIDS, 2010a). UNAIDS 2011-2015 strategy recognises the importance of including effective responses to GBV in NSPs (Joint United Nations Programme on HIV/AIDS, 2010c). There are concerns about how South Africa approaches the links between GBV and HIV and it has been argued that GBV should not be regarded “primarily or solely as a cause of HIV transmission rather than as a serious violation of women’s fundamental rights to bodily integrity, personal freedom and sexual agency in itself.” (Nath, 2012 : 4) While the focus on how to curtail the rising burden of HIV among young black African women within South Africa’s generalised heterosexual epidemic some attention has emerged to consider how other, more marginalised, women can be addressed. Some South African advocates have asserted that the country needs “both general and targeted prevention strategies that speak to the social risks facing lesbians, gay men...and other stigmatised sexualities” (Judge, 2009: 11-12).

2.3 Responding to key populations vulnerable to HIV

Frustrated with stagnant or rising HIV infection rates UNAIDS has urged countries to place greater focus on preventing new infections among ‘key populations’ in their epidemic contexts. UNAIDS’ guidance to ‘know your epidemic, know your response’ has been considered “an increasingly well-known rallying cry to put evidence at the heart of national AIDS programmes” (Buse et al., 2008: 572) and encouraging “an intensified focus on HIV prevention” (Wilson and Halperin, 2008: 423). Focusing on the evidence was intended to bring greater specificity to prevention approaches and overcome ineffective pursuits which did not align interventions to the main HIV transmission dynamics (Wilson and Halperin, 2008).

UNAIDS also challenged countries to foster interventions for vulnerable populations by changing “punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses” (Joint United Nations Programme on HIV/AIDS, 2010c: 7). The Global Fund introduced a Sexual Orientation and Gender Identities

(SOGI) Strategy in 2008 to enable grant implementers to overcome challenges that vulnerable groups including, men who have sex with men (MSM), transgender people and sex workers, faced in accessing Global Fund resources (Seale et al., 2010). Revised approaches from The US President's Emergency Plan for AIDS Relief (PEPFAR) allowed its aid to be allocated interventions for people who use drugs, sex workers and MSM (Needle et al., 2012).

The focus on MSM within the global HIV pandemic is largely based on epidemiological evidence that receptive anal sex carries a very high risk of HIV transmission (DeGruttola et al., 1989). Efforts to address African MSM have faced resistance because homosexuality is criminalised throughout much of Africa (Johnson, 2007). A decade ago a World Bank study asserted there was no available epidemiological evidence demonstrating prevalence of HIV among LGBT people, MSM nor male sex workers in Africa (Anyamele et al., 2005). While acknowledging that African countries were mainly concerned with heterosexual HIV transmission UNAIDS suggested increased attention be put on “many infections...occurring in...key populations at higher risk of exposure to HIV - especially among (MSM), a population...often overlooked or not acknowledged by policy-makers” (Joint United Nations Programme on HIV/AIDS, 2009: 9).

Within a few years evidence emerged that showed Eastern and Southern African HIV rates among MSM were highest within generalised heterosexual epidemics with transmission risks from both male and female partners (Needle et al., 2012). Recent analysis of modes of transmission found new infections among MSM to be important dynamics in the epidemics in Kenya and South Africa (Joint United Nations Programme on HIV/AIDS, 2013). Within this context it has been argued that “vulnerability to HIV is also a product of people whose sexualities are silenced...or directly subjugated...lesbian and gay sexualities are disproportionately at risk” (Judge, 2009: 8). While South Africa has improved its capacity to identify key populations vulnerable to HIV, including MSM, there remain blind spots particularly around the risks to HIV and other STIs faced by women in same sex relationships.

2.4 Evidence of STIs, including HIV, among WSW

Lesbians and bisexual women, or women who have sex with women (WSW), have been under-analysed in low and middle income countries as well as in high income countries for a range of health concerns including sexually transmitted infections (STIs). The existing literature uses a variety of terms for this population including lesbian, bisexual or queer women and also refers to women who do not identify in these ways but express same-sex sexuality. This study uses the term women who have sex with women (WSW) a behavioural marker that does not infer sexual identity (Hutchinson et al 2006) but establishes sexual behaviours and associated risks. It has been cautioned that the use of WSW might result in obscuring social dimensions of sexuality (Young and Meyer, 2005) and strips away identity and context which might be important in determining risk (Logie and Gibson, 2013). I decided to use the behavioural marker unless other terms are presented in the literature reviewed or the data collected in order to draw parallels between the behaviour related health needs of lesbian and bisexual women to the approach taken in addressing risks faced by MSM/gay and bisexual men which have greater prominence in global health policy as well as South African health policy discourse.

The public health argument for a focus STI and HIV prevention among WSW has not been strong (Lenke and Piehl, 2009) or at least not as persuasive as the discourse around the risks related to gendered power dynamics in heterosexual relationships and the behavioural risks facing MSM. As a result WSW have been excluded from public health strategies for both women and sexual minorities which they that might have been captured within. This exclusion seems to be in part because “healthcare professionals lack knowledge of lesbian and bisexual women’s specific needs” (Fish and Bewley, 2010:356). WSW who have some sexual contact with men have “lifetime risk for STIs is similar to that of heterosexual women” (Power et al., 2009: 69). WSW also “appear to have significantly higher sexual risk factors (for STIs including HIV) than exclusively heterosexual women” (Koh et al., 2005: 563) such as: higher number of sexual partners; selection of ‘higher risk’ partners, including MSM; and substance abuse (Koh et al., 2005).

Nevertheless there is a common perception that “‘lesbians’ as an identity group are not at risk of HIV or other STIs” (Power et al., 2009: 69). This is regardless of data that shows a

burden of common STIs among WSW including: HPV (Ferris et al., 1996), (Marrazzo et al., 2001); HSV 1 and 2 (Marrazzo and Stine, 2004); bacterial vaginosis (Marrazzo et al., 2002, Marrazzo et al., 2005); trichomaniasis (Sivakumar et al., 1989); (Kellock and O'Mahony, 1996) and syphilis (Campos-Outcalt and Hurwitz, 2002). Despite these findings there are persistent problems in communicating results to “counter the view that the prevalence of STIs is negligible among lesbians, implicitly reinforcing it” (Power et al., 2009: 68).

In the context of HIV/AIDS, misperceptions have resulted in WSW having a sense of invincibility to HIV transmission through the selection of same-sex partners (Dolan and Davis, 2003). This false consciousness which has been termed ‘lesbian immunity’ to HIV “may expose WSW to a much higher risk for contracting HIV than is generally perceived” (Fishman and Anderson, 2003: 53): 53). The lack of data on HIV/AIDS among WSW has resulted in views that the population is at ‘no risk’ or ‘low risk’ for HIV transmission which has in turn “restricted their inclusion in research, education and treatment programmes” (Montcalm and Myer, 2000: 134). Debate around the possibility of female-to-female HIV transmission remains an issue particularly whether it is ‘efficient’ compared to other highly ‘efficient’ transmission routes, such as anal sex among MSM (Richardson, 2000).

Typical HIV infection pathways emphasised in HIV prevention interventions may pertain to WSW behaviours but the population may not see the relevance in sexual health and/or harm reduction information which has been developed for heterosexual women and other populations at higher risk of transmission. Some studies indicate that WSW who have never had heterosexual sex or injected drugs are at risk of acquiring HIV through same-sex sexual behaviour (Power et al., 2009). Thus HIV prevention messages are incomplete for WSW if they do not also focus on the risks present same-sex sexual behaviours (Logie and Gibson, 2013). Studies have suggested that sexual HIV transmission between women can occur through mucosal contact with infected menstrual fluid or vaginal secretions (Chu et al., 1990); complicated where there are abrasions on the hands or internal or external oral sores (Kwakwa and Ghobrial, 2003); and through the sharing of unprotected/non-sanitised sex toys (Kennedy et al., 1995). Direct vaginal-vaginal or oral-vaginal contact is also thought to be capable of HIV transmission even in the absence of trauma or lesions (Rich et al., 1993).

There has been limited collection of epidemiological data on WSW by public health bodies during the HIV pandemic (Arend, 2003). The contestation of existing evidence of the burden of HIV and STIs among WSW and the limited interest in exploring this health challenge further is arguably a denial of WSWs' health rights which can be considered a form of structural violence. (Logie & Gibson 2013: 37) In 2006 the CDC acknowledged that "although there are no confirmed cases of female-to-female transmission of HIV, female sexual contact should be considered a possible means of transmission among WSW" (Centers for Disease Control and Prevention, 2006: 1). CDC guidance was recently updated based on a 2014 study of a previously sero-discordant WSW couple which found HIV transmission was likely to have occurred due to sexual contact between the female partners (Chan et al., 2013). Thus the CDC now recognises that "although rare, HIV transmission between WSW can occur" (ibid: 212). In this case the CDC established "other risk factors for HIV transmission were not reported by the newly infected woman, and the viruses infecting the two women were virtually identical" (ibid: 212). Thus WSW can no longer be considered at 'no risk' for HIV transmission within exclusively same sex partnerships.

Obstacles to expanding the evidence base on STIs including HIV among WSW include funding limitations as well as methodological problems (Meyer, 2001). Because large-scale random surveys of LGBT populations are not only expensive but difficult to carry out due to stigma and discrimination researchers have often used small samples which may be "be biased and uninformative for many public health purposes" (ibid: 857). Because the WSW population is small "modest measurement problems will lead to lack of power and type II error, especially for ambitious stratification analysis of subgroups" (Malterud et al., 2009: 707). While they may be difficult to fund and administer larger population based studies are necessary to define the epidemiology of STIs and HIV among WSW (Gorgos and Marrasso, 2011).

The existing data on WSW sexual health is dominated by research conducted in high income countries. Thus findings may not be generalizable due to differences among WSW, especially wherein opportunities to access to affordable and quality health care are limited (Malterud et al., 2009). But even in high income countries WSW "receive sub optimal care due to a variety of factors at the individual client level, the provider level and the health

care system or macro-social levels” (Hutchinson et al., 2006: 393). WSW often feel judged, dismissed or silenced (Fishman and Anderson, 2003) by health care workers who are unable or unwilling to challenge the construct of heterosexual sex as the only type of sexual behaviour which poses health risks for women (Power et al., 2009). The available data compels public health actors to consider whether a small population of HIV positive WSW could “grow exponentially if their high risk behaviours are not addressed without delay” (Fishman and Anderson, 2003: 54).

2.4.1 The burden of HIV and STIs among WSW in South Africa and Southern Africa

The assertion that WSW are at ‘no risk’ or ‘low risk’ of HIV infection has led to their exclusion in HIV prevention efforts, research and complicated their health care in South Africa as well (Cloete et al., 2011). Evidence demonstrating the prevalence of STIs including HIV among WSW in South Africa and other countries in Southern Africa has been limited. Nevertheless a few studies conducted over the past decade have shown that there are WSW affected by HIV and STIs in the country and the region and point to the need for further investigation and the development of interventions which can avert new infections among this population. A series of provincial surveys undertaken between 2004 and 2006 are considered the first to have presented quantitative data on the health status of LGBT people in South Africa. A summary of their findings is shown in table 2.4.1.

Table 2.4.1 Data from provincial health surveys among LGBT community 2004-2006

Authors, Year	Sample No/ Province	Health Data
(Wells and Polders, 2004b)	216 WSW Gauteng	9% of black WSW HIV + 5% of white WSW HIV +
(Wells and Polders, 2004a)	208 WSW Gauteng	14% of black WSW had recent STI 4% of white WSW had recent STI
(Wells, 2006)	392 WSW and MSM Kwa Zulu Natal	9% WSW HIV+ 11% MSM HIV+ 12% WSW had recent STI
(Rich, 2006)	460 WSW Western Cape	9% of black WSW had recent STI 8% of coloured WSW had recent STI 3% of white WSW had recent STI

The survey conducted in Gauteng province among 487 respondents from the LGBT community, including 216 WSW, found that among 123 WSW that 9% of black WSW

reported they were HIV positive while 5% of white WSW reported they were HIV positive. The authors found these results surprising in that “HIV prevalence for women is high. This is contradictory to a belief that lesbian women are relatively risk free for HIV transmission... some lesbians may have bisexual partners, experience high levels of rape and/or engage in transactional sex with men” (Wells and Polders, 2004b: 14). A subsequent paper from the Gauteng survey presented data on whether respondents had had an STI in the past 24 months. In a sample of 208 WSW 14% black WSW (n = 154) and 4% white WSW (n=54) reported a known STI infection. These percentages were similar to that of both black and white MSM and the authors commented “this finding is in stark contrast with international findings that report lesbians to be relatively risk-free in regard to STIs” (Wells and Polders, 2004a: 3).

The survey conducted in Kwa Zulu Natal province identified that among a sample of 392 LGBT people 9% of WSW were HIV positive and 11% of MSM were HIV positive (Wells, 2006). The author commented that “the HIV prevalence rate for lesbian/bisexual women is high, challenging the belief that this group is at low risk with regard to HIV” (Wells, 2006: 13). The survey of 948 LGBT people in the Western Cape province reflected lower HIV prevalence, 6.5% (62) of the total sample (n=948) which the author asserted was related to data showing “the general population of the Western Cape had the lowest prevalence of HIV of all provinces” (Rich, 2006: 49). Among the WSW surveyed only 1% were HIV positive but a sub-sample of 460 WSW revealed that 9% of black WSW, 8% of coloured WSW and 3% of white WSW had had an STI in the past 24 months. These findings reinforced the Gauteng study by showing higher rates of STIs among WSW of colour compared with white WSW.

This data suggested the need to build a more representational picture of prevalence and incidence of HIV and STIs among WSW in South Africa, particularly among black African women. In a 2010 survey of 641 HIV positive women in South Africa 11% reported that they had ever had sex with a woman and 57% of these WSW indicated that they usually had sex with a woman but also had had sex with men. 76% of HIV positive WSW reported having had an STI, 33% had received money for sex (Cloete et al., 2011). The findings suggested that “WSW are not insulated, by virtue of their same sex desires, from the risks of HIV/AIDS. Even though the study sample is small and only descriptive, the data illustrates a need for

HIV strategies tailored to the needs of WSW” (ibid: 3). Another community based participatory study among WSW in Lesotho argued that “self-identity as a lesbian was not associated with lower likelihood of HIV or STIs, highlighting the importance of behaviour rather than identity in vulnerability to HIV and STIs” (Poteat et al., 2014: 130).

A group of researchers working with LGBT community organisations in Botswana, Namibia, South Africa and Zimbabwe came together in 2009 with funding from the Open Society Initiative for Southern Africa (OSISA) and the United Nations Development Programme (UNDP) to undertake mixed methods research among WSW. Two published outputs of the research project were a quantitative survey and a qualitative study. The quantitative analysis demonstrated that among the 591 women participants from the four Southern African countries 78.3% had ever been tested for HIV, among them 9.6% were HIV positive (Sandfort et al., 2013). The transmission route for 31.7% of the women living with HIV could not be explained by injection drug use or consensual or forced sex with men. (ibid) While this is the case for only 13 women out of 591 surveyed the study established the possibility of female-to-female HIV transmission within hyper endemic contexts of Southern Africa.

The qualitative study included 24 WSW living with HIV in Namibia, South Africa and Zimbabwe with the majority living in South Africa. Nine WSW reported they had been infected by former male partners, eight reported that they had been raped and three of them had an HIV test immediately following the rape and could associate sero-conversion with rape (Matebeni et al., 2013). 20% of the sample self-reported, that their female partners could have possible infected them. These women reported that they had not had sex with men or been exposed through blood in a medical setting or through injection drug use. They had significant difficulty understanding how HIV transmission occurred in their same-sex relationship as “the only possible route of transmission and risky behaviour they could report was sex with other females...they were shocked to find out they had been infected with HIV and could not understand how it happened. They had all believed that because they had only been with women that they were safe...it remains unclear for many of them how transmission could occur between females” (ibid: 6).

Despite this data demonstrating a burden of HIV and other STIs among WSW in South Africa the continued invisibility and marginalisation of the population is leading to their sexual

health needs not being addressed (Tallis, 2007). In the context of HIV/AIDS there is an urgent need for prevention information and advocates have stressed that “safer-sex messages should include lesbian women, bisexual women and WSW and provision should be made for the distribution of prevention technologies for women” (ibid: 224). Targeted HIV and STI prevention interventions for WSW are scarce in South Africa though since, “dental dams and other appropriate barrier methods for lesbian women...are not available in the public sector” (Judge, 2009: 10). As a result it has been argued that WSW are “the most ‘at risk’ group of all, not due to biological susceptibility, but to sheer neglect” (Johnson, 2007: 41).

2.4.2 Violence against WSW in South Africa

Given that GBV is a significant factor in HIV transmission it is essential to understand the scope of sexual violence experienced by WSW. After South Africa’s transition to democracy, gay and lesbian people became more visible because of the Constitution’s assurance of equality (Reid and Walker, 2005). A further set of civil rights, including same sex marriage, were secured by South Africa’s LGBT movement, which is remarkable when compared to an overall negative climate in Africa toward sexual minorities (Johnson, 2007). Nevertheless, homophobic discrimination persists in South Africa and a general population survey showed that 80% of adults feel that same sex behaviour is ‘always wrong’ (Roberts and Reddy, 2008). LGBT people in South Africa experience discrimination and harassment particularly in resource poor settings in rural areas and townships. Within the South African context WSW experience marginalisation “both as women and as women who have sex with women living in a patriarchal, heterosexist society” (Tallis, 2012: 11).

Transgressions of heteronormativity are punished violently in South Africa (Jewkes and Morrell, 2010) and homophobic gender based violence is perpetrated against women who do not conform to gendered and sexual norms (Holland-Muter, 2012); (Bennett et al., 2010). Throughout the country there are numerous cases of WSW being targeted for rape and abuse, at times ending in murder, solely based on their sexuality (Holland-Muter, 2012). These hate crimes have come to be known as ‘corrective rape’ given that perpetrators have stated that they want to ‘correct’ their victim’s sexuality, to ‘cure’ or ‘heterosexualise’ them

(Holland-Muter, 2012); (Bennett et al., 2010). Such crimes are prevalent in South Africa particularly in townships where black WSW experience multiple forms of marginalisation and lack personal security (Martin et al., 2009). Due to the health risks of sexual violence both the Ministry of Justice and the DoH have been compelled to respond to 'corrective rape'. While the associations between sexual violence and vulnerability to HIV and other STIs are clear there is a concern that rape is not seen as the sole HIV and STI risk facing WSW (Logie and Gibson, 2013). That presumption would "continue to constrain lesbian, bisexual and queer women's visibility in HIV discourse and reinforce hierarchies among HIV-positive women based on reported transmission vectors" (ibid: 39).

2.5 Health Policy Analysis

This study utilises a policy analysis approach to understand the process by which WSW's sexual health needs emerged on the 2007-2011 NSP and were re-framed in the 2012-2016 NSP. The conceptual approach of the health policy analysis 'triangle' is helpful in understanding a particular policy, "referred to as *analysis of policy*" (Buse et al., 2012: 18). The triangle is a simplified representation of a set of complex interrelationships which are essential to making health policy: context, content, policy process anchoring the sides of the triangle and actors: individuals, groups and organisations the centre of the triangle (Walt and Gilson, 1994). The elements of each of these components of the health policy analysis triangle and how they relate to the study are explored herein.

The position of actors at the centre of the triangle reflect how individuals, groups and organisations shape policy making. Their power is sometimes executed through the influence of an individual and Buse and colleagues note the role that a particular statesman, such as Nelson Mandela in his role as former president campaigning for a better AIDS response in South Africa, can play. This study will consider the roles that certain individuals have taken within policy processes initiated by SANAC. It is important to note that "individuals cannot be separated from the organisations within which they work" (Buse et al 2012: 9). Organisations have a collective voice, although individuals within them may or may not share a common viewpoint, and also play an important role in policy making. This study will consider the role of organisations including: technical agencies, such as UNAIDS;

bilateral donors; public sector bodies, such as the DoH; and civil society organisations working in the response to HIV including LGBT community organisations. Groups, including social movements, coalesce around particular issues and impact policy making. This study will consider ad-hoc groups of advocates who made interventions into the NSP development process as well as others that were previously influential in raising issues on behalf of WSW.

The element of context in the triangle can be defined as the systemic factors that may have an effect on health policy such as: situational factors sometimes referred to as ‘focusing events’; structural factors like the political system; cultural factors including stigma and discrimination and international or exogenous factors demonstrating influence on national sovereignty (Leichter, 1979). Buse and colleagues assert that understanding how health policies change, or do not, requires an ability to analyse the context in which policy is made and whether these factors influence policy outcomes (Buse et al., 2012). In this study South Africa’s fluctuating political, social, cultural and economic context will be considered with attention to focusing events in 2007 and 2011 when the editions of the NSP were being developed. The element of policy content has been defined as the “substance of a particular policy which details its constituent parts” (ibid: 4). It is the actual text which sets out and describes what a policy intends to achieve including aims, objectives, goals and targets and how it will seek to meet them. This study considers the content of the South African National Strategic Plan on HIV and STIs 2007-2011 and 2012-2016, the mid-term and final evaluation of the 2007-2011 NSP and selected submissions to the consultation to develop the 2012-2016 NSP.

Policy process has been described through the application of the stages heuristic, a framework which has been refined over time and sets out the stages of: agenda setting, formulation, decision making/legitimation, implementation and evaluation (Sabatier and Jenkins-Smith, 1993). Agenda Setting refers to the process by which problems come to the attention of government (Howlett et al., 1995). This involves the recognition of problems and usually a set of problems are considered and prioritised (Kingdon, 2003). Formulation is the stage in which policy options to respond to problems are presented and discussed (Howlett et al., 1995). Decision making is the actual process by which a choice is made amongst the policy alternatives that have been generated (Brewer and DeLeon, 1983).

Implementation is the stage at which the agreed policy is carried out, wherein plans are translated into practice (McLaughlin, 1985). In the case of a multi-year plan, such as the NSPs, this is a protracted period. Evaluation is the stage at which policy in action is considered in terms of the means employed and the objectives that have been reached or not (Howlett et al., 1995).

A framework for the determinants of political priority in global health initiatives suggested by Shiffman and Smith (2007) responds to the need to understand why initiatives that pursue social or political change succeed or fail to attract political support. Their framework is summarised in Table 2.5 and considered factors that drive several key stages of the health policy process including: agenda setting; formulation and decision making. The framework outlines “the power of actors connected with the issue; the power of ideas used to define and describe the issue; the power of political context to inhibit or enhance political support; and the power of some characteristics of the issue, such as the number of deaths a particular disease causes, to inspire action” (Shiffman and Smith, 2007:1371).

I chose to use this framework as a basis of my analysis as it allowed me to consistently consider across two time periods how a variety of factors within actor power, ideas, political contexts and issue characteristics play a role in which voices and what messages are listened to as well as why and how health issues gain sufficient recognition in order to be integrated into policy. I adapted the framework to reflect the categories for determinates of political priority for WSW issues to be included in South Africa’s NSP and to highlight features of Kingdon’s (2003) theories particularly: the politics stream, the problem stream, policy windows and policy entrepreneurs. An advantage of using a framework Kingdon’s (2003) concept of the streams of problems, policies and politics also consider how a policy output is arrived at as the streams exist independently of one another but can converge and effect great policy agenda change.

The streams come together at crucial times, known as a policy window, where “a problem is recognised, a solution is developed and available in the policy community”(Kingdon, 2003: 165). Kingdon found that the policy window is an “opportunity for advocates...to push attention to their special problems” (ibid: 165). These advocates are also known as policy

entrepreneurs who are actors that “are more than mere advocates of particular solutions; they are power brokers...When policy windows open, policy entrepreneurs must immediately seize the opportunity to initiate action. Otherwise the opportunity is lost” (Zahariadis, 2007: 73).

I was cognisant of a number of caveats to be considered when applying simplified frameworks in policy analysis. For instance while the policy triangle helps to represent a highly complex interaction within policy making it has been critiqued for lack of consideration of other factors which explain how and why policies change, particularly how policy making institutions, actors’ interests and their ideas may change over time and as such re-define problems (Buse et al., 2012). Similarly the policy stages model (stages heuristic) presents a somewhat linear process where stages proceed smoothly when in reality it is “seldom so clear or obvious a process” (ibid: 14). Frameworks simplify complex realities and do not explain cause and effect but lead a policy analyst to consider different factors which may effect change. There is a risk that this may set up analysis to miss out factors not specified in them but as I applied the adapted framework I allowed for themes and factors to emerge.

I chose to incorporate features of Kingdon’s model although it has been criticised for a lack of clarity on the policy stream (Exworthy and Powell 2004) as well as for being ‘too circumstantial’ (Howlett and Ramesh 1995). Nevertheless I adapted the framework to include Kingdon’s concepts of policy windows and policy entrepreneurs as I found these allowed me to identify and explain findings around the power of personal testimony at a time when participation of civil society actors in policy making for the response to HIV/AIDS in South Africa had greater influence than it had previously, and indeed subsequently.

Table 2.5 The four categories for the framework on determinants of political priority of global health initiatives. (Shiffman and Smith, 2007: 1371)

	Description	Factors shaping political priority
Actor Power	The strength of the individuals and organisations concerned with the issue	<ol style="list-style-type: none"> 1. Policy community cohesion: the degree of coalescence among the network of individuals and organisations that are centrally involved with the issue at the global level 2. Leadership: the presence of individuals capable of uniting the policy community and acknowledged as particularly strong champions for the cause. 3. Guiding institutions: the effectiveness of organisations or coordinating mechanisms with a mandate to lead the initiative 4. Civil society mobilisation: the extent to which grassroots organisations have mobilised to press international and national political authorities to address the issue at the global level
Ideas	The ways in which those involved with the issue understand and portray it	<ol style="list-style-type: none"> 5. Internal frame: the degree to which the policy community agrees on the definition of, causes of, and solutions to the problem 6. External frame: public portrayals of the issue in ways that resonate with external audiences, especially the political leaders who control resources
Political contexts	The environment in which actors operate	<ol style="list-style-type: none"> 7. Policy windows: political moments when global conditions align favourably for an issue, presenting opportunities for advocates to influence decision makers 8. Global governance structure: the degree to which norms and institutions operating in a sector provide a platform for effective collective action.
Issue Characteristics	Features of the problem	<ol style="list-style-type: none"> 9. Credible indicators: clear measures that show severity of the problem and that can be used to monitor progress 10. Severity: the size of the burden relative to other problems, as indicated by objective measures such as mortality levels 11. Effective interventions: the extent to which proposed means of addressing the problem are clearly explained, cost effective, backed by scientific evidence, simple to implement, and inexpensive

2.5.1 Analysis of National Strategic Plans on HIV/AIDS

Since the late 1990s UNAIDS urged countries responding to HIV/AIDS to undertake strategic planning in order to identify “the main personal, societal, and environmental factors...that eventually expose people to HIV infection...to focus on those strategies that have the potential to alter the situation” (UNAIDS 1998: 4). NSPs have been critiqued for not having sufficient influence over the planning and implementation of all the sectors of government required to marshal an effective response to national HIV/AIDS epidemics (England 2006).

Analysis of national strategic plans (NSP) on HIV/AIDS have been conducted in other contexts with attention to how they have framed structural drivers affecting vulnerability to HIV and social marginalisation affecting access to HIV/AIDS services. For example, an international review by Gruskin and Tarantola (2008) considered how human rights and social barriers to access had been framed in 14 NSPs¹ as countries aspired to scale up HIV/AIDS services following UN commitment to universal access. The study noted that most of these NSPs explicitly referred to human rights but few neither noted how stigma and discrimination impose barriers to access nor highlighted the importance of participation of affected communities in NSP development and service delivery. The authors were encouraged that ‘vulnerable populations’, including sex workers, injecting drug users and MSM, had been identified in more NSPs but urged greater clarity around addressing these and other populations’ barriers to accessing services.

A recent systematic review of African NSPs presented the inclusion of MSM in national responses across the continent and found most African governments exhibited neither adequate knowledge of epidemic dynamics among MSM nor the social dynamics behind African MSM’s HIV risk. Of 34 African NSPs 22 identified MSM as being ‘most at risk’ for HIV infection while 10 acknowledged the role of social stigma and marginalisation with 11 noting criminalisation of same sex sexuality as a factor in the population’s vulnerability. (Makofane et al 2013)

¹ National documents reviewed: Brazil, Botswana, China, Germany, India, Indonesia, Kenya, Myanmar, Nigeria, Papua New Guinea, Pakistan, Peru, South Africa (2007-2011 NSP), and Vietnam.

2.5.2 Review of Health Policy Analysis of South Africa's NSPs

Given the large number of actors involved in South African HIV/AIDS programming the policy response has been commented upon by many researchers. Wouters and colleagues undertook an overarching analysis of the 2007-2011 NSP through the elements of the health policy analysis triangle (Wouters et al., 2010). They found that that the content was dynamic and comprehensive, the process was ideal in terms of participation and consultation, actors were meaningfully engaged following the “reconciliation between Government and civil society” (Wouters et al., 2010: 179) but policy context was fraught following a poor record of policy implementation as well as resource limitations including a lack of human resources for health service delivery. They cautioned that while the 2007-2011 NSP was a “dynamic and comprehensive”(Wouters et al., 2010: 181) document past policy failures demonstrated that context, in particular, might be the undoing of a well written plan.

Other reviews of the content of NSPs have sought to highlight whether they are serve to address gender inequalities driving women's vulnerability to HIV. An analysis of 20 southern and eastern African NSPs was undertaken using a framework for responding to women, girls and gender equality within NSPs (Gibbs et al., 2012a). South Africa's 2007-2011 NSP rated better in comparison with other countries in framing policy to address indicators of gender inequality such as: an enabling environment advancing human rights and access to justice; utilising a sexual and reproductive health and rights approach; preventing HIV transmission among women and girls; eliminating GBV and discrimination; increasing access to and uptake of treatment for women and girls and strengthening care and support by and for women and girls (ibid). South Africa's NSP was seen to be remiss in: setting clear processes and mechanisms for the meaningful involvement of and leadership by women living with and affected by HIV; interventions to alleviate stigma and discrimination on the basis of HIV status, gender and sexual orientation in institutions including health services (ibid).

A further analysis by the same authors considers how NSPs might more effectively frame policies to work against GBV and found that “although NSPs provide a useful opportunity to address a key human rights violation and driver of HIV, they are not doing so in their current form” (Gibbs et al., 2012b: 18). South Africa and three other countries were considered to have framed policies that approach GBV holistically in that they encompass economic or

psychological violence (ibid). Importantly neither South Africa nor the other 19 countries had outlined policy guidance for interventions to halt and address violence against lesbian, bisexual and transgender women (ibid). The authors also lament that the dominant ideology that HIV/AIDS in Africa is a heterosexual epidemic meant that “within NSPs women’s relationships are assumed to be monogamous and heterosexual, denying the rights of lesbian, bisexual and transgender women and female sex workers who do not conform to narrow stereotypes” (ibid: 18).

A commentary on South Africa’s 2007-2011 NSP identified concerns around how the goals and objectives were framed against the prevailing gender inequalities which are one of the contributing factors of the burden of HIV/AIDS among women. The reviewer found that the NSP did not adequately recognise the gendered social context and as such “the question as to whether or not women are indeed the adequate ‘target’ for interventions as compared to ‘targeting’ the societal context”(Kehler, 2007b: 11). Kehler suggested this would require addressing prevailing beliefs and values that define women’s subordinate status and underlie women’s greater vulnerability to HIV transmission as well as acknowledging the inherent limits that this places upon women being able to take greater control of their health and sexual rights (ibid).

Kehler considered the inclusion of MSM in the 2007-2011 NSP commendable particularly since at the time there was “limited consideration of MSM...due to the lack of knowledge of the current HIV pandemic amongst men who have sex with men” (ibid: 15). However she expressed concern that the NSP did not recognise WSW as a “population at higher risk” (ibid: 15). The NSP was also critiqued for not acknowledging that stigma, discrimination and violence against MSM and WSW places limits on their access to HIV prevention information and commodities and thus increases risk of HIV transmission. While Kehler acknowledged that there was scarce data regarding HIV prevalence among WSW she called into question whether the NSP could be assessed for its targeting of populations at higher risk if WSW were not “understood as an integral part of the ‘populations at higher risk’” (ibid: 15).

A subsequent critical review by Kehler of South Africa’s 2012-2016 NSP again took issue with the omission of WSW within the list of key populations particularly since “‘*women who have sex with women*’ – as defined by the NSP – may also engage in heterosexual sexual relations

and should thus form an integral part of the national response to HIV” (Kehler, 2012: 10). While Kehler again recognised that there was limited epidemiological data about HIV prevalence among WSW, evidence of their increased risks of sexual violence, specifically hate crimes targeting WSW, was compelling. Thus the NSP was critiqued for seeming to “to lack the understanding that sexual orientation and/or gender identity is as much a ‘*high risk*’ factor for women who engage in same-sex relations, as it is for men who engage in same sex relations” (ibid: 10). Kehler expressed that the concern remains that if WSW are excluded from the NSP then “their realities, risks and needs...will be excluded from the national response to HIV” (ibid: 10).

Conclusion

This chapter has presented the contextual background of relevant features of the policy response to HIV/AIDS in South Africa. The empirical literature which has been presented herein provides the epidemiological justification for policy analysis of WSW in the context of South Africa’s HIV epidemic and response to STIs. It has established that, while not well recognised or understood, in various settings including South Africa, WSW face multiple vulnerabilities to STIs including HIV. While it is a small population within a heavily burdened generalised epidemic it remains important to examine how and why WSW were initially included in policy to respond to HIV and STIs in South Africa and how the policy space afforded to raise those concerns changed over time.

While existing reviews of the content of South Africa’s NSPs helped highlight issues that might require greater policy attention no study has provided insight into the stages of agenda setting, formulation and decision making and the various contextual factors which influence why issues related to WSW have been selected for inclusion in the NSP. This study fills a gap in the literature by providing analysis of some factors shaping the process around NSP development and how they have been utilised to position WSW sexual health needs as a policy priority.

There has been a specific call for research into the process through which the interests of WSW have been represented in South Africa’s HIV/AIDS policy. It has been suggested such research seek to address questions such as “why did it take so long for same-sex sexuality to

be included in South Africa's National Strategic Plan...what attention is being paid to same-sex sexuality in policy and how can research based advocacy influence this?" (Sandfort et al., 2007: 236). It was recommended that pursuit of answers to these questions should take into consideration the context around developing South Africa's HIV/AIDS policy, the social context of MSM and WSW and the role of LGBT organisations in the response to HIV/AIDS (ibid). This study seeks to answer these and other pertinent questions and contributes to Health Policy Analysis literature and specifically to reviews of NSPs including South Africa's.

Chapter 3: RESEARCH STUDY METHODS AND CONCEPTUAL FRAMEWORK

Introduction

This chapter explains the conceptual framework used for the study, describes the data collection and analysis methods, the research sample and justifies why they were employed. It also presents how I maintained research ethics, validity and reliability and reflected on my process as a researcher.

3.1 Conceptual Framework

In order to analyse the process by which issues regarding WSW sexual health needs emerged onto the 2007-2011 NSP and were re-framed in the 2012-2016 NSP I adapted Shiffman and Smith's framework (2007) on the generation of political priority for global health initiatives which is presented in Chapter 2.

Table 3.1 illustrates the resulting adapted framework which was utilised to observe the determinants of political priority for WSW issues to be included in South Africa's NSP. Utilisation of the framework supported the study's ability to identify which of these were most central to achieving commitments to WSW health issues in South African policy on HIV and STIs over the two policy formulation periods. The framework incorporates all of the factors outlined in the health policy analysis triangle (Walt and Gilson, 1994) including: context, content, process and actors: individuals, groups and organisations.

The analysis of the process by which WSW's sexual health needs emerged on the 2007-2011 NSP and were re-framed in the 2012-2016 NSP considers the stages heuristic (Sabatier and Jenkins-Smith, 1993). In Chapter 4 it analyses the emergence of WSW issues within the objectives of 2007-2011 NSP through agenda setting, formulation, decision making/legitimation and then considers what evidence of implementation exists, to fulfil WSW related objectives, in the mid-term and final evaluations of the 2007-2011 NSP. Chapter 5 then reflects again on the process stages of agenda setting, formulation and decision making/legitimation stages in the development of the 2012-2016 NSP.

	Description	Factors shaping political priority
Actor Power	The strength and influence of the individuals and organisations representing WSW issues in the NSP development process.	<p>Policy community cohesion: the degree of coalescence in the networks of individuals and organisations involved with NSP development.</p> <p><i>Policy Entrepreneurs</i>: the presence of individuals who seize opportunities, are capable of uniting the policy community and acknowledged as strong champions for WSW.</p> <p>Guiding institutions: the effectiveness of DoH and SANAC mandated to coordinate the NSP.</p> <p>Civil society mobilisation: the extent to which grassroots organisations have mobilised together to press national authorities to address WSW issues e.g. LGBT organisations.</p> <p>Competition and conflict: both within civil society sectors and between civil society actors and public sector leadership.</p>
Ideas	The ways in which those representing WSW sexual health concerns understand and portray them.	<p>Internal frame: the degree to which the policy community agrees on the vulnerability of WSW to HIV and STIs.</p> <p>External frame: portrayals of WSW concerns in ways that resonate with the general public, especially political leaders who control resources e.g. media coverage of violence against WSW.</p>
Political Contexts	The political/socio/economic environment in which actors operate: <i>the politics stream</i> .	<p><i>Policy windows</i>: political moments when conditions aligned favourably for WSW issues and have presented opportunities for advocates to influence decision makers.</p> <p>Governance structure: the degree to which norms and institutions guiding NSP development provide a platform for effective collective action.</p>
Issue Characteristics	Features of problems of WSW sexual health: <i>the problem stream</i> .	<p>Credible indicators: clear measures that show the severity of WSW sexual health problems which can be used to monitor progress.</p> <p>Severity: the size of the burden of HIV and STIs among WSW, as indicated by objective measures.</p> <p>Effective interventions: the extent to which proposed interventions to address the vulnerability of WSW to HIV and STIs are clearly explained, cost effective, backed by scientific evidence, simple to implement, inexpensive as demonstrated by implementation evidence .</p>

Adapted from (Shiffman and Smith, 2007: 1371); (Kingdon, 2003: 227-228)

3.2 Study Approach

Given that the study sought answers to questions regarding ‘*why*’ and ‘*how*’ rather than ‘*how many*’ or ‘*how much*’ (Green and Thorogood, 2009) I used qualitative methods. Applying qualitative methods helped in depth investigation of complex and multi-dimensional contexts (such as political/socio/economic context) and multi-sectoral in order to reveal subjective experiences and/or meanings. This approach also helped to capture knowledge not documented elsewhere which is particularly useful when dealing with issues related to a marginalised community which often lacks visibility. Also a qualitative approach allowed for the flexibility to capture and explore themes as they emerged in the course of data collection. I was able to see beyond initial perceptions of issues related to my research question that I had gained through preliminary review of the literature and develop further insight in preliminary discussions with relevant stakeholders and take this further over the course of data collection, analysis and writing.

3.3 Data collection methods

Two data collection methods: semi structured interviews and document review were used to find information to satisfy the objectives and sub objectives. They were utilised as either principal or supplementary data collection sources as shown in Table 3.3.

Table 3.3 Application of data collection methods to achieve study objectives.

Study Objective	Data collection method	
	Semi structured interviews	Document review
1. To analyse why and how initiatives targeted toward WSW as a population vulnerable to HIV and poor sexual health were included in the 2007-2011 NSP considering:		
i. how the factors of actor power, ideas, political context and issue characteristics shaped the policy process, content and context;	Supplementary	Principal
ii. what the policy content of the 2007-2011 NSP indicated should be done to improve the sexual health of WSW.	Supplementary	Principal
iii. what implementation evidence exists for interventions targeting WSW.	Supplementary	Principal
2. To understand why there was a change in focus on WSW in the 2012-2016 NSP through analysis of:		
i. emerging evidence, political context, actor power and cohesion ideas	Principal	Literature Review
ii. the participatory process and how it shaped the content of that NSP	Principal	Supplementary
iii. how policy content on WSW differs in the 2012-2016 NSP.	Principal	Supplementary

3. To suggest relevant recommendations which may provide insight to policy actors, particularly within SANAC, concerned with developing policy to address the sexual health of WSW.	Principal	Did not use
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3.3.1 Semi structured interviews

Interviews are a common method of producing data for qualitative health research is grounded in the value of an informant’s perspective being “meaningful, knowable, and able to be made explicit”(Patton, 2002: 341). During seven weeks between late October and mid December 2013 I conducted 25 semi structured interviews in Cape Town, Durban, Johannesburg and Pretoria, South Africa. Three of these were conducted via Skype as individuals were abroad.

Approach

The methodological approach to this qualitative research study was interpretive in that it offers understanding from the point of view of the participants in it (Green and Thorogood, 2009). In an interpretive inquiry the idea of theory-free observation is problematized given that researchers can never capture reality exactly as it is as they cannot eliminate the influence of particular interests, influences and purposes (Smith, 2008). An interpretive view does not question that there is a definable truth accessible through the conduct of qualitative research but is concerned with the researcher’s interpretation of this truth as well as ways that research subjects make sense of the reality of their own environment and social context. For this study an interpretive approach was appropriate as I have relied on methods associated with it such as interviews and analysis of existing texts which allow meaning to emerge from the research process, particularly through dialogue (Qualitative Research Guidelines Project, 2014). Interpretation can present challenges when informing public health interventions developed to respond to the burden of poor health as evidenced by health metrics and other ‘hard’ data. For example, informants recounted varied reactions to the presentation of ‘anecdotal’ evidence in SANAC policy processes such as personal testimony from WSW living with HIV, which I will reflect on further in the discussion in Chapter 6.

Sampling

The sampling approach I used was purposive, this approach is used when a researcher intends to select informants based on their specialist knowledge of the issues and processes being analysed (Oliver, 2006). I began identifying key individuals working in organisations representing several constituencies involved with: research, advocacy or service provision in relation to WSW and others engaged in the consultations to frame the NSPs 2007-2011 and 2012-2016. For the conduct of the study I had the status of Research Associate with the Gender Equality and HIV Programme at the Health Economics and HIV and AIDS Research Division (HEARD) of the University of Kwa Zulu Natal in Durban, South Africa. My collaborators at HEARD and I discussed which actors it would be ideal for me to approach. They provided introductions to three key stakeholders with whom I discussed my study approach during a feasibility study undertaken in South Africa in August 2013. These stakeholders, and an additional one that I identified independently, referred me to other potential informants through snowballing, a method of sampling using “a small pool of initial informants to nominate other participants who meet the eligibility criteria for a study” (Morgan, 2008: 816).

Once I was in South Africa and working to set up interviews I identified six other actors which I determined important to include through another round of snowballing. I compiled a list of 40 prospective informants and inclusion centred on whether they or their organisation: had been engaged in NSP development in 2007 or 2011; was a member of SANAC; provided technical assistance to SANAC; or was involved in the development of evidence on the impact of HIV and STIs among WSW or other populations. I maintained a firm handle on the inclusion and exclusion criteria and drew clear boundaries around possible informants as the response to HIV and STIs in South Africa is made up of many actors e.g. SANAC includes 19 separate civil society sectors. There were actors who I decided not to approach because they were not directly engaged in the processes being analysed, such as other researchers.

My final sample included 25 key informants representing the following constituencies: academics; bilateral donors; civil society HIV organisations; faith based organisation; health service provider; LGBT organisations; multilaterals; private donors; and public sector (see

Appendix F). These were essential constituencies from which to select actors and are aligned to the factors explored when applying the framework for example: public sector representatives provided insight to the guiding institutions; LGBT organisations and other civil society organisations shed light on civil society mobilisation (LGBT organisations are distinguished from other civil society organisations given that they are directly concerned with representation of LGBT community concerns); donors grounded the external political and socio/economic context and activists and other researchers gave perspective on ideas and issue characteristics. I worked to ensure that these different constituencies, particularly from within civil society, would elicit a range of perspectives on participation in the NSP development process and collect a wide range of views about the relevance of WSW issues to the process. Appendix F presents the total sample indicating the constituencies represented and their locations. The total from each constituency are: academics 2; bilateral donors 2; civil society HIV organisations 4; faith based organisation 1; health service provider 1; LGBT organisations 4; multilaterals 2; private donors 2; public sector 8.

Interviewing in practice

The time I was able to make available to be in South Africa continuously was one of the main study limitations. After passing my Dr PH review on 7 October 2013 and receiving ethical approval on 21 October I commenced data collection on 29 October 2013. My last in country interview was on 10 December 2013. Having obtained a representational sample from the relevant constituencies I choose not to return to South Africa for further interviews.

During data collection I faced some limitations in peoples' time and interest in participating and six individuals did not respond to repeat invitations. Nine others responded to decline though several of these suggested other relevant informants. I do not feel these missed opportunities were significant as I was often able to speak to someone else representing the same constituency. There is a gap in capturing the perspective of SANAC executive leadership. I was unable to contact the former Executive Director (ED) of SANAC who moved on before drafting of the 2012-2016 NSP began. An interim ED was in place during the development of the 2012 -2016. I did not approach the current ED as they came into post in 2012 and thus would be unable to reflect on previous NSP development. I interviewed

members of the drafting team of the NSP, including from the DoH, thus had insight into actors who steered the process at a time when the influence of the SANAC executive leadership was limited.

Within the LGBT sector there are gaps from two prospective informants. I intended to interview informants from the three oldest LGBT community organisations in South Africa but was unable to include the Triangle Project, based in Cape Town. They did not have an Executive Director in post and the previous ED declined to be interviewed. Their Health and Support Services Manager was willing to participate but was travelling extensively during the period I was in Cape Town and did not respond to subsequent contacts. I also hoped to include the Director of the Coalition of African Lesbians. I had secured agreement to conduct an interview via Skype while the Director was travelling abroad but was unable to fix an appointment after repeated attempts. In both cases the prospective informants were willing to speak but competing demands prohibited their participation.

Most of the informants I contacted were very receptive to being interviewed and expressed interest and support for the issues I was trying to analyse and understand. I had to be vigilant in confirming their availability during the time I was in their location and during a very busy time at the end of the year. I was able to respond to openings in their schedule at short notice. There were some opportunistic opportunities to approach informants as I progressed especially given that I was able to attend the 17th International Conference and AIDS and STIs in Africa (ICASA) held in Cape Town December 7-11 where I conducted a few interviews with informants based elsewhere in South Africa.

I took a standard approach in practice during over half of the interviews wherein: I was able to sequence the questions from the topic guide in a similar manner; the informant contributed a response to the majority of the questions posed and the interview took place within one hour. There was varied approach to the sequencing of questions and attention to themes in the remainder of interviews as some informants were able to concentrate more on certain aspects I raised with them.

Data capture

As I have indicated, during interviews I utilised a topic guide (Appendix A) which was drafted for the DrPH review and subsequently finalised in advance of data collection. The topic guide follows from the factors being analysed in the framework and allowed me to structure the conversation to elicit data to explore these factors corresponding to the objectives. I didn't find reason to significantly revise the topic guide after applying it in the first several interviews but did not use a few of the follow up questions and/or probes. I recorded interviews using the voice memo app of an Apple i phone 4 and had a digital sound recorder available as a back-up. I took notes during interviews along with recording as a back-up in case of loss of transcripts before transcription and to highlight issues I would need to follow up e.g. an individual who was mentioned or a document that was recommended that I read or that the informant would send to me afterward. I achieved saturation of data on the range of issues explored with informants using the topic guide. There were neither significant gaps nor unexplained issues, there was some repetition of key findings and ultimately I had more data than required to explore themes in the results chapters.

3.3.2 Document review

Most qualitative studies draw on public documents to provide background information or to analyse content to answer the research question. (Silverman, 2006) The standard approach to document analysis focuses on, "what is contained within them...documents are viewed as conduits of communication between, say, a writer and a reader—conduits that contain meaningful messages"(Prior, 2008: 230). The public documents which have been analysed for this study represent the content element of the policy analysis triangle (Walt and Gilson, 1994) and are the essential conduit with which to accurately reflect what commitments were actually made by the South African Government in national policy and were utilised to verify statements made by informants about these commitments.

Document review of official publications were used as a principal method to achieve study objective 1: to describe how initiatives targeted toward WSW as a population vulnerable to HIV and poor sexual health were: originally outlined, what evidence exists for initial implementation of these strategies, and how the objectives differ between the two editions of the NSP. The selection criteria was strict and included only: the previous (2007-2011) and

current (2012-2016) editions of the NSP, official evaluations of the implementation of the 2007-2011 NSP and a report published by the Government which was cited by informants as influential in setting indicators for the 2012-2016 NSP. I accessed these strategic plans and evaluations through web searches and accessed the other two documents while in the field. I confirmed with informants that the selection of official documents, particularly the available evaluations, was complete.

Table 3.3.2: Official documents reviewed

HIV & AIDS and STI Strategic Plan for South Africa 2007-2011, Republic of South Africa, 2007
National Strategic Plan on HIV, STIs and TB 2012-2016, Republic of South Africa, 2011
National Strategic Plan 2007-2011 Mid Term Review, South Africa National AIDS Council, 2009
Final Report End of Term Review of the NSP 2007-2011, South Africa National AIDS Council, 2011
Know Your Epidemic, Know Your Response, Summary Report, South African National AIDS Council, 2011

Another set of public documents concerned with the development of the 2012-2016 NSP were included for review as a supplementary method to achieve objective 2: to understand what factors led to the change in focus between the two editions of the NSP particularly the position, ideas and interests of key actors. These documents, accessed while in the field, are listed in Table 3.3.3 and included: policy recommendations made in advance of the development of the 2012-2016 NSP; policy recommendations on the NSP draft and other submissions to the consultation from groups aligned with LGBT and or women's rights issues; iterations of the 2012-2016 NSP during drafting showing comments from consultation participants; and correspondence between SANAC and civil society addressing concerns about the NSP consultation process.

Table 3.3.3: Documents reviewed related to development of 2012-2016 NSP

Title	Type of document
Key Populations, Key Solutions Gap Analysis. Desmond Tutu HIV Foundation, Joint UN Team on HIV and AIDS, South Africa, 2011	Policy Analysis recommendations pre NSP development
'Draft Zero' South Africa National Strategic Plan 2012-2016 Recommendations submitted by: HEARD, ATHENA and World AIDS Campaign	Policy Recommendations on Draft 0

NSP 2012-2016 Submission On Overall Structure Of Draft Zero: What Is A Strategic Plan? Section 27	Policy Recommendations on Draft 0
Submission to SANAC on NSP Draft Zero, Encompassing HIV prevention within a Sexual and Reproductive Health and Rights (SRHR) Framework. Marie Stopes South Africa, IPAS South Africa, WISH consultants, Childline Rocks, NACOSA	Policy Recommendations on Draft 0
NSP 2012-2016 Draft 2 Submission on Strategic Objective 4: Protection of Human Rights and Promotion of Access to Justice, Law Human Rights, and Key Groups. HEARD, ATHENA and WAC	Comments on Draft 2
SANAC Women’s Sector and LGBTI Sector Submission October 2011	Comments on Draft 2
South African National AIDS Council Women’s Sector, NSP Drafting Summit Letter of Concern	Letter to SANAC Leadership
The SANAC NSP Process and Roadmap, 2011 A Response to Factual Issues in the Women’s Sector Letter of Concern	Letter from SANAC Deputy Chair

They were helpful in determining how actors framed ideas and raised concerns about issue characteristics and argued for their inclusion in goals and objectives of the NSP. They also provided some insight into the parameters around participation, particularly the timeline afforded by SANC for inputs.

3.4 Data analysis

Data collected through the application of qualitative methods is essentially about, “detection and the tasks of defining, categorising, theorising, explaining, exploring and mapping” (Ritchie and Spencer, 1994:176). I used an approach suggested by Green (2005) by taking initial steps to prepare the data, including transcription, and familiarise myself with the data and then undertook thematic analysis including developing a coding scheme, coding every transcript and reflecting on the key headings or themes to structure the results chapters. These steps are described below.

Transcription: I personally transcribed each recorded interview verbatim within a short span of time following the interview (one to six weeks between conducting the interview and transcribing). Having handled this myself helps to verify the accuracy of the data presented. Additionally field notes taken during the course of interviews were on hand in case there

was any problem in accessing the sound recordings but I did not face difficulties understanding the speakers' words.

Familiarisation: I read and re-read transcripts to refresh my memory of what informants said and in order to reflect on themes and how they could be presented.

Thematic Analysis: Using the NVivo 10 research software for qualitative analysis I constructed a coding framework aligned to my study objectives and a series of "nodes" (themes) which capture issues as they related to the conceptual framework utilised (as detailed in section 3.1) as well as themes that emerged in the interviews. I arrived at the final set of nodes by determining common issues that arose from the sub objectives and the framework. I then imported all 25 transcripts into NVivo and individually coded each transcript based on the thematic nodes.

Reflection: it was crucial to take the analysis beyond basic description and begin to develop hypothesis about the data (Mays and Pope, 2006). I mainly reflected as I wrote the results chapters, reflecting as I progressed and identifying issues to take up in the discussion chapter.

Chapters 4 and 5 include the results of the study and reflect my utilisation of the adapted framework (section 3.1) and the theories behind it in order to demonstrate how policy stages and factors for enhancing political priority were utilised to get WSW sexual health concerns on the NSP agenda as well as when these were not in evidence and/or when other factors came into play.

3.5 Validity and reliability

To ensure the quality of research it is crucial to demonstrate that the research is valid and reliable. This can be somewhat complex when applying qualitative methods as, "the issue of quality in qualitative research is part of a much larger and contested debate about the nature of the knowledge produced by qualitative research, whether its quality can legitimately be judged and, if so, how" (Mays and Pope, 2006: 82). Being situated in an interpretive approach allows for validity and reliability to be presented. I adopted Lincoln

and Guba's (1985) approach to naturalistic inquiry, which draws information from people in their natural settings, offers a revised set of criteria to establish the quality of qualitative research including maintaining credibility, transferability, dependability and confirmability (Seale, 2012: 535). Credibility is concerned with whether the results are a true/valid representation of reality. Transferability is a measure of determining if the results can be applied and/or generalised in other contexts. Dependability is in regards to whether the results will be consistent and reliable if the same research steps are repeated. Confirmability is concerned with showing that if the data is collected in a comparable manner by another researcher with they find the same results.

To show that my research approach was credible, and demonstrate internal validity characterised by engagement in the field, persistent observation and triangulation methods, I performed data triangulation as shown in Table 3.3 which reviews how the two data collection methods were used as a principal or supplementary method to confirm findings. The topic guide (Appendix A) shows that: I used open questions, avoided leading questions, began with more general questions before going into specifics and used clear language to avoid misunderstanding. I also focused mainly on current issues, such as the NSP development process in 2011, to avoid recall bias but did need some information on the 2007 process and used the data which informants expressed they were confident that they could convey what transpired during that time. I asked for concrete examples and drilled down into issues in follow up questions. I was certain to pick up inconsistencies emerging across informants recollections and establish an accurate record to the best of my ability. I also sought to establish rapport and maintain privacy and ensure confidentiality so that informants could be as open as possible.

Transferability is concerned with generalising from a sample to a wider group and to demonstrate external validity through representative sampling which offers findings that could be true for other populations. I believe that these findings centring on how WSW specific concerns emerged within NSP development could be generalised if one were to consider the position of another group within the LGBT sector, particularly transgendered people, or analyse another marginalised population in South African health policy development such as people with disabilities. I have sought to provide a 'thick' description

of the South African socio-political context and particularly the organisational context with the SANAC and its members to establish what is unique to this study. By following the NSP processes, a strategic planning method used in the HIV/AIDS response in many other countries, there are aspects that will be similar in other settings.

Dependability of the study to demonstrate reliability and objectivity can be confirmed by the systems I have used to document the primary data collected, the methods employed as explained herein and my decision making process. I ensured that the questions asked were consistently understood by interviewees and that I became accustomed to a standard style of working through the topic guide. I used a sound recording to ensure a reliable way of data capture that could ensure I had the exact language used by informants. Using the modified framework I sought to use a standard set of analytical categories that would be consistently understood by other researchers.

Confirmability in a naturalistic inquiry is not considered as a matter of establishing “proof whereby readers are compelled to accept an account” (Seale, 2012: 537) but to ensure the research is undertaken in a manner in which other researchers might reach the same conclusions. I have provided herein a transparent account of my methods and how the study was conducted in practice as well as reflecting on the limitations. I have endeavoured to exhibit objectivity through maintaining reflexivity on my approach as a researcher as reported below.

3.6 Research Ethics

I received approval to conduct the study from the Observational/Interventions Ethics Committee of the London School of Hygiene and Tropical Medicine on 21 October 2013 (Appendix B). I received provisional approval from the Humanities and Social Sciences Research Ethics Committee of the University of Kwa Zulu Natal on 21 October 2013 (Appendix C) and was subsequently awarded conditional approval on 6 November 2013 to proceed with data collection and met the conditions.

Prior to their interview informants received an information sheet (Appendix D) which detailed the study approach, what was required of them, stressed that their participation

was voluntary and that I would maintain confidentiality. I also reviewed this information and explained the study before the interview and gave informants a chance to ask questions. All informants signed a consent form (Appendix E) before the interview commenced which indicated that they agreed: to participate, to presentation of their statements as a data source and to have a sound recording of the interview taken. I have maintained hard copies of these signed consent forms in a secure file in my home.

To maintain confidentiality in most cases interviews were conducted in informants' private offices or in a private conference room in their workplace. In a few instances I met informants in public places and we located ourselves in an area to conduct the interview where we would not be disturbed, not overheard and I did not relay information to others about what I was discussing with that individual.

As the sample is small and the context in which the informants work is insular wherein many informants would be known to one another I have endeavoured to preserve confidentiality and ensure that no data can be linked to an individual. Each interview was assigned a number which is utilised when quoting so that names, positions and/or roles are never mentioned in association with quotes and the data is presented in summary. I explicitly kept the definition of constituencies (as noted in Appendix F) vague so that individuals strongly associated with these issues would not be easily identified by the type of institution they work for. A document containing the interview numbers with the corresponding informant name, role, organisation and constituency is maintained in a separate electronic file and protected with a password known only to me.

3.7 Reflexive Account

In order to acknowledge my role in collecting and analysing the data I have endeavored to take into account my personal context, biases, prior assumptions and experiences. I chose specifically to look at the commitments South African policy had made to WSW for several reasons. The commitments which I have analysed are unique to South Africa and remarkable as one of the few settings globally where WSW concerns in relation to HIV and SRH services have emerged onto national policy. I am personally familiar with another

setting where lesbians have addressed the impact of HIV in their communities. For four years in the early 1990s I worked for Gay Men's Health Crisis (GMHC) the oldest HIV/AIDS service organisation the US located in New York City. GMHC housed the Lesbian AIDS Project (LAP) which produced HIV prevention information for women who have sex with women and served up to a thousand lesbian and bisexual women living with HIV in the New York area. The risk of HIV and STI transmission among lesbian and bisexual women and the rights of WSW living with HIV was taken seriously in this context. Thus I empathise with the lesbian and bisexual women in South Africa working to raise the awareness of the burden of poor SRH and HIV within their community.

Nevertheless I realise I have little in common with WSW living in South Africa other than sexual orientation and that my experiences, including the health risks I face as a middle class Western white woman, have been incredibly different. I was 'out' only to informants working for explicitly LGBT organisations. This was a way of helping to establish rapport given that the nature of those informants work entails being 'out' and I wanted to ensure they were open with me about issues that the LGBT community might only discuss internally. In most other interviews I did not feel it was appropriate to purposely disclose my sexual identity and maintained a neutral professional/researcher identity. I did not find negotiating this problematic nor was I concerned that it changed the nature of the interviewer/interviewee relationship. While I was in South Africa I took a number of personal security measures given the high levels of crime, including violence against women and homophobia. Not being explicitly 'out' unless amongst friends and/or known allies was a form of self-protection.

One could argue I have strong convictions about the need to further investigate poor sexual health among WSW and to address these problems but I reflected on how this informed my approach throughout the conduct of the research and in the presentation of it herein. Regardless of my own interests and experiences I have demonstrated how I maintained objectivity through data collection and analysis. In the chapters which follow when forming conclusions and offering recommendations I have not stated personal views. My insights have been informed by the literature I have reviewed and the evidence I will present.

3.8 Study Limitations

Because the DrPH thesis is shorter in length and limited in scope compared to a PhD thesis I was unable to delve into certain aspects related to NSP development and delivery related to my inquiry. I was unable to look into the role of Provincial Departments of Health in NSP implementation. It would have been interesting to take one Province as a case study to analyse how the NSP is translated into programmatic activities as a few informants did point out challenges in maintaining consistency between national and provincial priorities.

While concerns around WSW are grounded in principles of ensuring sexual and reproductive health and rights (SRHR) and policy actors have raised the need to integrate SRHR in NSPs, I choose to focus on the sexual health of WSW linked to their sexual rights. In the South African context WSW access reproductive health services, including for maternal health care, as the multi-country quantitative study of 591 WSW in Southern Africa found “about a quarter of the women reported to be the biological parent of children” (Sandfort et al., 2013: 5). Regardless, few informants discussed specific reproductive health and rights concerns of WSW. Lastly, the study does not reflect on TB policy which is highlighted in the 2012-2016 NSP due to South Africa’s co-epidemic of TB. Analysis of TB programming from a gender lens has begun to emerge, particularly considering men’s vulnerabilities to TB, but has not been addressed by advocates for WSW health.

CHAPTER 4 - HIV & AIDS AND STI STRATEGIC PLAN FOR SOUTH AFRICA 2007-2011

Introduction

This chapter presents data collected through semi structured interviews and document review corresponding to study Objective 1 and its three sub objectives:

To analyse why and how initiatives targeted toward WSW as a population vulnerable to HIV and poor sexual health were included in the 2007-2011 NSP considering:

- i. how the factors of actor power, ideas, political context and issue characteristics shaped the policy process, content and context;
- ii. what the policy content of the 2007-2011 NSP indicated should be done to improve the sexual health of WSW;
- iii. what implementation evidence exists for interventions targeting WSW.

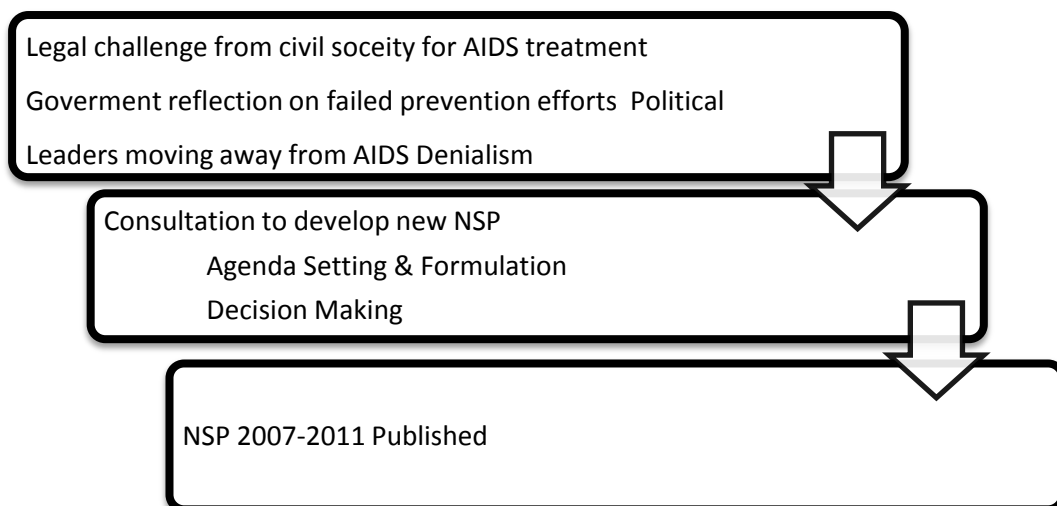
First the chapter will describe why and how initiatives targeted toward WSW, were included in the 2007-2011 NSP. This will be done utilising the health policy analysis triangle features of context and process and the stages heuristic: agenda setting, formulation and decision making and the resulting policy content. Throughout, actors: individuals, groups and organisations that were involved in each stage will be examined. The four categories of the factors of the framework on determinants of political priority for WSW to be included in the NSP development process: actor power, ideas, political context and issue characteristics will be utilised in the analysis.

Then the chapter will demonstrate what the policy content of 2007-2011 NSP indicated should be done to improve the sexual health of WSW. Lastly the chapter will present what evidence exists for initial action on strategies to address the sexual health needs of WSW which were outlined in policy. This section will consider the last two stages heuristic: implementation and evaluation. This presents reactions to the lack of evidence of implementation by Government as well as findings of other contributions to carry out the interventions for WSW set out in the 2007-2011 NSP.

4.1 Policy Context: waking up to the reality of HIV/AIDS

This chapter begins with reflections on the Political Context in the period before and during the development of the 2007-2011 NSP was developed, to present a picture of the reality within which all policy decisions were taken by the South African Government at that time. Walt and Gilson (1994) place context at the top of the policy analysis triangle to analyse political economic and social factors which may have an effect on health policy. Similarly Shiffman and Smith (2007) consider the role of the political context as the environment in which actors operate and one of four features of the determinants or political priority of policy initiatives. Figure 4.1 provides an overview of the policy context in 2007 and the processes leading up to the publication of the 2007-2011 NSP.

Figure 4.1: Policy context and processes around the 2007-2011 NSP



Many informants reflected that the year 2007 marked a period where the South Africa Government began to put their perilous position on HIV/AIDS behind them. Informant 11 stated that before this time *'certainly around the time that Manto was Minister...it was a big mess.'* In previous years it was very difficult to get political commitment on the response to the epidemic. Several informants referred to the example of the Government's refusal to provide antiretroviral treatment to HIV positive South Africans through the public sector as the worst example of past policy stances. Informant 22 recalled *'we had to sue the*

Government for PMTCT to be part of the public health system, there were lots of battles...with our...actual Government.'

Thus when the development of a new NSP was initiated in 2007 there was an intention to break with the past and a particularly strong focus on bringing up the numbers of people on treatment. Informant 25 indicated that the NSP development process occurred while the Minister of Health, Manto Tshabalala-Msimang, was hospitalised for a liver transplant and she recalled that *'it was widely held she might not come out of hospital but that if she did we needed to make sure we moved the policy forward as quickly as possible while she was out of action.'* The Deputy Minister of Health (DMoH), Nozizwe Madlala-Routledge pushed for a commitment in the NSP to move to universal provision of antiretroviral treatment. Informant 4 reflected that period of developing the NSP *'was a very...hectic period as well as a county....transitioning to...own a treatment programme. We come from a time of denial.'*

4.1.1 Policy Windows: conceiving of WSW affected by HIV

Kingdon (2003) describes certain political moments when conditions align favourably presenting advocates with opportunities to influence decision makers as 'policy windows'. There were several policy windows which were open in 2007 to advocates seeking to demonstrate the impact of HIV on WSW. Informant 20 stated that the NSP included *'some sections that were talking about key populations but...we were not very clear on what is it that we wanted to do in key populations...around the world there was not very much evidence...around key populations.'* Informant 1 pointed out that in May 2007 a group of social scientists and epidemiologists held a ground-breaking conference entitled *Gender, Same-Sex Sexuality and HIV/AIDS* which contributed evidence of the impact of HIV/AIDS on MSM and WSW. Government officials were in attendance and informant 1 noted that the conference *'got us talking about...the policies within the country...advocacy needs and issues...that...helped contribute towards that agenda.'*

A public focal point which raised some awareness of HIV among WSW occurred in 2007 when Jacob Zuma, who had served under Thabo Mbeki as Deputy President from 1999 until his dismissal in 2005, was on trial for rape. The victim was a woman living with HIV who identified as lesbian. Informant 5 reflected that the trial *'impacted in some way on raising*

the issues among lesbian women living with HIV...even if people didn't believe that Jacob Zuma raped her, it did bring together violence, HIV status and issues of sexuality.' Similarly informant 3 reflected that the trial raised issues to a public discourse on *'the meanings around patriarchy, the meanings around sexual choice, negotiation...all of these things did come to the fore...which...has some relevance to the policy debates.'* This high profile case was only one in a rising tide of sexual violence, particularly rapes targeting WSW which the public were becoming aware of. Informant 5 commented that in 2007 *'violence was becoming more and more part of the discourse of women and vulnerability'* and how this discourse was leveraged by actors will be examined within an analysis of the policy process.

4.1.2 Consultation Process: shaping the national response to HIV and STIs

The policy process around the NSP in 2007 had several stages which will be considered herein including: agenda setting and formulation. Many informants spoke to the fact that the formulation of the new NSP in 2007, which was led by SANAC, was much more consultative than when AIDS policies were developed in South Africa in the past. Informant 5 remarked that *'people had a sense of ownership...there literally was a sense of openness that things were going to be easier to impact onto the strategy.'* This context was critical in creating a space in which marginalised issues could be brought to light. Informant 5 continued *'that openness...paved the way for getting 'smaller' issues on the policy agenda.'*

Informant 20 concurred that there was more robust NSP consultation in 2007 than there had been in the past and reflected that *'we had quite a high political leadership buy in to that process.'* SANAC is Chaired by the Deputy President and thus is the most senior Government actor involved in the development of the NSP. From 2005 to 2008 Phumzile Mlambo-Ngcuka was Deputy President, the only woman to have served within South Africa's Presidency. An informant from the LGBT community credited Phumzile Mlambo-Ngcuka with acknowledgment of the need to focus on LGBT issues within SANAC reflecting her positive stance on LGBT rights which was actioned when she passed the bill that legalised same-sex marriage in 2008. The Deputy Chair of SANAC represents the civil society forum within SANAC and is elected from within civil society.

SANAC was operating as a programme within the HIV and AIDS cluster in the DoH in 2007 and a public sector informant argued that the DoH had driven NSP development in 2007. They stressed that the NSP was not intended to be strictly a health sector response but was to be a multi-sectoral plan. Nevertheless the DoH funded the consultation and gatherings then took the inputs that had been amassed and included them into a document which it produced. Informant 5 commented that in 2007 leadership changes within SANAC meant that it was able to *'new voices involved. Which was good because it was the same old faces all the time.'*

Many informants from civil society expressed great appreciation for positive characteristics of the 2007 NSP consultation process. Informant 19 recalled that they had *'a lengthy participatory process... with real consultations... there were... open, inclusive spaces we were all in one room...there you can strongly raise particular issues.'* Informant 22 remembered the process as *'very long and painstaking but it had a lot of participation and a lot of energy...because all of the organisations...who knew that this was the right way to go were very much involved.'* Several informants remarked that there were more organisations who were able to engage in advocacy and input into the drafting of the NSP consultation in 2007 compared with earlier and later policy development processes. The following section considers the range of actors who were involved.

4.2 The Power of Actors: voices of LGBT and women's rights activists

Actors are individuals, groups and/or organisations which Walt and Gilson (1994) place at the centre of policy making as they fundamentally shape policy. Shiffman and Smith (2007) propose that actor power can be measured by the strength of the individuals and organisations concerned with the issue e.g. how much influence they have been able to exert on getting their issues into a policy. Informant 25 observed that a vast range of actors were involved in the debates around the NSP in 2007. They noted the process was influenced by *'networks of activist organisations within South Africa and...across borders globally.'* Civil society movements like TAC were instrumental in changing the South African Government's response to HIV/AIDS and other organisations which represented civil society in national policy such as NACOSA, The National AIDS Coordinating Committee of South Africa, were influential in setting the agenda for the 2007-2011 NSP.

Several informants shared their perspective that WSW sexual health concerns would not have been included in the NSP if the advocacy from certain civil society actors had not been as powerful. For this study informants were asked which actors were most powerful in getting WSW issues on SANAC's agenda. Many highlighted that actors from LGBT community organisations and women's rights organisations involved in the response to HIV/AIDS exerted influence in bringing a rights based argument about the need to include WSW to SANAC discourse. Their power was in many ways derived from that of the wider social movements coalesced around the response to HIV/AIDS, such as TAC, which had held the South African Government to account. Informant 5 reflected that the women's movement had not been particularly strong since the 1980s but changes in the social context allowed '*smaller more focused movements of activism... pockets of resistance from women living with HIV who are raising really difficult issues ...they can be allies and support the WSW agenda.*'

In 2007 LGBT community organisations largely engaged with SANAC as individual entities. Informant 21 observed that the LGBT community did not have a collective constituency '*they themselves were not as organised...They didn't have strong spokespeople.*' Conversely informant 5 perceived that around the time of the NSP development in 2007 '*the LGBT community generally was fairly organised at least in terms of pushing agendas on HIV and AIDS...there are some really strong activists.*' The LGBT community had a history of collective advocacy and in the early days of the AIDS epidemic in South Africa gay men and other MSM were involved in leadership but this changed when the epidemic became generalised.

For example, between 2004 and 2009 a group of LGBT organisations formed a Joint Working Group (JWG), a coalition that included up to 25 organisations who campaigned for issues such as legalising same sex marriage and produced collaborative research on issues affecting the LGBT community. Informant 1 explained the JWG was '*the forum through which collective voice could be shared with the national structure.*' A former JWG member assessed that the group was strongest between 2004 and 2006 and that '*from 2007 we started shifting focus toward hate crimes, patriarchy.*' Informant 13 lamented that '*due to resources constraints that group kind of phased (out).*' But reasons behind its decline were

considered by another former JWG member to be *'because of...conflicting ideologies...it just got people stuck.'* This lack of cohesion had implications for joint working among LGBT organisations within SANAC from 2007 onward.

Informant 25 noted the role of private donors, such as Atlantic Philanthropies, in providing resources to LGBT rights work which allowed the sector to *'mobilise very strategically with the Government to introduce a policy that for the first time in South Africa's history really started to take HIV seriously.'* The range of organisations from the LGBT sector and the women's rights sector who were engaged in raising the visibility of WSW issues in the NSP in 2007 was remembered by informants as a wide range of strategically aligned organisations including: the 1 in 9 campaign; the Coalition of African Lesbians; the Durban Gay and Lesbian Centre, Gender AIDS Forum; Out LGBT Well-Being, the Triangle Project, and the Women's Legal Network. Informants perceived that these organisations were fairly influential at that point in time in raising the profile of the impact of HIV and STIs among WSW.

Many informants spoke about the role of the SANAC women's sector in bringing the issues faced by WSW forward in the development of the NSP in 2007. The sector is a group of organisations who collectively influence SANAC on issues relevant to women in the response to HIV/AIDS and includes a wide range of women's groups numbering over 300 members at one time. A SANAC women's sector summit which was held sometime during 2005-2006 focused on issues facing WSW wherein Out LGBT Wellbeing was invited to speak about their WSW clients' health concerns. Informant 4 stressed that that women's sector summit was *'when all of this started, it was the...space for women addressing women's issues. There were a limited number of people talking about lesbian women, WSW and transgender women at that time.'* One advocate from an LGBT organisation reflected that perhaps since discourse about WSW was not getting very far within the LGBT community it was strategic to integrate the concerns in the SANAC women's sector which was open to considering women in all their diversity.

Informant 25 countered that in 2007 the health needs of MSM *'were much more visible and a part of the discussion...at that point it was largely TAC who were raising awareness.'*

Informant 5 supported this perspective but asserted that there was *'solidarity around gay men taking up the issue of women who have sex with women.'* They were less certain to what extent women's rights organisations actively took up WSW issues but informant 5 argued that the LGBT community did raise the issues and showed *'a level of solidarity.'* Thus advocates for WSW found some level of support within both the SANAC women's sector and LGBT organisations.

4.2.1 Policy Entrepreneurs for WSW and HIV

Policy entrepreneurs were identified by Kingdon (2003) as those leaders who identify opportunities to highlight an issue within a policy process, particularly when a policy window open, and build greater buy-in for inclusion of their 'special problems' within policy. In the case of the 2007 NSP development process much credit has been given to the role of individual advocates in raising the visibility of WSW sexual health concerns. Informant 2 offered that interventions for WSW sexual health were included in the content of the NSP *'because there were a few individuals who...targeted specific people that were drafting the NSP.'* Informant 6 commented that the context in South Africa is somewhat unique in that *'there has been very visible lesbian organising in which women who have sex with women...have been leaders within the LGBT movement and have also been leaders within HIV work.'*

Advocates reflected that due to compounded marginalisation relating to HIV status and diverse sexual orientation few women would identify openly as a WSW living with HIV. Informant 5 stated the women who were open about their HIV status and their sexual orientation *'pushed a line...it's not like in other contexts where you don't know any lesbian women who are HIV positive. In South Africa you do know.'* This informant argued that personal testimony and representation from the affected community enabled a greater recognition of the links between HIV and same sex sexual behaviour among women. They credited advocates for utilising the 'know your epidemic' discourse in order to argue *'we don't know the epidemic, we don't know about HIV amongst women who have sex with women.'* Informant 24 offered that powerful advocates *'stood up...they were screaming and fighting for the inclusion for women who have sex with women...within the NSP...that's how it got onto the table.'*

Certain advocates who were instrumental in raising WSW concerns within the formulation of the NSP were identified by several informants. The individual cited most frequently in connection with leading on this agenda in 2007 is Steve Letsike who was working in an advocacy role at Out LGBT Wellbeing at that time. She was part of the SANAC women's sector reference group and used that as a space to urge the sector leadership to raise WSW health rights within the NSP development process. Informant 2 identified Steve as *'one of the people who probably pushed the hardest, had first-hand access to the information...she was really passionate about the issue because she knew so many people who were personally affected.'* Several other informants identified Prudence Mabele, the founder and Director of the Positive Women's Network, as another SANAC women's sector member who pushed WSW issues. She was also a member of the People living with HIV sector and used both of those sectors to lobby for the sexual health of WSW. Informant 24 offered that Prudence had been *'really really really influential.'* Other individuals noted for their engagement in raising the profile of WSW issues include: Dawn Cavanagh, Melanie Judge, Professor Vasu Reddy, Dr Vicci Tallis and Fikile Vilakazi.

Some informants raised concerns that certain leaders had not received adequate support to carry out their demanding advocacy. Informant 17 recalled that the social movements against apartheid actively worked to develop and support the next cadre of leaders with intensive political/leadership training. Informant 17 wondered *'how can we expect somebody...who is committed, able, passionate to do it with very limited support?'* Informant 24 similarly worried that in regards to advocates for WSW sexual health they see *'very few actors and I see them being spread very thin...they... become more and more representational and are called upon to lend their voice and their presence...to so many different forums and that's how you get burn out.'* Questions regarding whether it was sustainable to rely on a small pool of advocates over the long term are implicated in both the ability to implement activities to benefit the sexual health of WSW and re-engage buy in from other policy actors.

4.2.2 Policy community: cohesion and opposition

Shiffman and Smith (2007) describe one aspect of actor power as the degree of coalescence among the individuals and organisations centrally involved with a policy issue. There were

varied levels of cohesion in 2007 among the policy community engaged on WSW sexual health needs. While the 2007-2011 NSP development process was considered highly participatory informant 16 lamented that *'everybody was trying to get a word in...but in a very scattered and unstrategic manner.'* Informant 3 remarked that there were a range of stakeholders and that strategic interests being pursued wherein there were *'divided interests while there may be some common nodes.'* Additionally informant 3 remarked that while MSM and WSW interests were pursued with varying levels of success by LGBT organisations they were not necessarily inclusive of the transgender movement which *'increasingly over the years have become quite separate...and probably also quite innovative in their own approach.'*

Informant 2 revealed that there was some resistance from the LGBT community to the inclusion of WSW issues and a concern that MSM health in the context of HIV and STIs should be addressed with greater urgency. As this informant stated some questioned *'why don't we get that (MSM) embedded properly?'* to which advocates for WSW would say *'why must one proceed the other? Why shouldn't these go parallel...we need services yesterday not when you are properly integrated into (services).'* Another concern among LGBT advocates and their allies was that WSW might be further stigmatised through focusing on their poor sexual health. Informant 2 provided an example that after awareness of WSW living with HIV was made public *'there were religious leaders that blamed the AIDS epidemic on lesbian communities...just the weirdest things.'* This was not a mainstream religious community message and as another informant from the LGBT community expressed they were pleasantly surprised that they did not perceive opposition from the religious sector represented in SANAC when raising MSM or WSW issues in their forums.

Other informants spoke to contextual factors undermining cohesion within the LGBT community which were particularly evident in the JWG's ideological differences. These emerged when the membership opened up and groups coming from African feminist perspectives joined. Informant 7 *'if I can use their term....black lesbian post-colonial anti neo-liberal thinking came into the room and it imploded that structure.'* This informant recalled that facilitating dialogue became difficult *'if you say something...as a white man, there's a four hour analysis 'how dare you say anything'...I find it offensive and we pulled*

back from that structure. They also expressed concern with how ideological arguments and identity politics were perceived in situations where the LGBT community was trying to influence public health officials seeking evidence of health burden among WSW. Informant 7 proposed that public health officials *'cannot sit around...chasing your own tail about ideology...that's not going to cut it...it cannot dominate the discourse.'* Informant 15 clarified that the issues around identity politics included objections by some lesbians about being referred to by the WSW behavioural marker. This was problematic within public health discourse where informant 15 recalled questions arose around *'who is your target ...is it WSW or is it WSW and lesbians'* and the informant reflected that a focus on identity rather than behaviour *'bogged down a lot of progress.'*

Informant 8 perceived that some messages from advocates arguing for WSW sexual health were delivered forcefully and sometimes with anger. Nevertheless informant 8 thought that some of the actors who expressed themselves angrily *'really made progress for us but...if...that's the only voice that's heard...people who's (sic) got the power...to fund...to make programmes available...close down and say, 'we don't want to work with those people.'* Additionally they reflected that ideological arguments around WSW issues within a public health response had done nothing to render HIV and STI prevention services for WSW.

An informant from the donor community revealed there was definitely resistance to the inclusion of a focus on WSW from the South African Government. Informant 21 held the view that the LGBT community's efforts did not make an impact on the 2007-2011 NSP underscoring that *'it's not a big issue not because they're not important but because we are a generalised epidemic.'* Informant 2 recalled that the argument they encountered from Government *'over and over and over again... was really an argument about money.'* Given that South Africa had limited resources to make essential HIV and STI services available to the general public there were concerns expressed about dedicating funds to reach marginalised populations which require specialised services and whether this would divert funds from the general population that was already experiencing barriers in accessing mainstream services. Informant 2 recalled the LGBT community responded to these arguments by focusing on a human rights perspective and raising questions such as *'how*

much value do you put on a person's life? At what point does that person become valuable enough for you to want to invest in their health?' An analysis of how ideas framing the vulnerability of WSW to HIV were expressed will be considered further in the following section.

4.3 Policy Formulation: Ideas and Issue Characteristics

The framework proposed by Shiffman and Smith (2007) considers two other factors that shape the political priority of inclusion of a health issue in policy: the ideas that are presented and the health issue characteristics they represent. The adapted framework used for this study posits that ideas are the ways in which those involved with WSW issues understand and portray the issues. When reflecting on how the sexual health problems of WSW in South Africa were being discussed in 2007 it is important to remember that actors were still in an initial period of reflection on an emerging problem that had not been clearly defined or fully studied. They were beginning to consider what responses might work and what they should urge the South African Government to do. There was some consensus but not an advanced understanding of what Shiffman and Smith (2007) called the 'issue characteristics' or what Kingdon (2003) considered as 'the problem stream'. Given that this was a nascent period of presenting ideas and some objective health metrics and other data these two factors will be taken in turn to consider how arguments for inclusion of WSW sexual health needs were framed in the NSP process in 2007.

4.3.1 Ideas: the Internal Frame - forming consensus on positioning WSW sexual health

Shiffman and Smith (2007) identify that the degree to which the policy community agrees on the definition of, causes of, and solutions to a problem sets the internal frame. A civil society informant reflected that before the NSP consultation process began in 2007 those representing WSW issues had not agreed on clear terms about how to raise WSW sexual health needs in the context of a HIV and STI policy process. An informant from an LGBT organisation recalled that at this time the behavioural marker WSW was not commonly used and most arguments were framed around the sexual health of lesbians and other vulnerable women from sexual minority groups. As the LGBT community began to identify its priorities there was even less knowledge of the health status of transgender women and men compared to WSW and thus, as one LGBT community member recalled, there was more

focus on crafting arguments around lesbian and bisexual women's sexual health needs. Informant 1 shared that the community struggled with how to present the evidence as there was anecdotal knowledge of WSW living with HIV but no clear sense of the overall burden of HIV among WSW and specific factors underlying their vulnerability. Informant 1 said that advocates made a strategic choice to push these issues nevertheless given the sense that *'just because we do not know does not mean it should not be a priority for Government.'*

Thus crafting these arguments was not straightforward and informant 2 noted that the contribution of a researcher, the late Jill Henderson, *'making the argument work for difficult audience...getting the right words...to convey in a very short space of time.'* Messages that seemed to be influential from the perspective of informant 2 were around *'the vulnerability of lesbians and the vulnerability of their heterosexual sisters weren't that different...we did show...some commonality....that was a tactic to not distinguish lesbian women...all the time.'* This message tied in to a focus on access to health services which informant 2 presented as an argument around *'you needed services that would target women that...identified as lesbian but that the vulnerability was the same so...some of the issues that you had to deal with were the same.'* Informant 24 recalled when WSW were arguing for themselves on the need for inclusion in the NSP their message was *'we are women, even though we are lesbian these issues affect us too...why aren't we reflected in this document?'*

Despite there being concerns with how African feminist perspectives were raised within public health discourse it seems that these perspectives allowed for a focus personal testimony from black WSW affected by HIV in the consultation on the NSP. Informant 3 reflected that testimonies underscored that *'it's not just the numbers that count but also the...narratives of people which is...sometimes more powerful.'* Through the NSP development process in 2007 many actors presenting WSW concerns spoke from their own experience, providing real lived examples. Informant 3 public sector felt the value of personal testimony was that it showed that *'we should not live in a country that has all of these wonderful, progressive constitutional protections ...and...the mis match between good policies...and...real implementation. There hasn't been any tangible difference to the real lives of women.'* Informant 3 went on to say that this messaging helped to connect WSW

issues to common concerns of other social movements in South Africa that there is a disconnect between *'policy and practice and real change in the country. It's increasingly becoming a factor.'*

As was pointed out in section 4.1.1 a few policy windows were available to policy actors in 2007 including media coverage of hate crimes targeting WSW. Advocates for WSW sexual health needs highlighted 'corrective rape' and the impact on survivors' vulnerability to HIV and STIs in making their case. Informant 3 recalled that within national meetings testimonies of women who had personally experienced sexual violence and were living with HIV were delivered and these women also told *'the stories of those who did not live to tell their tale...(and made) the broader connections around violence and health...the challenges of living in a deep seeded patriarchy.'* Several informants considered that the rise in rape and murder of WSW to be 'topical issues' and informant 12 argued that violence 'provided the push to say that the NSP...should address those issues.'

Informant 1 credited the community's ability to highlight 'corrective rape' and use it as a main argument for inclusion of commitments to WSW in the NSP *'we used hate crimes and the rape of lesbians as the reasons why it should be put on the agenda.'* A former member of the JWG regretted that while the LGBT community had begun to respond to hate crimes through the JWG before 2007 they felt the sexual health risks had not been well integrated into this work. Informant 22 reflected that messages around violence against WSW were used more commonly than other sexual health concerns of WSW because *'that is the biggest threat...in relation to HIV.'* Whether other threats were greater or equal was not explored extensively at that time due to lack of data on transmission factors among WSW. Informant 3 indicated that over and above allowing for a discussion of the vulnerability of WSW a focus on GBV provided advocates an opportunity to bring attention to *'the strong patriarchal culture and context within which South Africa operates.'*

Informants remarked that many organisations worked to ensure that a human rights perspective was raised when discussing violence and discrimination against LGBT persons. Informant 3 noted that messages around WSW often demonstrated how concerns, especially around GBV, were interconnected with issues such as *'human rights, citizenship,*

identity, well-being, good health,...in terms of mental, physical...spiritual and positive living.' They noted that the TAC, along with people living with HIV/AIDS, contributed to debates around the need for HIV policy to address intersectional issues such as well-being and positive living with HIV. Informants noted that as more WSW were identified as living with HIV it was becoming clear that their sexual health and HIV prevention needs were a human rights issue. Similarly informant 7 said the resulting messaging was *'not necessarily only about prevalence but it's about human rights.'*

There was also internal discourse about what interventions which might improve WSW sexual health should be argued for inclusion in NSP activities. Informant 1 remembered that an outcome of the HSRC conference, *Gender, Same-Sex Sexuality and HIV/AIDS*, in 2005 was the need for targeted sexual health information saying that *'there was a very clear need identified that we want information communications.'* Informant 1 indicated that the LGBT community had complained that the safer sex information that was produced and circulated in the public health system was *'silent on the experience between two women and between two men.'*

Another set of ideas centred on concerns that WSW faced significant challenges in accessing sexual and reproductive health services through the public health system, one of the aforementioned disconnects in policy and practice. South Africa had made commitments to secure women's sexual and reproductive health and rights (SRHR) as a signatory to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Commission on Human and Peoples' Rights, 2006). Thus the NSP was seen as a policy instrument that could help underscore SRHR and ensure they were extended to all women regardless of sexual behaviour. The LGBT community raised concerns about the ability to access non-discriminatory health services wherein health workers had the correct information in order to diagnose and/or refer them to HIV and STI treatments. Informant 13 stressed that the messaging acknowledged that *'all women and everyone else is facing the same...problem in terms of service provision'* and thus were mindful to not convey a sense that WSW wanted to be *'treated in a special way and be provided with these things when other people...other women are not.'* They underscored the importance of working in

coalition around demanding improved health care and not to portray that *'my problems are bigger than yours...they are not. We all should be accessing good health care.'*

There was a certain amount of conflation of ideas around WSW sexual health needs with issues affecting MSM in part due to the fact that the HIV epidemic among MSM brought LGBT health concerns to the attention of the policy community. Informant 15 indicated that at this time advocates for the LGBT community *'could not really isolate one of the groups within this...umbrella and only deal with that group alone.'* While some of the messages addressed LGBT health issues broader than the health concerns of MSM the dialogue around health interventions became more focused on MSM needs as it was the part of the LGBT community demonstrating higher vulnerability to HIV. Informant 17 who was active in TAC at that time remembers discussions around women's rights, gender equity and sexual orientation but they clarified *'I don't think there was any reflection at all on women who have sex with women within TAC branch level... it was actually MSM.'*

4.3.2 Ideas: the External Frame - media coverage of violence against WSW

Shiffman and Smith (2007) define the external fame as the public portrayals of an issue to resonate with external audiences and reach political leaders. The influence of the media taking up messages is a key way to create greater visibility of an issue. As it was noted previously advocates in South Africa were taking advantage of the growing public awareness of GBV as a structural driver of vulnerability to HIV. Informant 5 observed some of the arguments demonstrated links between the GBV experienced by women and the similar but different acts of sexual violence targeting WSW. They indicated that advocates argued *'the violence that women who have sex with women experience is often more violent when you talk about hate crimes.'* Informant 4 remarked that within messaging about the response to GBV advocates for WSW needed to raise different perspectives given that WSW were raped *'because of their perceived sexual orientation or gender expression.'*

Media outlets became increasingly interested in covering hate crimes affecting WSW, often sensationalising the most atrocious attacks which result in murder. Informant 13 reported there were some media organisations and newspapers that sought to cover these crimes without sensationalising them but that *'unfortunately press most of the time...sells with the*

negative things.' Informant 3 concurred that *'certainly the media operates in ways that sometimes reflects the facts...but...the media ...also sensationalises...there's shock and dismay and responses by the broader public.'* Informant 3 felt that while this was not an ideal representation that it did have an impact in that *'it opens up a debate... gives visibility to these issues...to public discourse that these issues are out there.'*

Informants noted that since there was very little reporting or visibility around any other issues in WSW lives, particularly the lived reality of low income black lesbians, they feared that the public was left with an impression that rape and violence was a dominant life experience for women identified as lesbian. Informant 19 lamented *'you actually wonder if not reporting these cases may actually be more helpful then reporting them in the way they are reported.'* Additionally the links between GBV and vulnerability to STIs including HIV were lost in the reporting. No informant could cite a media story about hate crimes against WSW featuring a victim living with HIV or another STI as a result of sexual violence. While it was not picked up on in reporting the community was well aware of numerous cases of WSW who tested positive for HIV or STIs following an attack.

A more thoughtful response was projected from a civil society managed media outlet, the Community Media Trust (CMT), which broadcasts programming on public television and ties their programming in with public campaigning that makes HIV information and prevention commodities publically available. The CMT covered GBV issues widely as the stories are prevalent throughout the country. Informant 22 shared that CMT had *'done many episodes and segments and stories and discussions in our work on violence on women specifically for being lesbian.'* CMT's approach is to take a more sensitive look at the lives of people and informant 22 remarked that they while work closely with their subjects they regretted the aftermath of some stories that featured WSW where there were *'repercussions for some people in the community...they would get threatened...we had to...help them after the fact.'* Nevertheless informant 22 asserted that *'having it on television...makes people feel like it's a national issue...you can talk about it cause everybody's talking about it.'*

Whether media visibility of WSW issues led to greater awareness among decision makers, especially the potential links between sexual violence experienced by WSW and

vulnerability to HIV, is not clear. Informants did not see evidence of policy makers responding with any sense of outrage to these shocking stories being covered in the press. No informants could cite a public statement by an official condemning the rising number of hate crimes targeting WSW. Informant 19 expressed regret that rapes of WSW *'makes the headlines but...never speaks about condoned homophobia at the Government level.'* This section has considered the role of both internal and external ideas around WSW sexual health in policy formulation of the 2007-2011 NSP.

4.3.3 Policy Formulation: Issue Characteristics

Moving to the last part of the framework on determinants of political priority for issues to be included in South Africa's NSP I consider how issue characteristics on the problem of WSW sexual health vis a vis STIs including HIV were utilised in the policy formulation of the 2007-2011 NSP. Kingdon (2003) considers what he called 'the problem stream' to consist of conditions that policy makers want to address noting that only some conditions come to be defined as problems and thus receive more attention than others. Shiffman and Smith (2007) propose that some health problems are intrinsically easier to promote as a political priority than others. A set of metrics on a given health issue can be used to promote it including: credible indicators, clear measures that show the severity of the problem and that can be used to monitor progress; the size of the burden relative to other problems, as indicated by objective measures such as mortality levels; and effective interventions, the extent to which proposed means of addressing the problem are clearly explained, cost effective, backed by scientific evidence, simple to implement, and inexpensive. Few of these metrics were available in 2007 to demonstrate the problem of poor sexual health of WSW in South Africa.

Around the time that the NSP was being drafted in 2007 evidence on the impact of HIV on MSM in South Africa was emerging demonstrating that MSM were very vulnerable. Previous to this data being available MSM were not considered a key population. Thus programming to target MSM was outlined in the 2007-2011 NSP. Concurrently evidence on the burden of HIV and STIs among WSW available in 2007 was viewed by informant 2 from the donor community as *'incredibly weak...the evidence was weak the communication was weak.'* Informant 3 cited that the reason why WSW were not particularly high on SANAC's agenda

related to the lack of a strong evidence base and thus they stated WSW were *'not necessarily seen as a... vulnerable key population...evidence seems to suggest that they're not... vulnerable...from an HIV perspective.'* Informant 5 stated more emphatically *'there wasn't any evidence at all, everything was very anecdotal.'* But a civil society informant argued that the absence of evidence allowed for a more open point of view around WSW's risks in the context of HIV and STIs wherein it could not be proven that WSW were low risk either. Informant 2 stressed that despite the poor evidence base interventions for WSW were included in the 2007-2011 NSP because *'individuals that got it in there.'*

Informants spoke about the importance of LGBT community based organisations' support of the building of an evidence base on MSM and WSW sexual health as they have a mandate to improve the health of their clients. A study conducted in 2004, coordinated by the JWG, surveyed clients attending the Out LGBT Wellbeing clinic in Pretoria and the results were reported by Wells and Polders (2004b) cited in Chapter 2. Informants from LGBT community organisations remembered this report had an impact in underscoring the reality that there were WSW living with HIV. Informant 7 was involved with the study and remembered that *'the self-reported data for black Lesbian women was 9% HIV prevalence which...relative to international...available research pointed to a problem.'*

When applying Shiffman and Smith's (2007) definition of issue characteristics there is an expectation that advocates should be able to present credible indicators including disease severity. But given there was such a small data set on WSW sexual health available in 2007 the burden of disease was not well demonstrated. The only data readily available to advocates was reported in the provincial LGBT community studies (summarised in table 2.4.1) that showed there was a higher percentage of black WSW living with HIV than expected when compared with either MSM or white WSW and that black WSW had higher rates of other STIs when compared with white WSW. This data underscored what LGBT community based clinics knew to be true in regards to their clients, that sexual health among black WSW was poor. Informant 4 spoke about the Out LGBT Wellbeing clinic in Pretoria recalling that *'a number of women that came into that clinic had a lot of STIs.'* Thus the rising burden of STIs and the relatively high prevalence of HIV among black WSW was something advocates could highlight to SANAC and back up with data.

Informant 4 stated that the concerns raised by the study were less to do with how WSW had contracted HIV but focused on *'how we respond and prevent the virus.'* The SANAC women's sector took up the data on WSW and used it to present another side of discourse about women's diversity in the context of HIV. Informant 5 stressed that the provincial LGBT community studies revealed that women in the LGBT community faced poor access to health services and found *'WSW were very often reluctant to go to services...don't really have access to good health in general.'* Apart from the provincial studies 2004-2006 no other South African research was mentioned by informants when they were asked what evidence was used in their input to the 2007 NSP.

Informants seemed to have limited awareness of research undertaken in other countries demonstrating the burden of STIs and HIV amongst WSW. Informant 5 reported that the LGBT community was aware of *'one study done in the US but there wasn't any information out there at all.'* This informant mentioned the work of Richardson (2000), cited in Chapter 2, which addressed the exclusion of same-sex sexual behaviour among women from defined HIV risk categories and raised concerns that this provides a false perception among lesbian and bisexual women that they cannot contract HIV regardless of behaviours. While informant 5 felt that Richardson's (2000) work helped bring awareness to the possibility HIV risk among WSW they noted that *'I don't think there were actually studies done'* that quantified WSW living with HIV. Informant 4 recalled *'there was a clinical journal (article)...that spoke to three ways of transmission: either the digital/vaginal contact so there's that exchange of fluids, second is sex with men and third...unsafe use of sex toys.'* While they were familiar with the content they could not recall the name of the journal or the author of the article and did not elaborate if these modes of transmission were being discussed among WSW in South Africa.

Lastly within the issue characteristics factors effective intervention should be available to demonstrate the extent to which proposed interventions to address the vulnerability of WSW to HIV and STIs are clearly explained, cost effective, backed by scientific evidence, simple to implement, inexpensive as demonstrated by implementation evidence. Given that no interventions to address the spread of HIV and other STIs among WSW had been piloted, other than in small community based settings, there were no metrics associated with

whether or not potential interventions could be proven cost effective nor could their impact be scientifically reviewed. Nevertheless the available evidence pointed to poor sexual health among black WSW as a problem that could rise within 'the problem stream' requiring a health policy response.

4.4 Policy Content: objectives including WSW in the NSP 2007-2011

After agenda setting and policy formulation was complete there was a more closed process of decision making in the drafting of the NSP. Civil society actors who had been consulted had to wait until the NSP was published to see what content was included on the issues that had advocated for. *The HIV & AIDS and STI Strategic Plan for South Africa 2007-2011* (Republic of South Africa, 2007) was adopted by Cabinet in late 2007. The plan set out 4 key priority areas relating to: Prevention; Treatment, Care and Support; Research Monitoring and Surveillance; and Human Rights and Access to Justice. Under these are 19 goals and 64 objectives and many more individual interventions. Informant 20 reflected that they felt that the policy process resulted in a document which was *'clear... what are the key interventions, which departments...are responsible for each of the key interventions, what are our indicators, what are our targets?...combination of a strategic and operational plan....'* Appendix G documents the policy content of the NSP related to improving WSW sexual health.

The policy document stated that concerns around the sexual health of WSW would be addressed through targeted prevention interventions, that their needs would be taken into consideration in treatment, care and support services and that stigma and discrimination in service access would be addressed. There were various reactions to how messages raised in the policy formulation process around WSW were expressed in the policy content. Informants concerned with the weakness of the evidence base used to argue for the inclusion of interventions for WSW offered that many who read the NSP would have been surprised that these issues had been included. Informant 2 stated bluntly that *'having WSW in as a high risk community did actually...come back and bite us because it was an oversell.'* Informant 2 reflected that they could understand why actors had urged that these commitments be included in the NSP given that *'people were desperately trying to get it in'* but that it didn't necessarily explain why the different vulnerable groups within the broader

LGBT community were dealt with jointly in NSP objectives given the different health burdens that had been demonstrated.

A number of informants raised the possibility that a range of LGBT health issues were misunderstood by those who drafted the document. Some informants thought that the different concerns around the health of MSM, WSW and transgender people were brought together without much thought when the NSP was being finalised. Informant 21 reflected that perhaps the LGBT community had not expressed clearly what they wanted SANAC to commit to and offered that *'if we were in a country which had a different kind of epidemic then I guess they would have organised themselves better...other(s)...would have taken them more seriously.'* A lack of consideration about how to address WSW vulnerabilities was evident particularly in Objective 2.5 wherein there are neither HIV prevention activities nor commodities specifically targeted to the needs of women whose only sexual partners are other women.

Informants perceived a lack of understanding around sexual identity and sexual behaviour among those who were responsible for drafting the NSP. Many were concerned that including WSW within other populations that were considered at high risk of HIV and STIs was probably not be well understood by most people. Informant 5 expressed that perhaps the drafters *'didn't really know what to do with WSW so they just lumped it together in a clause... without any real understanding of what that means...needing or wanting to be seen politically correct.'* Another informant from civil society expressed that the inclusion in the NSP of broader LGBT issues and WSW in particular *'was more about political correctness, which is not to say tokenism, but it was.'*

Informant 8 was not surprised that the drafters, especially if they were from within the South African Government, might not understand different concepts of sexual behaviour and sexual orientation that they were grappling with. Informant 8 stated that even within the LGBT community there is not necessarily a common understanding around the *'difference between gender and sexuality/sexual orientation and...sexual behaviour.'* Informant 8 expressed concern that the drafters were not clear on these distinctions and

thus they *'tried to do something...and that's how it came out...it shows...how...confusion still continues around identity politics (and) around (sexual) behaviour.'*

Informant 11 offered their perspective that they would have preferred to see WSW more accurately defined in the 2007-2011 NSP in terms such as *'they are not the most at risk but they are amongst the most vulnerable because they are highly marginalised.'* Informant 25 expressed concerned that *'labelling any kind of population as high risk is incredibly problematic...it is epidemiologically inaccurate to generalise to that extent particularly about women who have sex with women.'* Several informants reflected that perhaps activities to reach WSW were framed with less accuracy because the need to address them was considered to be less urgent in comparison to key populations such as MSM as well as the need to target women within the generalised HIV epidemic in the context of heterosexual sexual transmission.

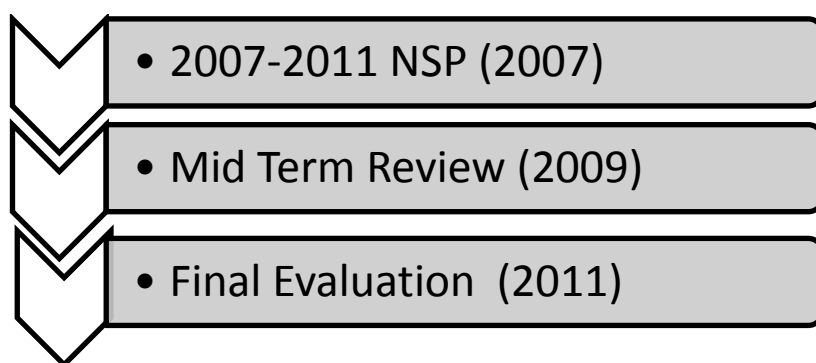
Several informants stated that they were surprised about the conflation of the needs of MSM and WSW with other vulnerable populations without noting the different risks between and among these groups. But given that issues affecting MSM brought the health needs within the LGBT community to the attention of policy makers informant 15 indicated that *'they used the correct language but in practice the interventions...were only ever directed to the one group (MSM).'* The next section will consider how those interventions were actioned in practice.

4.5 Policy Implementation: monitoring and evaluating action on the NSP

This section presents data on the final sub objective of study Objective1 reflecting on the implementation evidence that exists for SANAC led actions on 2007-2011 NSP commitments to address WSW sexual health. It considers the last two elements of the stages heuristic: implementation and evaluation in order to assess how policy content on WSW was translated into action. These actions would be initiated by Government with funding provided to partners from within SANAC to deliver programmes. The methods used for this section are primarily document review of *The National Strategic Plan 2007-2011 Mid Term Review* (South African National AIDS Council, 2009) and *The End of Term Review of the NSP*

2007-2011 Final Report (South African National AIDS Council, 2011a) as well as data that emerged from semi structured interviews to triangulate the findings.

Figure 4.5: Timeline of publication of 2007-2011 NSP Policy Document and Evaluations



Informant 5 reflected that while it was obviously a good thing that there was broad engagement in policy formulation they lamented that there was less focus on following through. They said *'it's all very well to have great plans but...it's the implementation and the monitoring of the plans that are really lacking or...don't receive much attention as the initial drafting of the plan.'* Informant 5 underscored this by stating *'South Africa is not unique...it's always been great at the plans, terrible at the implementation.'*

The National Strategic Plan 2007-2011 Mid Term Review (South African National AIDS Council, 2009) reflected on the first two years of SANAC's implementation of NSP objectives. Table 4.5a summarises the Mid Term Review's (MTR) documentation of implementation of objectives of the 2007-2011 NSP that included WSW interventions.

Table 4.5a: MTR evidence of SANAC implementation of interventions for WSW.

Objective/Intervention	EVIDENCE
Objective 2.5: Intervention: Incremental roll-out of comprehensive customised HIV prevention package for MSM, lesbians and transsexuals.	None
Objective 8.3: Intervention: promote integration and equitable representation of LGBT people in care, treatment and support programmes.	None
Objective 16.3: Intervention: Develop and distribute information materials on rights to HIV prevention, treatment and support that responds to the special needs of groups including...MSM, gay and lesbian people.	None

The MTR uses a revised set of definitions and targets for the LGBT population in its documentation of NSP outcomes. For example within reporting on *Goal 2: reduce sexual transmission of HIV* the MTR states in narrative on 'prevention and behaviour change in most at risk populations' that the "the present NSP describes...high risk groups often labelled globally in the UNGASS indicators, namely sex workers, men who have sex with men" (South African National AIDS Council, 2009: 34). The other populations 'lesbians and transsexuals' which were included in the original objective are excluded and no information is reported on any prevention activities undertaken for transgender persons or WSW. Similarly progress on *Goal 8: mitigate the impact of HIV and AIDS and create an enabling social environment for care, treatment and support* contains no mention of objective 8.3 or any impact mitigation efforts focused on LGBT people.

A technical report on progress towards goals in Annex A of the MTR includes a section on 'prevention of HIV transmission to high risk groups' which accurately reflects high risk groups defined in the NSP include both MSM and LGBT people. But nevertheless reporting focuses on MSM and does not provide any information about the broader LGBT population. This report does provide relevant context in a statement that "several township face social discrimination of Gays and MSM and there is silence on MSM in public health. When MSM and Lesbian, Gay, Bisexual and Transgender (LGBT) people go to clinics, there is no guarantee that they will not be refused service." (South African National AIDS Council, 2009: 114) Overall the inconsistent use of terminology between the NSP and the MTR results in making invisible the WSW content of NSP objectives and provides no data on progress on interventions related to their needs.

The End of Term Review of the NSP 2007-2011 Final Report (South African National AIDS Council, 2011a) was submitted to SANAC in late 2011 during the period when the subsequent NSP was being finalised. Table 4.5b summarises the evidence available on implementation of the WSW interventions outlined in the 2007-2011 NSP.

Table 4.5b: Evidence of SANAC implementation of interventions for WSW in Final Evaluation.

Objective/Intervention	EVIDENCE
Objective 2.5: Intervention: Incremental roll-out of comprehensive customised HIV prevention package for MSM, lesbians and transsexuals.	None
Objective 8.3: Intervention: promote integration and equitable representation of LGBT people in care, treatment and support programmes.	None
Objective 16.3: Intervention: Develop and distribute information materials on rights to HIV prevention, treatment and support that responds to the special needs of groups including...MSM, gay and lesbian people.	None

Again language was reframed in this document and the term ‘key populations’ which includes MSM and transgender people, but excludes WSW, was utilized. The report states that “to date, no national programmes exist within the South African HIV response to address the HIV prevention, treatment, care and support needs of key populations...South Africa did not reach any of its NSP targets for key populations...Evidence of discrimination towards individuals from key populations from health care and other service providers have been identified, and are major barriers to the provision of public health services...(and) have contributed to the increasing number of HIV infections among key populations.” (South African National AIDS Council, 2011a: 62)

Reporting on Goal 8 includes no mention of LGBT people. Reporting on Goal 16 is included in a section on ‘the human rights priority area’ which states that “the NSP explicitly provided for the promotion and protection of human rights...However, there was no clear strategic plan for this component and an absence of costing and funding for this area meant implementation and monitoring was compromised.” (South African National AIDS Council, 2011a: 14) None of the human rights objectives reported on were related to LGBT community issues. The section points out that the South African Constitution and other laws include provisions for vulnerable populations including MSM. This statement explicitly ignores that WSW’s rights are also protected by the Constitution. Several informants confirmed that there was no other documentation available that would demonstrate the Government’s initiation or SANAC implementation of activities related to WSW in the NSP objectives.

4.5.1 Reactions to Implementation Evidence

Most informants had negative reactions to the lack of implementation evidence around WSW sexual health in the MTR and Final Evaluations. Informant 19 stressed that the interventions outlined in the NSP are *'primarily aiming for Government programmes'* among these they hadn't *'seen...(nor) heard of one'* dedicated to WSW. Informant 4 confirmed there was no evidence of the three commitments in the 2007-2011 NSP concerning WSW being implemented by Government stating *'no, they were not actioned.'* Informant 24 confirmed that in regards to WSW policy content in the NSP that *'nothing happened.'* Informant 4 shared that they perceived that SANAC justified the lack of implementation by stating *'we don't have capacity, we don't have knowledge, we don't have (a) baseline.'* Informant 4 was concerned that after raising the profile of WSW in the policy process that there was a lack of follow through and they were left with the impression that WSW issues were *'kicked out of the national agenda from that point.'* Informant 7 noted that outlining LGBT issues in the NSP was *'typical to South Africa...affirming policies around sexuality'* the trouble was that it was also typical that *'in practice it wasn't pulled through...there were no programmes...no funding to achieve those targets.'*

Informant 2 expressed that they were not surprised that these commitments were not reported in the MTR or Final Evaluation and said *'I don't think that people realistically thought that Government was going to report on the indicators that way.'* Informant 5 commented that there was *'a lot of lip service paid'* and argued that perhaps LGBT issues had been included so that the NSP would be seen in a positive light by external stakeholders, such as the Global Fund, interested in targeting key populations. Informant 5 was concerned that issues had been outlined in the NSP without a clear idea of how to implement commitments and commented *'it's one thing for them to say we need to do something... but they probably didn't know what to do and how to do it...(we) can't really be surprised that it wasn't done.'* They expressed that given that SANAC set so many objectives for the 2007-2011 NSP it was unlikely that many specific commitments would be fulfilled by Government and that community based organisations should have been clearly implicated to take certain interventions forward and given sufficient resources to implement activities. But few LGBT organisations were implicated in NSP delivery and none were specifically engaged to action the commitments to WSW.

Informants reflecting on the intervention around provision of 'information materials on rights to HIV prevention, treatment and support that responds to the special needs of...lesbian people' found that the wording did not really capture the problems which had been expressed during NSP consultations. Informant 10 stated bluntly that *'there isn't any prevention information.'* From the perspective of informant 19 what was needed is not information for LGBT people on their right to services but *"what we need is respect education...your respect about what I'm doing."* Informant 19 reflected that SANAC should be commended for identifying marginalised communities including WSW but that they did not think that focusing on raising awareness of rights among LGBT persons was the solution and offered *"if anybody needs rights education I think it's the communities where women who have sex with women try to live."* Regarding the commitments to promote equitable representation of LGBT people in care, treatment and support programmes informant 19 reflected there had been no reforms in the health system to change the reality that *'queer women are still experiencing the same stigma and discrimination, denial of access to services, rude health care providers.'*

Informants lamented the absence of any targeted interventions for WSW delivered by Government and no resources being dedicated to WSW sexual health needs. Furthermore no research was funded by the public sector and no targeted prevention commodities were delivered to WSW in the public health system. Informant 21 stressed that expenditure had to be seen *'in the context of South Africa having a generalised epidemic.'* They concurred with the perspective that few resources were dedicated to WSW and classified expenditure within that population as *'insignificant.'* But informant 21 argued that the public health system was trying to reach maximum numbers of the most affected communities and thus allocations were *'purely looking at it from the numbers.'*

4.5.2 Implementation by LGBT community organisations

Informant 19 noted that in the absence of targeted programmes within the public health sector that LGBTI organisations *'try and fill in the gaps.'* Over time many LGBT community based organisations experienced a shift from offering social services to becoming providers of health services. LGBT community organisations operated the two largest clinics serving LGBT clients, Out LGBT Wellbeing based in Pretoria and Triangle Project based in Cape

Town. These two organisations also continued to advocate with policy stakeholders to consider how a focus on meeting the LGBT community's health needs could be mainstreamed into public health services. Another LGBT community organisation, Durban Lesbian and Gay Community and Health Centre were amongst a few other actors responding to the increase of STIs including HIV in the LGBT community.

Informant 1 suggested that if the Government had reported on any commitments delivered to the LGBT community it would have been *'primarily based on the work by Out (LGBT Wellbeing) and Triangle (Project).'* Nevertheless informant 1 was concerned that if the Government based reporting on LGBT interventions on funding provided to those two organisations that would convey *'this is what the country is doing'* which would not be fully representative at a national level *'because those are the only two that they have funded.'* Informant 1 presumed that the DoH provided funds for Out LGBT Wellbeing and the Triangle Project for clinical and health promotion work but another informant from an LGBT organisation was not aware of any specific DoH support of LGBT organisations to implement the NSP and maintained the perspective that *'there is no funding.'*

SANAC's reaction to the MTR was to try to highlight sectors which were failing to implement and identify areas where there were additional opportunities. There was a sense that programming for MSM was an area where SANAC saw momentum for scaling up based on the emerging evidence. LGBT community organisations clarified that the DoH reached out to certain organisations to ask them to implement services for MSM. Informant 7 concurred that resources for MSM services were made available to certain organisations but stresses that the funding was from *'PEPFAR (and) private foundation funding but not Government funding.'*

The focus on MSM health was unsurprising to many informants given that the evidence based on the burden of disease among MSM continued to advance as the 2007-2011 NSP was being implemented. Informant 7 recalled that *'major funding and research...developed around that.'* Informant 1 shared that the stipulations that came with external funding meant that the clinic operating within their organisation was catering almost exclusively to MSM to provide *'STI screening and...treatment... health seminars...(that) discuss health*

issues that impact men... men in relationships. ...we're not doing women in relationships...that has not been funded.' Several informants confirmed that there was neither domestic nor external funding available for provision of clinical services for WSW. Informant 8 confirmed that they were *'not aware of any funding'* for the NSP's commitment to a customised HIV prevention package to address WSW. Informant 10 confirmed that within the public health system *'there isn't... any recommendation...when we are talking about STIs (WSW) don't even think they fit into the picture.'* Informant 3 stated that in relation to either public or private provision of health services for WSW *'I think that if there are interventions there are few and far between.'* The impact of lack of resources meant that opportunities to address WSW sexual health needs were severely limited and that WSW have little conception of their HIV and STI risks.

Those organisations which had capacity to provide MSM services faced significant difficulties in raising funds for WSW. Informant 8 from an LGBT organisation argued that this was in part due to internal conflicts in the sector and that *'the people who were supposed to make sure there was funding actually didn't. There were powerful players in this court and... there's nothing for us to work with.'* Informant 8 stated *'you have to be very creative now in making sure that at least the nurse knows how two women have sex so they can give the right information ...there's no spaces...(for) a programme.'* Lack of health worker awareness of the sexual health needs of WSW created significant barriers in WSW access to accurate advice on prevention and treatment. Informant 3 stated that when WSW respond to health worker questions about their sexual behaviour honestly that *'we have ...examples of...nurses responding in utter shock.'*

Thus while the Government was critiqued for not including WSW programming in the public health system informant 3 expressed concern that the public health system is not *'adequately placed to deal with these issues.'* Informant 16 concurred that public health services experienced limitations in reaching *'people outside the mainstream population.'* Another LGBT community member reflected that the experience of LGBT people in the health sector has been documented as being poor but they stressed that *'the experiences of all South Africans using public health services are terrible.'* Thus they found it hard to

envision how service provision could be improved, particularly for WSW, when lifting up the system overall is complicated.

4.5.3 Broader constraints with Government's implementation of NSP objectives

Many informants spoke to the overall frustrations in seeing tangible deliverables from broader NSP targets. Informant 2 shared that *'there were so many fights going on just to keep Government accountable to some of the major indicators that affected the general population.'* Informant 18 said that *'none of the key population objectives were (fully) reached and many of them, in terms of an epidemiological perspective, have had a greater consequence in terms of the number of new HIV infections.'* Overall informants reflected that the 2007-2011 NSP was too ambitious, that its targets could not be reached, that implementation was uneven and some issues were overlooked. Informant 3 reflected that it would be *'impossible to actually implement everything'* and they felt that SANAC made decisions to prioritise only a few of the main objectives.

Several informants mentioned that there may have been a lack of buy-in to deliver the NSP within certain sectors of the South African Government. Informant 20 stated that while the Cabinet had endorsed the NSP that *'Treasury was not really on board in terms of funding the plan.'* Informant 20 inferred that even though certain populations such as WSW managed to be reflected in policy content there were no explicit resources available to make interventions for the population available. Informant 3 stated that *'if there aren't resources then it's the state's responsibility to make those resources available...that's where part of the problem lies.'* It was recognised that the LGBT community in particular was eager to be involved in implementation but did not sufficient resources to deliver services. Informant 3 found that if Government had nothing to report *'you can't pass the buck to the community.'*

Several informants inferred that if there was a NSP goal which was prioritised over others it was scaling up access to antiretroviral treatment. Due to South Africa's poor record on provision of ARVs it was important for the 2007-2011 NSP to place significant emphasis on scaling up treatment. This was backed by internal stakeholders and significant support from external partners including the donor community. But the emphasis on scaling up treatment seemed to result in trade-offs in terms of SANAC's ability to prioritise other essential HIV

services. Informant 20 remembered *'everybody was focusing on getting numbers on treatment and that's...where we slipped our grip on prevention.'* Nevertheless there remained questions about the reach of the treatment programme. Informant 3 noted that greater numbers were able to access ARVs but they stressed *'we don't know about the quality of these services...it's a mixed bag in some places there aren't any...people are struggling to get medication...at particular hospitals. It might be...good in particular urban sites but certainly not in non-urban sites.'* Conversely informant 16 considered that South Africa had made substantial improvements in delivering treatment and offered *'this is where I think South Africa can say, 'we have achieved'.'*

Other informants found that shortfalls of the 2007-2011 NSP were related to activities being included in policy content but not fully explained. Informant 18 felt that the NSP *'included things that may be representative of what people wanted but they weren't feasible.'* They noted that provision of services for WSW and other *'unique things'* were amongst the activities which were not well articulated. They also felt that the NSP's monitoring and evaluation framework was poorly defined and thus tracking the achievement of activities and identifying outputs was limited. Other opportunities for evaluation of policy implementation emerge from the objective role civil society has played in South Africa such as through campaigning groups like TAC. Regardless of this record of AIDS activism informant 5 stated that more recently *'there's not enough of a watchdog role played by civil society.'* Many informants noted that expectations among South African citizens are quite low with respect to Government's ability to provide health and other essential services.

Conclusion

This chapter has presented several stages in the policy process around South Africa's 2007-2011 NSP and the commitments to improve the sexual health of WSW in the context of their vulnerability to STIs including HIV. It demonstrated that through agenda setting and policy formulation the power of individual policy entrepreneurs using personal testimony from the affected community of WSW living with HIV led to partial inclusion in policy outweighing a dearth of evidence of the burden of HIV and STIs in this population. The strength of

coalitions around women's rights and LGBT rights was also examined to consider policy community coherence as well as internal opposition.

Following decision making the published policy document was not fully actioned and constraints in achievement of NSP objectives were discussed. Document review and interviews confirmed that neither Government nor non-state actors implemented the three commitments made to advance the sexual health of WSW. The role of LGBT organisations providing clinical services to members of the community, mainly to address the HIV service needs of MSM, were presented as part of the mandate to address key populations. Whether LGBT organisations were well positioned to serve their entire community and address the barriers that WSW, in particular, face in accessing quality health care was considered. The next chapter will review how the subsequent NSP set out revised commitments to address HIV and STI prevention within key populations and whether and how a focus on the sexual health needs of WSW was maintained in policy making.

CHAPTER 5 – NATIONAL STRATEGIC PLAN ON HIV, STIS AND TB 2012-2016

Introduction

The chapter presents the data collected on study Objective 2 and its three sub objectives:

To understand why there was a change in focus on WSW in the 2012-2016 NSP through analysis of:

- i. emerging evidence; political context, actor power and ideas;
- ii. the participatory process and how it shaped the content of that NSP;
- iii. how policy content on WSW differs in the 2012-2016 NSP from the 2007-2011 NSP.

The chapter will explore reasons behind a change in policy content regarding WSW as a population vulnerable to HIV and poor sexual health within the 2012-2016 NSP. This will be done utilising the policy triangle features of context and process and the stages heuristic of agenda setting, formulation and decision making. Throughout, actors: individuals, groups and organisations that were involved in each stage will be examined. The factors of the framework on determinants of political priority for WSW to be included in the NSP development process are considered with a focus first on evidence related to the issue characteristics and then the other factors political context, actor power and policy ideas.

5.1 Emerging evidence: efforts to convey Issue Characteristics

As reviewed in Chapter 4, issue characteristics as defined by Shiffman and Smith (2007) are health metrics and other data utilised to pose a problem to be addressed by policy. While WSW emerged onto the agenda for the previous NSP without rigorous data demonstrating the burden of HIV and STIs among WSW was necessary if commitments on the population would feature in the 2012-2016 NSP. Informant 1 involved in advocacy on WSW sexual health reflected that the policy and research community interrogated small community based studies on WSW *‘the questions...kept on coming...it didn’t matter how you present it...that’s not good enough.’*

Informant 2 reflected that SANAC took a more rigorous evidence based approach to developing the 2012-2016 NSP and that *'the element of surprise that we had in (2007) was not going to happen with the second NSP (2012-2016)...people were making sure that there weren't surprises.'* Informant 11 added that the discourse around WSW had to overcome perceptions that the population was 'low risk' *'that legacy...has remained...now...everything has to be evidence based so you can't...speculate.'* Informant 19 expressed their perception that between 2007 and 2011 the space for raising emerging evidence regarding WSW within SANAC and other policy forums *'got smaller and smaller'* and that the response to available data was usually to compare the statistical significance of WSW living with HIV to populations with a higher burden and as a result *'the discussion (around WSW) is pretty much put to an end.'*

The lack of prominent international research on the sexual health of WSW, particularly the possibility of HIV and STIs transmission among WSW, has had an impact on policy makers in South Africa. Informant 18 indicated that *'where we don't have local data we look at regional data, when we don't have regional data we look at international data...(which) is not showing compelling evidence for...female to female transmission.'* Academics involved in building the evidence base on WSW sexual health in South Africa expressed concern that even where studies on WSW were conducted, such as in the US, they seemed to have little impact on breaking through denial and silence around the HIV and STI risks of the population. Informant 3 offered that WSW were a *'misunderstood, underrepresented population'* and in their view the 2012-2016 NSP did attempt to *'create a knowledge base...I wouldn't say that they are fully prioritised but they are certainly recognised...that work needs to be done...with that particular population.'* Nevertheless they did not think that policy makers gave much attention to prioritising research on WSW *'probably because they were...not convinced that it would yield any fruitful results.'* They urged that the research agenda requires, among things, *'a biomedical study that looks at the broader issues around HIV, around sexual health.'*

Several researchers within South Africa and neighbouring countries came together during the period 2009-2012 to conduct a mixed methods multi country study on the sexual histories of WSW as part of efforts to grow the evidence base in the Southern African

context. The literature reviewed in Chapter 2 presents the two research outputs of this study published by Matebeni and colleagues (2013) and Sandfort and colleagues (2013). Members of the research consortia initially faced resistance to undertaking the research because of the common perception that WSW are not at high risk for transmission of STIs including HIV. Informant 6 said *'we were talking about women who have sex with women who are already living with HIV...what the circumstances were by which they contracted HIV but also...access...to treatment, care and support as well as questions around prevention...from that stance...we made the case for doing the research.'*

Informant 6 found that the results underscored *'the enormous presence of violence in the lives of women which is equally true for WSW as it is for women in general...we know that lesbians are getting targeted for rape... that needs...service response and policy response...however limited the research is, its strong enough to make that case.'* They found their colleagues were surprised that the research suggested the possibility of female to female HIV transmission in the region. This unexpected finding was compelling because *'the numbers...were significant...not huge...but significant enough that it raised real questions about the...common wisdom that it's virtually impossible for women to transmit HIV to other women.'* Informant 24 stated that there were concerns with the language that could be used to present this finding and that they were asked to indicate *'that there is direct transmission but it seems ...you...can't say...it was another female, you say 'it seems like'.'* This apprehension is apparently linked to lack of evidence of female to female STI transmission in research elsewhere until confirmation of a case in 2014.

The study's findings were available during the period leading up to the development of the 2012-2016 NSP. South African based organisations including the Durban Lesbian and Gay Community and Health Centre and Open Society Initiative for Southern Africa (OSISA) were in a position to use study findings in their advocacy within SANAC. A member of the research consortia presented findings in a briefing to SANAC around August/September 2011 which was followed by a press conference. Informant 24 commented *'I think people were not interested...the press conference was empty.'* Informant 2 found that when the study's *'credible info'* was presented to policy makers *'the reception wasn't as warm as we had wanted.'*

Although there was now more data on the sexual health of WSW it was not considered sufficient. Informant 2 lamented *'it still wasn't absolutely conclusive...it was meant to be one of many pieces that would come together to make an argument.'* The research consortium had been tasked with ensuring the study findings would be publicised in the media and delivered in advocacy to SANAC. By the time the research project was concluded funding for these communications efforts was unavailable. The consortia partner responsible for media work that had secured a tender with a national newspaper had to cease operations before they were able to publish. Informant 2 lamented that they had aimed to publish *'very clear messages around vulnerability of WSW to other STIs and HIV...we lost out on that.'* Similarly informant 6 stated that the project partners were unable to fulfil original vision of the project as *'there wasn't money for doing...follow-up advocacy anymore... the circumstances really worked to the detriment of the project.'*

Throughout 25 key informant interviews there was some limited awareness that research on the burden of HIV among WSW had been conducted in South Africa but few were aware that the results had been published in two articles in early 2013. Informant 4 lamented that perhaps researchers were not able to interview enough women and thus the data was not sufficiently powered. In their view *'that research failed to...articulate the issues...there's quite a lot of sero-discordant lesbian couples in the country.'* Moreover informant 4 was concerned that the study did not provide a base line *'if the country is...saying we will implement based on evidence...if you don't have...this number of...WSW that are HIV (positive)... and they've contracted...(due to)... same sex...we did not have that baseline.'*

Informant 19 reflected that in policy spaces there were critiques about the evidence. They reported that critics found that *'the sample wasn't big enough, it's self-reported...those question marks...can...actually discredit that there is risk.'* They added that similar concerns were not raised when considering data on HIV and STIs among MSM *'I never heard a similar argument used against the many self-reported studies...in relation to men who have sex with men.'* They were concerned that there was not more of a focus on human rights based arguments and stressed that in their perception when policy makers consider affected WSW

'it doesn't really matter if its 5% or 50%' they don't work in a policy making space. Which is highly disconcerting.'

Besides the multi country study another piece of research that was available to policy makers prior to the development of the 2012-2016 NSP was the study by Cloete and colleagues (2011) on WSW living with HIV. The study was cited by informant 18 *'that's the only thing I've come across... that's an opportunity sample... a small number of women...that's...one of the small things that have been done.'* There were also public events to raise visibility of the burden of HIV among WSW. Informant 4 involved in SANAC recalled *'OUT had an event...(around) 2010/2011...they tested 12 women...5 were HIV positive, 3 of them...have never slept with men...self-identified lesbian women...you have 3 of them saying 'we have never slept with men we have never been raped'...you need to ask ...How did they get infected?'*

A report which did shape the content of the 2012-2016 NSP was commissioned by UNAIDS and published by the Desmond Tutu HIV Foundation as *Key Populations, Key Solutions: A Gap Analysis for Key Populations and HIV in South Africa*. (Scheibe et al., 2011). It was made available in advance of SANAC's decision making around key populations to include in the 2012-2016 NSP. Informant 18 clarified that WSW were not considered for inclusion in the report and that the groups what were included were *'based on epidemiological data and...what UNAIDS...had identified from their modes of transmission studies...important areas for impact...where there had been lack of progress in the previous NSP...the things that weren't included weren't very robust studies.'* They offered that the report *'relied quite heavily on the NSP mid-term review and...feedback in terms of...programmatic development.'* They indicated that during the process of developing the report Dr Vicci Tallis, then working for OSISA, urged the inclusion of data on HIV among WSW. Nevertheless they felt that there was inconclusive data to show *'that WSW was a population of particular risk...that's why they weren't included.'*

Informant 1 interrogated the process around defining the priority populations for inclusion in the gap analysis report. They admitted that an *'absence of critical, scientific, research or information to...justify why (WSW) is supposed to remain a...high risk key population'*

undermined the continued inclusion and conceded *'when we did the key populations study...it was not necessarily prioritised.'* Their perception was that the gap analysis would include a recommendation that WSW sexual health *'still needs further research'* in the context of addressing key populations but that was not reflected in the report.

Informant 24 bemoaned an apparent lack of interest among policy makers *'the invisibility and marginalisation of lesbians...tells you...why this never became a public, national discussion... its women's issues, it doesn't bring money...you are tapping into...power and patriarchy and gender non conformity that people aren't really interested in.'* They concluded that in comparison MSM have been prioritised in African research more recently *'there's tons of money being given to MSM work all over the continent...because they fit into what we understand within a patriarchal system.'* Informant 12 stressed that gaps in the evidence base have a greater impact on lack of inclusion of WSW in policy. They offered *'I don't think anybody was opposed or was disputing the risk...if somebody...says 'I'm a WSW and these are the risks that I've identified' you cannot argue with that. But we use evidence to prioritise in the NSP and...that has been the biggest challenge.'* Similarly informant 23 added *'the data is not sufficient, the cases of reported transmission tends to be individual...that is what affecting inclusion of this...as a group that deserves more focus.'*

Informant 20 reflected that the high burden of HIV and STIs within other the general population and other key populations affected the prioritisation of WSW. They inferred that policy makers' standpoint is *'we've got bigger problems this is not a problem.'* Nevertheless this informant noted that attention to WSW sexual health is growing within SANAC *'we're starting to see data...people are going to start thinking 'how do we...start focusing'.'* Nevertheless because of the dearth of data advocates for WSW were less effective in 2011. Informant 1 noted that SANAC members who come from a scientific perspective *'would not listen...you may be civil society and recognised...but the question is 'where is the scientific research?'* As will be explored in the subsequent section there were also contextual changes which resulted in a focus on the evidence base becoming more prominent in decision making for the 2012-2016 NSP.

5.2 Political context: leadership changes

Just as the analysis of the previous NSP began with reflections on the Political Context this section considers the period leading up to and during the development of the current NSP in 2011. It will reflect on the socio-political setting within which policy decisions were taken by the South African Government at that time. As briefly discussed, in the review of the HIV/AIDS policy response in South Africa in Chapter 2 many changes in Government took place in the period between 2007 and 2011 at Presidential, Ministerial and Departmental levels.

Jacob Zuma became President of South Africa in May 2009 and following his election Zuma continued to express himself in problematic ways in relation to women's rights and LGBT rights. Informant 17 noted that while South Africa had a strong reputation for promotion of LGBT rights President Zuma seemed not to support this stance. They offered *'anti homophobia has always been part of the struggle...but it doesn't get unpacked...it's not helped by our President...in fact his misogyny and patriarchy...actually enables it.'* They recalled President Zuma making public remarks whilst in office such as *"Homosexuality is un-African. Women shouldn't wear skirts, you're asking to be raped."* Informant 13 lamented that any focus on hate crimes *'came through pressure from international groups'* and that the rise in violence against WSW had not been condemned by the President *'his lack of response...says a lot...Government people...(contradict) the Constitution...they don't get reprimanded.'*

A civil society informant could not recall any politicians speaking out about violence against WSW. They indicated that the Department of Women, Children and People with Disabilities was tasked with the response to GBV. The Department was established in 2009 and informant 21 clarified that it was a coordinating ministry not a line ministry and thus had limited resources *'they have to depend on the rest of us...to point us in the right direction...but...they don't have the leverage.'* Informant 12 lamented that the Department *'should have been an opportunity'* to focus on a range of issues affecting women, including hate crimes and other issues facing WSW, but that it *'has serious challenges in terms of...things that are...under their mandate to address.'*

Dr Aaron Motsoaledi's leadership of the Ministry of Health (MoH) seemed to be widely welcome by informants from both civil society and the public sector. Informant 9 regarded the MoH as *'the most progressive Minister that we've had who looks at health holistically.'* Informant 3 concurred that there was *'renewed energy by the Ministry of Health to deal with issues in its broadest possible terms.'* Informant 1 expressed their impression that Motsoaledi put less emphasis on HIV prevention which undermined efforts to support WSW prevention programming. They shared that when leadership changed to the current MoH the strategy changed to a greater focus on scaling up treatment at *'that national political level that the climate changed.'*

The social context in South Africa also changed and social conservatism grew. Informant 19 linked the public's frustrations with poor service delivery to social conservatism *'the increasing desperation of lack of progress...has a lot to do with people...getting more and more conservative...more judgemental.'* Within policy spaces the influence of civil society voices which are socially conservative increased. Informant 2 argued that Government had promoted the perspectives of some women's groups, often the more conservative groups, to be *'the legitimate voices'* on women's concerns including HIV/AIDS. At the same time many faith based groups involved in HIV programming became engaged in policy on the HIV response. This informant reflected that while faith based organisations have a role to play *'they took up more space than they were really entitled to...that was very much...encouraged by government.'* Informant 3 offered that among women's groups they have seen *'an infusion...of faith and religion in the way perspectives are put forward.'*

Informant 14 provided insight into how the ANC moved away from inclusion of views expressed by the main established Christian denominations in South Africa and *'are now consulting with the non-aligned...charismatic churches...those churches will give them the pulpit...(and) do not support LGBTI rights in any way shape or form...the issue has been quite effectively side-lined.'* They noted that within this growing conservative context WSW are not *'even seen'* and that they have few advocates within even progressive faith communities as *'there are very few religious leaders...that will take on that whole culture, gender, legal nexus.'* The informant did not sense that growing social conservatism would necessarily lead

to re-criminalising same sex sexuality but sees how it affects the ability of LGBT people ‘to live life to the full.’

Several informants found it ironic that given the rise of anti-homosexuality laws being proposed or passed elsewhere in Africa, South Africa is still considered progressive on LGBT rights. Informant 13 offered that ‘we live under this belief that what we can be free...yet there is a...backlash... we know that we can’t get arrested but the...police can do a lot of other things to a gay person.’ Informant 15 said ‘discrimination towards sexual minorities is widespread...within policy makers and that definitely has implications on...how policies are drafted and what gets implemented, what gets prioritised, what gets funded. But it may not be unique to WSW issues.’ Informant 16 remarked that regardless of WSW being cited within the 2007-2011 NSP ‘South Africa as a whole...is not willing...to acknowledge there (are) WSW...and therefore address (them).’ Homophobic views may be ingrained among some policy makers and could be another factor that contributes to invisibility of WSW health needs. The next section reflects on changes in the position of advocates to counter political and social conservatism.

5.3 Actor Power: maintaining attention in a new context

As Shiffman and Smith (2007) argue the relative strength of individuals and organisations concerned with improving an issue is key to getting an issue seen as a political priority. Between 2007 and 2011 there were a number of developments which negatively impacted the ability of actors concerned with WSW to influence HIV and STI policy making. The balance of power within SANAC seemed to shift from civil society to development partners, including donors and technical agencies, and privileged their input over the interests of community based organisations. The influence of individuals, such as WSW affected by HIV, seemed to be easily overlooked as organisations with greater power and resources rose to prominence in policy formulation. Informant 1 who became active in SANAC around 2009 learned from more experienced that civil society input used to be intrinsic to all decision making within SANAC ‘we were thoroughly consulted...we got side lined and we want that again.’

The positionality of civil society organisations in South Africa changed because of shifts in the way official development aid was delivered to South Africa and the influence of the Paris Declaration on Aid Effectiveness, with a focus on ownership, alignment and aid harmonisation which resulted in streamlining aid through Government and closed off funding that could be channelled directly to civil society. Informant 11 offered that this *'had a very negative impact on civil society...organisations that have much more clout than the LGBTI community have suffered...how much more so an organisation that didn't have a very strong voice?'* Informant 4 concurred that social movements in South Africa had by 2011 *'become weak not only LGBTI but civil society as a whole.'* A bilateral donor noted that given development partners cannot provide NGOs with core funding they become involved in service delivery and thus in policy spaces NGOs are working to safeguard funding for services rather than advocating for the strategic interests of their constituency.

Informants noted the global economic crisis of 2007-2008 affected many actors involved in HIV and STI policy in South Africa. Informant 22 from civil society reflected that external development partners had rescued South Africa's HIV/AIDS response in the past but had less urgency now *'when we were fighting and people were dying it was easy to raise funding. Now that we have medications and these policies are correct...it's much harder to...get international funding...its seen as...'you're ok now'.* Informant 11 reflected that development partners have *'very much dictated'* the direction of the HIV/AIDS response. They noted the larger development partners offering by way of example *'where PEPFAR's money goes is where programmes go.* It was noted that given South Africa is classed as a middle-income country certain donors are withdrawing. For example, in 2013 the UK Department for International Development stopped Official Development Assistance to the country.

Informant 3 cited that the economic downturn had *'a profound impact on the sustainability of LGBT organisations...many organisations have folded.'* As a result they see *'competition for resources and basically survival'* within the LGBT sector and those organisations which remain approach the sustainability of their organisations more strategically. Informant 3 reflected that because all the funding for sexual health in LGBT organisations is directed towards MSM interventions there are *'divided interests'* in the LGBT community wherein

WSW sexual health is *'somewhat lost.'* They noted that while the LGBT community still comes together to address human rights abuses they are not coalescing *'strategically around...programming and...policy implementation'* within SANAC.

South Africa is regarded by development partners to have progressed on the range of LGBT rights and informant 3 remarked that the country has *'overcome a lot of the hurdles...so far (as) sexual orientation is concerned...the donors reprioritise and they move out.'* An influx of private foundation grant making to the LGBT sector in South Africa from 2000 was as critical but several of these donors began to phase out support at the time the impact of the economic downturn was being felt. Informant 3 commented that regardless of external resources *'the capacity of some...LGBT organisations have not necessarily been strengthened.'* Informant 2 admitted that they *'cannot deny the effect that the withdrawal of major donors had on this sector and on the rights and health of WSW.'* Informant 17 remarked that *'international donor...money for women's rights...gay rights...has disappeared'* and underscored that *'lesbian...rights (are) at the bottom of that.'* Informant 05 argued that in the context of constrained resources WSW sexual health *'is not something that's going to get any prioritisation at all.'*

5.3.1 SANAC civil society forum

The capacity of SANAC to fulfil its coordination mandate was questioned by several informants and a few judge SANAC to be quite ineffective. Informant 2 called SANAC *'an incredibly powerful body without the capability.'* Informant 23 concurred that that SANAC *'needs to be capacitated a little bit more to be able to do its coordinating activities.'* One of the reasons informants cited for a lack of coordination capacity is that SANAC has increasingly become involved in implementing projects itself. Informant 9 said that this mission creep had come about because *'they also want to be seen to be doing something... where they would be implementing.'* Informant 20 was concerned that this not only changes the focus from coordination but undermines the role which SANAC is meant to play in oversight of the national HIV/AIDS holding public sector to account and *'identify...departments that have dedicated funding ...(to) deliver on their mandates.'*

Regardless of the influence of development partners within SANAC it is a key mechanism for civil society mobilisation. Informant 3 said that SANAC is *'led by civil society in many ways with oversight from the state.'* Between 2007 and 2011 the sectors of SANAC's civil society forum increased from 17 to 19. In 2010 UNAIDS conducted an audit of the civil society sectors of SANAC to consider their impact and possibilities within a structure of 19 separate civil society sectors. The audit was presented within discussions on the restructuring of SANAC in 2011 and civil society representation was scheduled to be revisited within the restructure but no substantive changes were made. The SANAC women's sector emerged from the UNAIDS audit as one of the stronger of the civil society sectors. Informant 12 said that the sector had comparative strength because *'they had very good funding.'* Nevertheless informant 11 reflected that the women's sector had experienced contestation of leadership which made it hard to *'get on with the job...everybody's position became very contested...there was a distraction because of politics.'* Informant 16 reflected that the sector was *'disrupted in themselves...they're also disjointed from SANAC.'*

As noted in Chapter 4, advocates concerned with WSW sexual health emerged from the SANAC woman's sector in 2007. By 2011 there was less space for WSW advocacy within the sector and difficulty in coming to consensus with more conservative women's groups. Informant 20 noted that there were fewer vocal members to raise WSW issues *'one (or) two people that are...trying to put the agenda on the table for discussion.'* Informant 21 was asked whether WSW issues are better articulated through the women's sector than in other sectors responded *'I think it should be, I don't think it is frankly.'* Informant 16 felt the women's sector should continue to include WSW issues *'not all LGBTI...part of it.'*

5.3.2 The emergence of the SANAC LGBTI sector

The need for a dedicated forum in SANAC within which to raise LGBTI issues led to the establishment of LGBTI sector. Informant 4 remembered they had argued that *'we need a sector because issues are disappearing...we were coming really close to the end of the NSP 2007-2011 (asking) what has been done?'* The sector began as an observer from 2009 and then with full sector status by 2011 and was operating in advance of the development of the 2012-2016 NSP. A LGBTI sector meeting convened in March 2011 made the case for the HIV prevention needs for the LGBT community considering the health risks and the human rights

violations in the public health service. An informant from a multilateral agency said it was at this meeting where they heard messages around: the HIV and STI prevention needs of WSW; WSW living with HIV; and issues around stigma and discrimination of WSW in health services.

A member of the LGBTI sector clarified that among the 13 organisational members only 3 explicitly prioritise WSW issues. Informant 13 lamented that the LGBTI sector is not prioritising concerns around HIV or STI prevention interventions for WSW and shared *'for us there's not so much...tangible results that we can see'* from being involved in the sector. Informant 9 said that the LGBTI sector is *'facing the same struggles that other sectors are facing...coordination issues.'* There seems to be a lack of policy community cohesion within the LGBTI sector and a balanced representation of the needs across lesbian, gay, bisexual, transgender and intersex persons are as priorities within SANAC processes. An informant from the public sector argued this lack of cohesion in the sector is based on rational choices and prioritisation of interventions which are evidence based.

Many informants perceive the SANAC LGBTI sector to be almost wholly concerned with MSM policy and programmes. Informant 12 said the LGBTI sector was *'able to advocate...largely around men who have sex with men'* and any WSW issues were mainly around *'corrective rape, murders.'* Informant 18 argued that the LGBTI sector's focus on MSM was justified by epidemiological data and *'appropriate in terms of the...epidemic.'* The evidence base around MSM and HIV in South Africa developed considerably over in a short time period to provide data on the risk behaviours as well as socio-economic metrics of the MSM population which have been utilised to target interventions. Informant 7 expressed that previous difficulties in making public health based case around WSW resulted in the MSM research agenda progressing much faster *'they did...epidemiology...and didn't focus on the identity politics.'* Informant 21 noted that once the sector was included in SANAC *'donors took a new interest in the LGBT community'* and cited PEPFAR's funding of MSM interventions as an example. They felt that this resulted in the LGBTI sector having *'more resources to organise themselves.'*

Informant 4 lamented that the additional resources *'led the movement in a desperate mode...to...focus where money is, we'd all then be able to survive.'* The need for LGBTI sector members to survive with the programme funding available seems to have resulted in trade-offs in terms of prioritising WSW. Informant 19 stressed that there was not policy community cohesion within the LGBTI sector *'there isn't a united voice...in the context of HIV exposure, transmission and related rights abuses, WSW have extreme(ly) different realities and risk(s) than MSM.'* Informant 21 reflected that the LGBTI sector is *'quite fractious...there's been a lot of infighting...within the LGBT community.'* Informant 15 implied that some members *'sabotage(d) efforts'* to integrate WSW health within MSM programming. They recalled that a joint proposal to the Global Fund developed by several LGBT organisations to resource both MSM and WSW interventions did not go forward saying *"we...have to go through the MSM channels but even those channels are not working.'*

Informant 17 worried that the emergence of the LGBTI sector damaged the ability of the women's sector to pursue WSW interests. They wondered if *'we really thought through the politics of having these two different sectors with...very limited ...capacity.'* Nevertheless they argued *'it's not right that the women's sector deals with LGBTI issues...it's bigger than a women's sector issue...I'm not seeing an overlap between the two sectors.'* The fact that MSM and WSW issues were combined in the 2007-2011 NSP may have resulted in setting up the wrong structure within SANAC. Informant 19 tried to unpack what could be achieved by a joint LGBTI sector *'either you have five different groups within the one sector or you have a sector which claims be LGBTI but...is fundamentally MSM.'*

It is clear that the WSW actor power had diminished considerably between the framing of the NSPs in 2007 and in 2011 due to a variety of factors: economic constraints due to changes in external resources; growing social conservatism including among women's groups; and a lack of cohesion among LGBT organisations trying to capture the policy participation opportunities afforded them by prioritising the issues where they have the strongest evidence of health impact.

5.4 Policy Ideas: actors maintain interests in a new context

Herein both internal and external frames of ideas expressed in 2011 by advocates for WSW sexual health will be considered. Consensus among SANAC's technical partners, particularly UNAIDS, on the key populations which should be considered within the 'Know Your Epidemic Know Your Response' paradigm corresponded to limitations in the ability to address WSW sexual health. Informant 4 offered that SANAC priorities on followed changes in the *'the international priorities...for this sector'* prioritising key populations, including MSM, and reflected *'that's where the money is.'* Informant 20 noted that there were *'quite a lot of programmes that are currently taking place around MSM...with Global Fund as well (as) PEPFAR.'* Informant 21 offered that perhaps South Africa has not struck the right balance but *'the key question is...within a generalised epidemic how do you deal with marginalised communities... we don't have it fully right yet...we have focused on is MSM to some extent because they are a vocal group.'*

The necessity for WSW advocates to fit their ideas and arguments around the focus on key populations marked a change from how they engaged in previous discourse around most at risk populations (MARPs). Informant 17 remembered *'we had this whole MARPs language and MARPs was MSM...people who were more progressive...trying to push it...to be LGBTI.'* They recalled that they were aware of a push for Africa to consider MARPs and their interpretation was *'that's good cause all women are a marginalised population so we can do MARPs...(we'll) do women. But that's not how it was seen... it was seen as an MSM issue.'*

Once the focus on key populations became a priority in South Africa advocates for other groups had to reconsider how to present their needs. Informant 1 recalled *'we moved from minority groups to key populations...that...placed a dent in how you get... WSW issues back into the NSP.'* Informant 11 recollected that the definition of key populations was where the next 1000 HIV infections will emerge from. They said this caused confusion about how to frame other populations *'marginalised populations are not necessarily key populations...WSW would...fall under the category... of vulnerable... because of the marginalisation but they're not where the next 1000 infections are coming from.'*

Some informants expressed frustration with the focus around infection risk that the key populations discourse seemed to impose. Informant 20 confirmed that WSW were not a SANAC priority because they *'don't fall in any of...the traditional key populations as defined by UNAIDS. They're also not in the long list of key populations that have been identified in the (2012-2016) NSP.'* Informant 19 raised concerns with the perceived grading of HIV risks *'because it creates false sense of safety.'* They pointed out that in the South Africa context of *'highly stigmatising...communities we live in not testing for HIV is a safety measurement.'* Thus many South African's do not know their HIV status or whether they have STIs *'we don't know how infectious we are...then this whole grading falls apart and creates (a) sense of safety which there isn't.'*

Similarly the perception that WSW are at low risk of STI and HIV infection seems to have obscured concerns around the poor sexual health of WSW. Informant 15 reflected that while the evidence of female to female HIV and STI transmission in the research discussed in section 5.1 had been perceived as being inconclusive they still wondered why more wasn't being done to address potential risks *'we know that there are lesbians who are HIV positive...are we supporting...lesbians to...go for tests, are we supporting them to access treatment...once they discover they are HIV positive?'* This informant stressed that regardless of the outcomes of research conducted thus far categorising WSW as low risk was not accurate in the South African context *'you can't use that language any more about no risk and low risk...not in our settings. That language...(is) giving people a false sense of security.'*

One of the main ideas that continued to be raised by advocates for WSW was the ongoing experience of violence and hate crimes targeting WSW. There seemed to be some fatigue among the general public around press coverage of these issues and informant 17 noted that over time *'media coverage around...hate crimes has been declining.'* The sub optimal response of the criminal justice system wherein these crimes are not being prosecuted effectively is undermining victims' reporting. Informant 16 lamented the poor conviction rate in South Africa and claimed *'these cases never get convicted, never.'* Informant 9 expressed frustration and wondered *'these things take so long to be resolved it's as if our justice system is actually condoning that...behaviour.'* Informant 15 said that they see

discrimination of WSW even within rape care centres *'lesbians are being raped everyday but they cannot access...services because... services are discriminatory.'*

Informant 4 recalled that when GBV/IPV was identified as a driver of the HIV epidemic in South Africa a focus on WSW did not emerge to consider *'in the context of lesbian women, how do you address that?'* Informant 16 said it was important to note that the sexual assaults experienced by WSW are *'targeted violence... not intimate partner violence'* the terminology used to describe violence against women within heterosexual relationships. Informant 18 argued that awareness around WSW experience of sexual assault was the main frame through which WSW vulnerability to HIV and STI transmission are perceived *'because we're very aware that most of the HIV infections that occur...the probability of transmission (of) penile/vaginal sex is much higher.'* Informant 19 worried that WSW experiences of sexual violence are insufficiently differentiated *'there is no political context attached to women who are raped, violated and killed are often specifically targeted due to their sexual orientation.'* Because of this 'sexuality blind' approach the informant asserted that there are no targeted interventions for WSW *'from a programming point of view...in the state response.'*

Informant 21 expressed regret that South Africa has not had a *'major national campaign against corrective rape...when it happens people speak out against it but that (is) episodic.'* They were dismayed that within SANAC they perceived that advocacy about WSW affected by 'corrective rape' *'isn't vocal enough and I don't understand why... I don't think they have been good advocates for their own cause. Notwithstanding the fact that all of us should be concerned.'* Similarly informant 20 said that within SANAC a focus on hate crimes against WSW was inconsistent *'one person will have a comment around it...then after that it will be quiet.'* Informant 9 reflected that while 'corrective rape' continues to be seen as something that should be condemned advocacy on the issue still does not include the links to HIV and *'the vulnerability of... women who have sex with women...to HIV because of the violence.'* Informant 12 agreed that hate crimes raised the profile of WSW issues and *'that should have been an entry point...for...the advocates to say 'these are not the only challenges that we're facing'.'* Informant 20 said it would be opportune to raise WSW issues within national advocacy around the 16 Days of Activism Against Gender Violence, for example, *'but we*

haven't heard much(in those events)...we're just talking about an ordinary vulnerable woman.'

Informant 1 lamented that SANAC framed concerns around GBV/IPV within targets on human rights, safety and security and asserted that it should also be dealt with as a *'mental health and...sexual health issue.'* The focus on violence experienced by WSW had resulted in a partial picture of the sexual health needs of WSW *'we're only worried about the violations...we're not talking about healthy fulfilling sexual lives.'* They also felt that pertinent questions are not being asked to tailor HIV and STI services such as *'how many women are survivors of rape, how many are testing positive, what kind of on-going support are they receiving, are they in lesbian relationships?'* Informant 22 said that even when WSW are recognised in the GBV discourse *'when it comes to HIV (WSW) they are the last group that anybody thinks about. Including the activists and Government.'* This informant was unclear why the links to HIV in sexual violence targeting WSW were not being highlighted *'it's really difficult to say whether because (they) are lesbians they are going to the bottom of the pile or whether sexual assault goes to the bottom of the pile.'* It seems not many new ideas were presented by advocates for WSW sexual health in 2011 and attention issues the community had been bringing attention to such as 'corrective rape' were waning in public attention and not being addressed by the government. It was difficult for advocates for WSW to fit their arguments within the focus on key populations wherein concepts around the vulnerability and marginalisation of WSW were not given due consideration.

5.5 Policy Formulation: the participatory process for consultation on the 2012-2016 NSP

The next two sections correspond to the second sub objective of study Objective 2: to analyse the participatory process for consultation on the content of the NSP. This part of the policy process relates to the formulation and decision making stages of the stages heuristic. Informants were able to recall a great deal more about policy formulation in regards to the 2012-2016 NSP than for the previous NSP as it occurred around two years previous to data collection. SANAC's 'roadmap' for NSP development was first discussed among its sector leaders in March 2011 and in subsequent committee meetings in the following months. One informant remembered that it was at one of the civil society sectors' summit in July 2011

that they first heard the Deputy Chair of SANAC provide initial guidance on the opportunities to input into NSP development.

Informants revealed that SANAC intended to reflect on where the 2007-2011 NSP had succeeded and where it fell short before developing the 2012-2016 NSP. Implementation evidence from the MTR had been available since May 2009 but the Final Evaluation were not released until November 2011 giving little time to reflect on the findings. Informant 9 argued that the drafting process should have reflected on implementation of the previous NSP *'it's a process...(that) should be...what has come out of the implementation...where do we need to make an improvement.'* Informant 22 concurred that they did not think that the 2012-2016 NSP had meaningfully reflected on the outcomes of the 2007-2011 NSP and that it would have been strategic to consider *'did we make the last one?...we had some successes but where were the failures?...the failures should have been focused on more in this NSP which they are not.'* Another informant argued that there was reflection on the limits in implementation of the previous NSP, particularly that not much had been achieved around key populations. Given the failure to implement any WSW related interventions SANAC may have considered whether it could legitimately recommit, for instance to prevention interventions for WSW, in the 2012-2016 NSP.

Informants gave varying views about the participatory nature of the NSP development process in 2011. Informant 12 expressed that the NSP *'was developed in a really meaningful participation...people sitting around the table.'* Informant 16 recalled *'there was a lot of emphasis put on consultation...the civil society consultations around the NSP was three days of three hundred civil society people...a lot of...what came out of that was operational...very little about strategic policy directions.'* Informant 11 said that there was a *'genuine attempt...for....meaningful participation...there were...big summits where everybody had a chance to...engage.'* Nevertheless they noted meaningful participation depended on sector strength and cohesion as noted *'part of the problem is that the sectors are not always resourced'* and the summits often *'became highly politicised with...sector politics.'*

Several informants felt that the NSP consultation process in 2011 could not be regarded as legitimately participatory. The consultation process was considered by several informants to

have been led by the DoH and UNAIDS. Informant 14 stated that the development *'involved very little civil society consultation. It was driven with technical support from UNAIDS.'* Informant 1 said they witnessed *'consultants basically working with the various departments to gather a plan.'* Informant 24 regarded it as *'a very managed process...a document that was...developed by the DoH...shared with key constituencies and not in a long consultation process, not in a fully participatory process.'* Informant 19 was unaware of the summits that SANAC had held saying *'there was not one big consultation everyone had their own consultation in their own...corners.'* Informant 14 revealed that they were involved in a separate consultation involving TAC and the National Association of People living with AIDS *'we were called in...at quite a high level...we were...given the plan and we had some deep concerns about that plan that are...not reflected.'*

Given the outcomes of implementing the 2007-2011 NSP with its numerous, ambitious targets there was an increased emphasis in 2011 on developing a set of priority interventions. Informant 16 said *'the idea was to have a 20 page NSP...we said we cannot have a shopping list.'* SANAC sectors were asked to prioritise effective interventions within the Know Your Epidemic, Know Your Response paradigm. Several informants cited use of the concept of developing 'game changer' in the response to HIV and STIs within guidance provided to participants. Informant 11 explained that *'key SANAC people...driving the NSP...specifically from the Department of Health...(said) 'what is in the NSP is... the strategic stuff we're going to do in the next five years...hence the game changers.'* This informant's impression was that there was a *'thrust from SANAC leadership and the DOH...was, 'what are the game changers?'*

It seemed that the policy community was not entirely clear on how to apply a mind-set around 'game changers'. Informant 11 said that lack of understanding resulted in consultation participants coming up with points that did not fit the brief *'you could hear what people were saying...but you knew it was never going to...(be included) in the NSP...issues would have been better...if they were framed within that game changer terminology.'* The informant added *'the reality is that what is in the NSP will be what is focused on'* and they felt SANAC had a responsibility to clarify what would happen to interventions which were not included in the plan. They reflected *'people don't trust the fact*

that it will be dealt with' if interventions are not in the NSP. Given that SANAC did not clarify what other mechanisms would set programming decisions 'sectors...were not misguided to be pushing' for all of their priorities to be included. They went on to say 'it becomes hard...particularly (for) sectors representing marginalised communities to make sure...these things are on the agenda' but conceded that 'even if the team write that in, it's going to get a...strike out from the powers that be' within SANAC leadership and the DoH.

Some informants were concerned that the NSP development process was not only steered by the DoH but the drafting team was perceived to be very focused on biomedical interventions. Informant 16 said that *'the drafting committee continued with what they knew best'* but that they *'didn't have very strong people'* to write the sections on Strategic Objective 1 (social and structural drivers of HIV, STI and TB) and Strategic Objective 4 (protection of human rights and improving access to justice). One informant recalled that the SANAC sectors had to bring perspectives around the structural drivers of HIV back into the plan. Informant 16 remembered *'there was quite a strong push from the PLHIV sector who put the socio economic drivers on the table.'* Informant 11 stressed that it was important to deliver messages at SANAC summits but emphasised that concerns had to be written in sector submissions to the NSP consultation. They added *'it leaves too much up to chance...if I wasn't at a particular meeting where a representative...from the LGBTI community...said 'these are the key issues'...there was some sense of security...knowing what was in the sector submission.'*

Attitudes were mixed about whether civil society engagement in the consultation processes that were made available was worth the effort. Informant 19 shared *'honestly I think we all got fatigued...there was enormous commitment, passion leading up to the first NSP and then you've seen the final product'* expressing disappointment with the outcomes of the 2007-2011 NSP. When reflecting on the lack of implementation of WSW interventions, this informant added that engagement in NSP development had not paid off *'we tried that avenue, obviously that is not a real space.'* There were limits of engagement from the LGBT community related to the weakened state of LGBT organisations as discussed in section 5.3. Informant 2 reflected that by 2011 *'there were fewer organisations around...the funding crisis had ...hit the LGBT community and other...partners ...there were...fewer voices.'* They

added that the lack of policy cohesion in the SANAC LGBTI sector had an impact on messaging around WSW within the NSP development. They recalled that *'those voices were not a critical mass...there wasn't always one coherent voice from the LGBT community.'* Informant 11 offered that they had concerns around policy cohesion within the LGBTI sector as they perceived *'there was a stronger voice of MSM.'*

The actors who remained engaged through the SANAC LGBTI sector had to fit their arguments within the 'game changer' paradigm. As informant 2 viewed it they *'had to decide where they were going to put their energy and it wasn't going to be on WSW issues.'* Informant 11 conceded that both the key populations discourse and the 'game changer' paradigm impacted the space within which to frame WSW issues *'there was probably an assumption that it wasn't the next 1,000 (infections)...so in terms of dealing with WSW as a game changing intervention...that probably wouldn't have made a difference.'* Informant 2 perceived that *'tiredness... had settled in...it wasn't just with the lesbian community it was across the LGBT community...people were fighting for survival...the NSP was another process on top of everything...when they were still involved it was limited.'*

Informant 16 stated that the SANAC LGBTI sector *'weren't strongly represented in this consultation...they...didn't come through with strategic suggestions.'* They reflected that even when the LGBTI sector engaged in the NSP consultation process some of their concerns were misunderstood *'the more complex...less understood issues fell out...of those is...LGBTI.'* The informant reflect that the approach to key populations recommended in the *Key Populations, Key Solutions Gap Analysis* (Scheibe et al., 2011) expanded in the development of the NSP and they were concerned that there seemed to be no *'link between these analytical tools and the writing of the NSP...there was very little analysis but it felt politically correct.'*

The decline in funding for LGBT organisations as well as women's rights organisations placed limitations on the ability of advocates for WSW to engage in the NSP development process. Informant 17 noted *'we don't have a sector of paid people driving these issues. Which is why when the NSP comes out we didn't have people who could do that work...because they were...doing it in the evenings.'* This was echoed by informant 15 who said there *'aren't*

enough strong advocates for WSW issues in the country...extremely few... these few people...have to find work elsewhere...and...do this...as a second issue.'

5.5.1 Civil society input into NSP drafting

Some advocates were able to get their points across directly to actors leading the drafting of the 2012-2016 NSP. Informant 21 recalled that *'while we were writing the NSP...groups would ask to see me.'* In relation to the SANAC LGBTI sector they regarded such intercessions as a *'clear indication that they're not working together.'* They recalled that Steve Letsike, an advocate for WSW issues *'would meet quite often...we'd meet with the MSM community as well...because the (LGBT) community is not one thing.'* Informant 11 said they were *'petitioned by a number of organisations'* who were concerned that they might be forgotten. They recalled that there was an organisation representing transgender people who were *'very proactive in making sure that their voices were heard in the writing process...someone... said 'please listen...to these people'...somebody...knew that this was going to be completely marginalised if it wasn't brought to our attention.'* Informant 24 who was involved in the multi country study on WSW was not clear if anyone involved in that research had the opportunity to present the findings to the drafting team by saying *'here, look, this is the data.'* Informant 11 could not recall anyone representing WSW issues approaching them directly *'that actually does make a difference...not to say that WSW is not (at the) top of (the) mind...just...maybe I didn't know enough of the issues.'*

Concerns around participation in the NSP development process emerged as initial drafts of the plan were made available for comment. Informant 9 recalled that the SANAC women's sector wrote a letter of concern to those leading the NSP drafting regarding perceived flaws in the policy process. The letter was particularly concerned with absence in the NSP drafts on perspectives on the burden of HIV and STIs among women. The informant remembered that the women's sector claimed that *'the NSP is not reflective of the nature of the epidemic in the country.'* The women's sector letter stated "We are concerned regarding the absence of women living with HIV, WSW and women living with disabilities from our dialogues. MSM overrides the particular risk that women face, with research on WSW continuously ignored in spite of the growing body of evidence" (SANAC Women's Sector, 2011: 1). The official response from the SANAC Deputy Chair stated "given the feminisation of the HIV epidemic

in particular, as well as the roots of infection in gender inequalities, gender equality must be reflected in each strategic objective of the next NSP... The roadmap for the development of the NSP has been developed with all sectors of civil society” (Heywood, 2011b: 1). The response did not address the perceived exclusion of WSW and other marginalised women from NSP dialogues nor the allegation that evidence of poor WSW sexual health was ignored by the drafters.

Organisations which had the capacity to review NSP drafts and write submissions had a very demanding process to fit into. Informant 17 revealed that after the consultation process began in June 2011 there was a delay of several months in the release of the initial draft (Draft Zero) *‘we saw the first draft...that was October already.’* Thus the finalisation of drafting had to be completed within two months in order to publish the NSP by December. A set of Policy Recommendations on Draft Zero of the 2012-2016 NSP submitted by the civil society organisation Section 27 pointed out that the NSP must “resist the temptation to be everything to everyone” (Section 27, 2011: 2). Informant 17 remembered being surprised by the thrust of Draft Zero saying it *‘was an HIV/TB document, it had dropped gender...dropped LGBTI.’*

Informant 24 recalled that the tight timelines were unreasonable *‘draft zero to draft 3 or 4 were rapidly...moving...organisations did not have the full time...people who were...drafting were moving at the speed of light...picking up things when people would come and lobby them.’* Informant 19 lamented that the condensed timeline meant that SANAC sectors were operating in silos as well as fragmenting within themselves. They noted rather than a more coherent approach witnessed in the 2007 process and felt that in 2011 there was no time to ensure joined up messaging across interests *‘cross referencing was rather scarce especially given the short... turn-around time...within three days you just about managed...to have a response let alone...cross reference with other sectors.’*

Informant 17 said that multiple submissions from ad hoc coalitions of organisations who would have traditionally engaged through the SANAC women’s sector showed a lack of coherence. They pointed out that they collaborated on a submission that utilised the Framework for Women Girls and Gender Equality in NSPs in Southern and Eastern Africa

which drew from policy analysis presented in Chapter 2 (Gibbs et al., 2012a); (Gibbs et al., 2012b). Their submission on Draft Zero recommended that the NSP “specifically mention women within marginalised groups vulnerable to HIV infection” (HEARD et al., 2011: 1). Regarding GBV the submission recommended that the NSP “expand interventions that address stigma and discrimination based on HIV status, gender, and sexual orientation...(and) develop interventions to address violence against lesbian, bisexual and transgender women, including ‘corrective rape’” (HEARD et al., 2011: 5). These recommendations were reiterated in their subsequent submission on Draft 2.

While that submission went through the SANAC women’s sector informant 17 was dismayed that *‘there were other submissions like...(on) SRHR... which I don’t think went through the women’s sector...should have been coming through the women’s sector.’* Another submission responding to Draft Zero on *Encompassing HIV prevention within a Sexual and Reproductive Health and Rights (SRHR) Framework* was developed by a consortium of SRHR implementing organisations (Marie Stopes South Africa et al., 2011). The submission raised concerns that the NSP was not integrating SRHR programmatic interventions and stated “Access to and uptake of SRHR services for women and men of all ages should be placed as the first and foremost goal in the NSP...(but) the NSP shies away from talking about sex and sexuality”(Marie Stopes South Africa et al., 2011: 5). These comments seemed mainly concerned around the need for acceptance of guidance for and sexually active young people and did not explicitly mention a need for the NSP to address sexuality issues beyond heterosexuality.

The rapid process of the NSP development negatively impact those closely involved in the finalisation of drafts. According to informant 17 the SANAC women’s sector leader was also acting as leader of the LGBTI sector at that time but *‘there wasn’t a strong women’s sector behind (her).’* Nevertheless that leader made a collaborative effort to provide comments and suggest additions to the text of the later drafts which were jointly lodged by the SANAC women’s and LGBTI sectors. Informant 12 could not recall whether this submission *‘highlighted those (WSW) issues.’* The following text relevant to WSW sexual health concerns were suggested in the joint submission from the SANAC women’s and LGBTI sectors on NSP Draft 2:

- **NSP Principles:** The NSP must ensure the inclusion in all processes and consideration of specific needs of all women...Lesbian, bisexual, transgender women and men...;
- **Implement interventions to address gender inequities and gender-based violence:** Develop interventions to address violence against lesbian, bisexual and transgender women, including 'corrective rape';
- **Social interventions:** Health Care Provider may refuse MSM service based on their believe (sic) ignoring Batho Pele principles (the policy and legislative framework regarding service delivery in the public service);
- **Make accessible a package of sexual and reproductive health (SRH) services:** Maximised coverage of male and female condoms and lubrication through distribution in health facilities and non-traditional outlets;
- **Prepare for the potential implementation of future innovative, scientifically proven HIV, STI and TB prevention strategies:** The provision of oral PrEP for MSM; The provision of oral PrEP for key populations that would benefit, such as discordant couples;
- **Protection of Human Rights and Promotion of Access to Justice:** Develop interventions to address violence against lesbian, bisexual and transgender women, including 'corrective rape';
- **Auditing interventions to identify potential for human rights abuses:** Secondary victimisation at service point...hampers response for women particularly lesbian women, sex workers and transgender women and men;

5.6 Policy Content: a lack of focus on WSW in the 2012-2016 NSP

The National Strategic Plan on HIV, STIs and TB 2012- 2016 (Republic of South Africa, 2011) was launched on World AIDS Day, 1 December 2011. Reviewing the policy content of the 2012-2016 NSP reveals that no WSW specific commitments were made. Of the three concerns around WSW sexual health that were framed in the 2007-2011 NSP only one was retained in the 2012-2016 NSP. Concerns regarding barriers to health service access experienced by WSW are reflected on in Strategic Objective 2: Preventing New HIV, STI and TB Infections as shown in Box 5.6.

Box 5.6 Policy Content of the NSP 2012-2016 relevant to interventions for WSW

“The NSP cannot achieve its prevention objectives unless key high-risk determinants of HIV, STIs and TB are addressed...Social interventions include efforts to change cultural and social norms that increase vulnerability to HIV and STIs and to reinforce those norms and behaviours that are protective...Social norms may also promote discrimination against members of the community with... different sexual orientations (e.g. men who have sex with men and women who have sex with women) and may result in reluctance to attend health services for fear of discrimination” (Republic of South Africa, 2011: 39).

While WSW are mentioned in the contextual narrative of the prevention objective none of the sub objectives, the actual prevention activities, include interventions around the HIV and/or STI prevention needs of WSW. In order to fulfil the prevention objective the NSP states that South Africa would implement “a comprehensive national social and behavioural change communication strategy with a focus on key populations...to increase the demand and uptake of services, promote healthy behaviours, and address norms and behaviours that put people at risk for HIV, STIs and TB.” (Republic of South Africa, 2011: 15) While the list of key populations outlined in the 2012-2016 NSP maintains a focus on MSM and transgender persons from the previous NSP it does not include WSW.

Informants could not reveal the decision making within DoH and SANAC, as well as directives given to consultants, to finalise the text of the 2012-2016 NSP for publication. A few informants mentioned that in the final days of the drafting process the acting SANAC LGBTI sector leader continued to negotiate to include any of the recommendations reviewed in section 5.5.1 from the joint SANAC women’s and LGBTI sector submission. Informant 5 reflecting on the omission of policy content on WSW *‘I don’t think that the drafters of the NSP...Government or the Health Department really understand WSW and I don’t think they’ve done much for WSW.’* Informant 1 added that they were not sure what factors led to the shift in the agenda on WSW in the NSP *‘if it was a political thing if it was just a research...thing or what really, what were the drivers...we don’t know we just saw a change and nobody was willing to say exactly.’* Several informants who were asked whether the reason for exclusion of WSW related commitments in the 2012-2016 NSP because of

poor implementation evidence from the 2007-2011 NSP did not think that it was and felt it had more to do with lack of epidemiological evidence.

Informant 5 felt that an emphasis on policy content is not necessarily the only mark of successful participation in the policy process. They reflected that in terms of WSW being framed in either of the NSPs *'it's kind of a victory to have it in a plan but one needs to do a lot more advocacy with policy makers to really get them to understand and see it as an important issue.'* Nevertheless informant 23 found that the mere fact that WSW were mentioned formed a basis with which to begin to develop interventions saying *'the South African Government...is aware that this population exists...it was there in the past NSP...what could be argued is that there's not enough data to allow Government to make...financial decisions...leading to implementation...the issue becomes what works.'*

Conclusion

This chapter reflected on several important developments affecting advocates for WSW sexual health that occurred between 2007 and 2011 when the two editions of the NSP were published. Contextual changes in political and social spheres brought more conservative voices to the fore and limited the influence of key actors and constituencies with an interest in advocating for WSW. The constrained economic climate put significant pressure on the operation of many organisations which had previously been able to engage in SANAC processes.

The chapter presented stages in the policy process to develop South Africa's 2012-2016 and considered whether the development of the plan was managed in ways that allowed for meaningful participation of civil society. A dedicated space which could have been used to bring issues affecting the sexual health of WSW to the attention of SANAC was available following the establishment of the LGBTI sector but it was shown that this forum did not prioritise these issues nor was it influential in getting suggested interventions for WSW into the NSP. The SANAC women's sector was not effectively utilised to highlight WSW concerns due to general dysfunction as well as the sense that the LGBTI sector was mandated to take up these issues.

Advocates for WSW were disempowered by not being explicitly linked to the key populations under consideration for targeting of HIV and STI prevention programming in South Africa. These advocates seemed unable to effectively marshal evidence of the burden of HIV and STIs among WSW despite compelling results from recent research conducted in the country. The following chapter will consider these observations and the findings in Chapter 4 in greater detail.

CHAPTER 6: DISCUSSION

Introduction

This chapter discusses themes emerging from the results presented and the literature reviewed. It is structured around a three main cross-cutting themes that have emerged from the utilisation of the framework on determinants of political priority for issues to be included in South Africa's NSP. These are related to: 1) how evidence on WSW sexual health concerns have fared within the emphasis on an evidence based approach to developing the South African NSPs; 2) actor power, coordination and competition among actors involved in NSP development and implementation; and 3) implications for framing ideas around WSW sexual health within arguments around addressing HIV and STIs from women's rights perspective. Attention to how the political as well as cultural, economic and social contexts inform these thematic areas is integrated throughout to consider a range of questions the findings have raised and present some responses to them.

6.1 Making the case for WSW in the NSPs: the problem with the evidence

As chapters 4 and 5 demonstrate the application of several of the categories of the amended framework on determinants of political priority for issues to be included in South Africa's NSP elicited rich findings on how interventions to improve sexual health and enhance prevention of HIV among WSW were initially proposed in the NSP and how they changed over time. The attempted application of the category which Shiffman and Smith (2007) refer to as 'issue characteristics' and what Kingdon (2003) called 'the problem stream' showed some disconnect from the theory on factors which shape political priority. Through both NSP development periods the features of the health problem of poor sexual health and vulnerability to HIV within the population of WSW in South Africa were not well grounded by data to make the severity of the problem clear and/or propose interventions that could be used to meet WSW sexual health needs.

Given the lack of specific attention to WSW within health services, data on WSW is limited in health literature and thus it is considered "unsurprising to find that lesbians have been

marginalised within medical research and practice into HIV and AIDS” (Richardson, 2000: 41). Some have argued that this marginalisation is a form of structural violence perpetrated against WSW wherein “heterosexist medical practices and the erasure of lesbian, bisexual and queer women in epidemiological classifications and HIV research” (Logie and Gibson, 2013: 37). As discussed in Chapter 4 a lack of extensive evidence did not impede advocates to urge for the inclusion of WSW health needs in the 2007-2011 NSP. These advocates, some who were WSW living with HIV, convincingly utilised findings from small opportunity samples, along with personal testimony to persuade decision makers. However informants lamented that WSW STI and HIV prevention needs were actually poorly understood by NSP implementers which undermined the ability to take action to achieve the proposed activities for WSW.

Chapter 5 considered how influential actors in South African Government and its technical and funding partners stated the intention of developing an ‘evidence based’ plan to set out ‘game changers’ in the response to HIV/AIDS in 2011. Meanwhile new qualitative and quantitative data identifying a burden of HIV among WSW had emerged and could have been marshalled to make the case for maintaining WSW as a focus population within HIV and STI prevention efforts. Several reasons undermined efforts to communicate this emerging evidence which resulted in missed opportunities to enhance understanding among public health actors on the ‘problem stream’ of WSW sexual health.

In this study two paradoxes occur when applying the theory around ‘issue characteristics’ as an intrinsic factor of the determinants of political priority for issues to be included in South Africa’s NSP. Firstly, in the development of the NSP in 2007 there seemed to be less of an emphasis on a plan that was ‘evidence based’. The inclusion of WSW within several objectives was based primarily on anecdotal evidence which might have been easily overlooked if not for the efforts of some influential actors that were concerned with the problem. Secondly, as additional data around WSW sexual health emerged (thus justifying the inclusion of WSW in national strategy on HIV prevention, treatment and care and demonstrating the need to continue to include WSW in interventions) a range of actors seemed uninterested, uninformed or unimpressed by the findings. Clearly in 2011 the available evidence, including all South African studies on HIV and STIs among WSW

undertaken between 2004 and 2011, was a small and incomplete data set when evaluated in terms of credible indicators, severity and effective interventions. Thus the theory around the need to employ a full set of 'issue characteristics' in order to influence political priority is somewhat validated by the analysis of the 2011 NSP development process.

In summary the trouble with attempting to analyse the position of WSW within the South Africa NSP development processes through the 'issue characteristics'/'problem stream' lens is: initially anecdotal evidence was enough to result in policy content on the health needs of the population, yet subsequent findings that provided a greater understanding of the same health problem were not considered rigorous enough to attract political priority nor be considered a 'game changer' within a generalised HIV and STI epidemic. Researchers undertaking health policy analysis in relation to 'emerging' issues (such as new health problems or the emergence of an existing health problem in a new community, especially within a population that is societally marginalised) could face challenges tracking the role 'issue characteristics' play when health metrics are not yet available. The awkward fit between the theory and my findings elicits questions such as: how can an 'emerging issue' gain enough traction to be included in national health strategy setting; and what kinds of data can ignite the agenda setting process?

These paradoxes also implicate structural barriers within the conduct and application of health research. There is a particular conundrum around how a health problem can overcome the seemingly vicious cycle of lack of political buy-in to fund studies when there is limited evidence of the problem (in a 'hidden' population). Perhaps the strategic approach to advocacy for WSW sexual health in the 2007-2011 NSP should have been to urge for a well-resourced research agenda to undertake HIV and STI prevalence and incidence studies among WSW in various communities/locations in South Africa. The results show that in 2007 the LGBT community already had a sense of urgency to call on Government to address health threats they experienced. Taking painstaking linear steps towards scientifically validated 'issue characteristics' around WSW sexual health is not particularly reminiscent of the traditions of impatient South African AIDS activism.

It may have seemed like a victory for advocates for WSW that the 2007-2011 NSP set the intention to address WSW sexual health but given that nothing really transpired as a result it was a somewhat premature success. The inclusion of the commitments reflected neither an accurate understanding of the health problems and potential solutions nor a commitment to implement interventions. It is possible that an entrenched *scepticism* or actual ignorance among public health actors about the possibility of WSW living with HIV and STIs remained due to the scarcity of data on the population in national and international research during three decades of the AIDS epidemic.

Thus it seems that the documentation of policy content may have been only an initial point along an incomplete journey of this 'problem stream' emerging as an issue worthy of prioritisation in implementation. The literature reviewed presents several WSW sexual health studies, each in turn considering an exponentially larger cohort, evidence that was not considered credible enough to make the case that prevention efforts for WSW be included in the 2012-2016 NSP. The exclusion of this evidence seems rooted in a variety of assumptions within evidence based health policy which are explored in the next section.

6.1.1. Pathways for evidence to influence health policy

Among policy actors there is an increasing awareness that the process of the results of research being integrated into policy or 'getting research into policy and practice' is not solely a technical process of transferring the knowledge that research findings offer but it is also a political process. Actors involved in health policy decide on the selection of priorities and the allocation of limited resources. Authors of a systematic review of political and institutional influences on the use of evidence in public health policy found that many health issues have intrinsically social aspects and thus issues around equity, justice or morality come into play when decisions are made based on health evidence (Liverani et al., 2013). Others argue that given the politicisation and contestation of research findings is by no means unusual in decision making in health policy there really is no such thing as 'evidence based policy' rather what we see in policy documents should be considered to have been 'evidence informed' (Humphreys and Piot, 2012).

Given the political context of getting evidence into policy it is understandable that the results of this study showed that presenting the problems of WSW sexual health was overpowered or overlooked within wider arguments around applying evidence to 'strengthen' the NSP and decide the 'game changers' for a generalised HIV epidemic. Nonetheless advocates for WSW were proposing 'game changers' for that population and were underserved by the available 'issue characteristics'. Some policy analysts consider that 'issue characteristics' equate to something more than health metrics but also include the political aspects of health issues (GRIP-Health, 2014). These political aspects include moral factors which play a complex role when being applied to sexual health (and reflections on sexual behaviour and identity) as well as the relatively disempowered positions of marginalised populations which hold less political influence.

Policy analysts have argued these 'political' aspects shape how evidence is understood and why it is contested in policy processes (GRIP-Health, 2014). Looking at the political aspects of the evidence of HIV and STIs among WSW in South Africa gives greater insight into why the problem has been misunderstood or ignored as well as why there has been very little research undertaken. The literature review showed that issues such as the social marginalisation of women, especially gender non-conforming women, and non-heteronormative sexual behaviour are embedded in WSW sexual health studies. These challenging features played a role in complicating discussions about these issues and may have been a factor in relegating WSW to the background of SANAC dialogue.

There are also a set of methodological critiques relevant to WSW sexual health studies undertaken in South Africa which have disadvantaged the use of this evidence in policy making. In quantitative studies there are inherent problems with conducting population based research with small sample sizes as the resulting data is often insufficiently powered to be considered statistically significant. As reflected in Chapter 2, WSW sexual health research has been implicated in this weakness. Malterud and colleagues (2009) expressed concern that small WSW population sizes in health studies result in lack of power and type II errors. Similarly Kwakwa and Ghobrial (2003) queried whether it was possible to prove, with any statistical power, the existence of a risk factor for HIV infection among women who

exclusively have same sex partners and have no other identified HIV infection risk factors due to the low numbers of women who meet those criteria.

Another methodological problem is associated with the use of 'opportunity' or 'convenience' sampling e.g. wherein study participants are recruited among clientele of a clinical or social service institution. While such sampling is considered to be a weak form of sample selection it is often used to gain access to study populations which might be harder to reach through broader sampling among a general population. At least one WSW study included in the literature review was cited by an informant as utilising an 'opportunity' sample and thus the informant somewhat minimised the study's findings.

A bias towards the consideration of quantitative findings seems to have occurred in the evidence used to support the development of the 2012-2016 NSP. The few times informants referred to studies they had accessed to consider STIs and HIV among WSW they were citing quantitative studies. Researchers recognise that there is value in both quantitative and qualitative approaches but the application of quantitative findings are sometimes given greater value in biomedical approaches in treatment, and increasingly prevention, of HIV/AIDS. The findings reveal that beyond methodological concerns factors that are intrinsically moral and political in nature undermined the reception to qualitative research on WSW.

An informant involved with the qualitative research undertaken by Matebeni and colleagues (2013), which utilised a community participatory approach to data collection, reported that the study's findings were questioned by academics and public health practitioners. Those who expressed scepticism of the outcomes of the study did not necessarily focus on methodological issues but reacted to the personal narratives of 24 self-identified lesbians living with HIV in South Africa, Namibia and Zimbabwe. The informant explained that sceptics did not believe what these women had to say about their sexual histories and the HIV and STI transmission risks that occurred in their lived reality. This critical stance reveals how dominant cultural and personal belief systems, informed by heteronormative views of women's sexuality, are entrenched in the public health field. Such views contribute to a

particularly intractable feature of the politicisation of evidence on WSW sexual health which relies on understanding a range of women's sexual behaviours.

Another form of evidence which might have been utilised to make the case for inclusion of WSW sexual health concerns in the 2012-2016 NSP could have emerged from monitoring and evaluation findings of the interventions undertaken by SANAC partners to fulfil the objectives of the 2007-2011 NSP. The outcomes of public health evaluations have traditionally been a source of evidence of impact which can be used to inform policy making. Informants for this study expressed a preference for a comprehensive review of NSP evaluation outcomes to be used to inform subsequent NSP development and noted that the monitoring and evaluation component of SANAC's work seems to be a weak point. In this case the lack of implementation evidence on the WSW related interventions in the MTR or Final Evaluation of the 2007-2011 NSP was not only a missed opportunity in terms of service provision in those five years but it also subverted the chances of such interventions being rearticulated in the 2012-2016 NSP.

6.1.2 The influence of global health policy and normative guidance

The results reveal that at some time between 2007 and 2011 SANAC refocused on ensuring that the 2012-2016 NSP would be 'evidence based'. This emphasis seems to have partly come from South Africa's development partners and potentially without much guidance on how to navigate the range of available global and national evidence on HIV, STI and TB programming. Policy analysts have cautioned that issuing a call for health policy to be 'evidence based' may encourage decision makers to prioritise biomedical interventions backed by robust data rather than grapple with how to apply innovative programming which draws from the social sciences, e.g. interventions that address the structural drivers of vulnerability to health threats, particularly among marginalised populations (Liverani et al., 2013).

The desire for SANAC to focus on evidence based responses to HIV, STIs and TB is likely grounded in frustrations with earlier policy failures in South Africa and the lethal outcomes of the influence of AIDS denialism on South African leaders. Similarly donors would be

particularly keen that their resources be spent on effective solutions and the findings revealed there was a sense of disappointment among donors and others that the 2007-2011 NSP was unable to achieve more in terms of averting new HIV and STI infections. As discussed in Chapter 2 global health policy actors, particularly within UNAIDS, began to urge national leaders to take a more nuanced approach to HIV prevention employing a discourse around the need to target key affected populations. Normative guidance on 'key populations' was concretised in the Political Declaration on HIV/AIDS from the UN General Assembly Special Session in July 2011 which noted that "many national HIV-prevention strategies inadequately focus on populations that epidemiological evidence shows are at higher risk, specifically men who have sex with men, people who inject drugs and sex workers" (United Nations, 2011: 5) and urged that each nation "should define the specific populations that key to its epidemic and response, based on the epidemiological and national context" (ibid: 5).

The results show that the normative guidance on key populations was employed to consider South Africa's domestic priorities for prevention efforts in the 2012-2016 NSP. While South Africa's HIV epidemic remained classified as generalised, SANAC considered how to address evidence of increased HIV incidence among certain populations which were stated in the NSP as being "areas where the epidemic seems to be concentrated" (Republic of South Africa, 2011: 25). As discussed in Chapter 5 UNAIDS commissioned the *Key Populations, Key Solutions Gap Analysis* (Scheibe et al., 2011) to provide a set of recommendations on the South African populations that should be considered for prevention interventions in the 2012-2016 NSP. The analysis included the three globally agreed key populations as well as transgender people, migrant populations and prisoners. Around the same time period SANAC published a summary of a study also conducted to inform the 2012-2016 NSP, the *Know Your Epidemic, Know Your Response* summary report (South African National AIDS Council, 2011b), which highlighted MSM, sex workers and their clients and another eight populations representing higher rates of new HIV infections in the country.

These inputs were integrated into the 2012-2016 NSP to produce an even more exhaustive set of fourteen key populations defined as "those most likely to be exposed to, or transmit, HIV and/or TB" (Republic of South Africa, 2011: 25). Half of the populations listed were not

cited in either of the commissioned reports but were nevertheless considered by SANAC as the populations to show “a definite overlap with the global list of key populations” (ibid: 25). It seems that there was an imperative to connect the consensus held by South Africa’s technical assistance and funding partners on the global ‘key populations’ to a broader range of South African groups from which new infections are fuelling the generalised epidemic. It is important to distinguish the discourse used in the NSP wherein key populations are defined as ‘those most likely to be exposed to or transmit HIV’ and the understanding expressed by informants involved in drafting the 2012-2016 NSP that they should consider populations ‘where the next 1000 HIV infections will emerge from’. The former is reminiscent of how vulnerable populations might be described while the latter has a more precise scope that could be used to target prevention efforts.

Public health actors seek to prioritise the drivers of sexually transmitted infections, also known as ‘core groups’ or ‘super transmitters’ who have a high number of sex acts per person (Barnett and Whiteside, 2006). Over time researchers have found that the concepts around these drivers have often made assumptions regarding sexual behaviour that are over simplified (Watts et al., 2010). In a public health response individual relative risk is not as important as population attributable risk and when there is a large population with a major reservoir of infection, such as is the case in South Africa, even ‘low risk’ sexual behaviours can add to a lot of new infections. Thus revisiting the question of why WSW were not included in the prevention imperatives for the 2012-2016 NSP when key populations were classified as those likely to be exposed to or transmit HIV we must reflect on whether the vulnerability of the population could have marked it for inclusion. Perhaps public health actors view HIV infections among WSW as ‘dead end’ infections which will not lead to a lot more transmission but given the limited data on the sexual behaviour of WSW in South Africa the picture is too incomplete for such an assertion.

Women are represented within ten of the fourteen key populations highlighted in the NSP 2012-2016 related to HIV, STI and TB risks associated with factors such as: their age; location, profession, including sex work; income level and substance use among other issues. For instance, the NSP notes that people living in informal settlements in urban areas known as townships have higher HIV prevalence and thus looks at risk in terms of

geographical area or 'hot spots'. Clearly all sexually active residents in such settings are at risk but informants lamented that WSW living in townships do not receive targeted HIV services. Factors that impede WSW access to South Africa's public health services include: stigma and discrimination by health care workers; misinformation; misdiagnosis and refusal to treat especially when requesting HIV counselling and testing (HCT) when the health worker is aware that they have same a sex partner. The results reveal various informants struggled with the discourse around at risk populations and how these multiple classifications could be implemented without causing fragmentations in service delivery in South Africa's public health system.

Furthermore given the focus on 'bridging' populations seems to have been part of the motivation for prioritisation of men who have sex with men and women similarly WSW who have male partners are a 'bridging' population which could have been integrated within the NSP. This inclusion might have required a more nuanced understanding of: sexual behaviour among WSW; how behaviours do not necessarily match sexual and/or gender identity; realities WSW face, including survival mechanisms that necessitate transactional sex and the preponderance of 'corrective rape', which bring WSW into sexual contact with men. Increasingly global health normative guidance on HIV prevention draws on a broader understanding of sexual risk behaviours to set parameters for populations to be targeted. Although this has challenged public health actors to target interventions based on sexual behaviour, the key populations discourse may have resulted in a new orthodoxy which has resulted in the exclusion of considerations of the vulnerability of WSW.

The 2012-2016 NSP states that one of the principles of the plan is that it is 'evidence based' and declares that "initiatives should be based upon evidence and implementation should focus on the achievement of well-formulated objectives and targets. Instances in which there is a lack of evidence, a clear motivation should be given...supporting the prioritisation of the intervention, e.g. rights-based arguments"(Republic of South Africa, 2011: 21).

Chapter 4 demonstrates that in 2007 policy actors were receptive to rights based arguments around WSW vulnerabilities to HIV and other STIs but Chapter 5 shows that advocates for WSW faced a range of challenges within SANAC in 2011 which are discussed in the next sections.

6.2 Actor power, coordination and competition

Chapters 4 and 5 provided insight into SANAC processes, particularly the opportunities afforded to a range of civil society sectors to represent the interests of groups involved in the national response to HIV, STIs and TB. The results showed that while these sectors are meant to be representing the strategic interests of their constituencies within policy making and implementation often the organisations comprising the sectors focus instead on their organisational interests, particularly concerns around the funding for implementation of NSP interventions and other HIV/AIDS programmes. While this is indeed a strategic interest there are some trade-offs which may hamper the ability of the civil society sectors to raise issues on the SANAC agenda. It is not clear if the preoccupation with organisational sustainability is inherent in how SANAC leads collaboration processes with civil society organisations or rather reflects the realities of a resource constrained context where anxieties about sustainable funding are inevitable.

Whatever the reasons, the results show that there are missed opportunities to consider strategic or emerging policy issues when the SANAC civil society sectors are mainly concerned with technocratic implementation of their funded work to deliver NSP priorities. The findings also showed that the sectors were a site wherein the prioritisation of issues and interests are contested. Contestation in policy making sometimes leads to a refinement in agenda setting and enhances coordination but often results in competing interests. These preoccupations were evident in the findings on the functionality of the SANAC LGBTI sector which are explored in the next section.

6.2.1 Coordination and competition: who is addressed by the SANAC LGBTI sector?

In 2009 the lesbian, gay, bisexual, transgender and intersex (LGBTI) populations came to be represented by one sector in SANAC. Gay men and lesbian women had been involved in South African activism during the struggle against apartheid and after democratisation they worked in solidarity to secure their rights in the Constitution and subsequent laws to ensure non-discrimination on the basis of sexuality. As has occurred elsewhere, over time in gay and lesbian rights movements have expanded their agenda to fight for the sexual rights of

bisexual women and men and transgender and intersex people, including their right to determine their gender identity. As was explored in chapter 4, the interests of WSW emerged from the SANAC women's sector in 2007 but no informants elucidated exactly why or by whom it was decided that there should be a separate sector to coordinate a response to WSW and the other populations within LGBTI community that they may or may not be closely aligned with in making the case toward SANAC.

Nevertheless the new LGBTI sector was mandated to coordinate SANAC's response for these broad populations and some informants reflected this was perhaps premature for WSW advocates as it has led to depreciation of attention to their agenda. There seem to be some overall complications with placing the health interests of these populations under the umbrella of LGBTI sexual and gender identities. Doing so does not resonate with a renewed public health focus on targeting interventions based on sexual behaviour. Within public health research at global and national levels concerns around MSM vulnerability to HIV has been consciously delinked from the sexual identities of gay and bisexual men in order to place attention on high risk sexual behaviours. As Chapter 4 discussed arguments around sexual identity versus behavioural markers was one of the factors that complicated effective discourse around the HIV and STI risks faced by WSW. It seems ironic that the SANAC sector is labelled by the sexual identities of the LGBTI community while the main outcomes of its work have been to address the sexual behaviour based HIV risks faced by MSM.

It is also problematic that there seems to be a conflation of the use of broad term LGBTI with only two populations that are commonly recognised as facing higher HIV risk which are MSM and transgender women, whose vulnerability centres on unprotected anal penetration. A precarious precedent is being set which makes it seem that LGBTI peoples' health needs are broadly represented and responded to whilst lesbian and bisexual women, in particular, are remaining invisible and unaccounted for in HIV and STI programming. This conflation seems to be reoccurring in global health policies and evaluations, for instance a recent PEPFAR gender strategy outlines key affected populations that its' funding will focus on including 'LGBT populations' but highlights HIV prevention interventions for MSM and transgender persons (The President's Emergency Plan for AIDS Relief, 2013). Similarly, the European Commission Regional HIV/AIDS Helpdesk's assessment on HIV prevention gaps in

South Africa included a section titled LGBTI which only highlighted data on HIV prevalence among MSM and explicitly conflated terminology in their recommendation to “increase financial resources and/or technical support for organisations that provide health service specifically to LGBTI, as many MSM feel more comfortable using services specifically targeting MSM” (Aguilera, 2011: 23).

This conflation and invisibilisation is fundamental to the competition taking place within the LGBTI sector and is also central to the inquiry as to why WSW lost prominence within SANAC discourses over time. The results reveal that informants perceive the LGBTI sector to lack the capacity and/or the will to advocate for all the populations which it was mandated to represent and coordinate. WSW are not the only group within the LGBTI sector structure that has missed out. The health needs of transgender and intersex people have been overlooked in SANAC processes. For instance the findings noted that a transgender community organisation took independent actions to influence the 2012-2016 NSP drafting team lest their issues be forgotten.

The findings reveal that advocates for MSM succeeded in gaining attention within SANAC processes and several organisations in the LGBTI sector received funded interventions to target that population. The evidence base on MSM vulnerability to HIV and STIs, grounded in global data collected over three decades of the HIV pandemic, provided a strong basis for reflecting on what could be done for the population in the South African context. As was reflected in the previous section the global consensus around the need to target key populations, including MSM, spurred the efforts of South African public health actors. Major health financing partners, including the Global Fund and PEPFAR, enhanced their ability to dedicate funding for interventions for MSM and other key populations. For example, PEPFAR’s Partnership Agreement with South Africa 2013-2017 states US Government intentions to support the South African Government’s prevention efforts for key populations including MSM.

As resources for MSM programming began to flow LGBTI sector members worked together to coordinate implementation of funded initiatives and fulfil corresponding NSP priorities. Thus the results showed that the sector’s discourse became more and more dominated by

implementation of MSM interventions as those organisations with the capacity and/or remit to respond to MSM took the one option they had to attract funding. The opportunity cost is that there is greater competition within the sector as it has been unable to serve as an effective advocate for the strategic interests and unmet health needs of WSW and others represented within LGBTI. The SANAC LGBTI sector is missing opportunities to consider the health needs of all the populations under its mandate and represent their strategic interests to the South African Government and its development partners. Some informants expressed a sense of resignation that the LGBTI sector would not be in a position to prioritise WSW sexual health agendas in the future.

If that prediction is correct then advocates for WSW will have to seek other alliances within which to make their case for the Government's response to WSW rights to health. While solidarity in confronting homophobia and enshrining sexual rights in law was the basis for South Africa gay men and lesbians to collaborate in the past, the disparate contexts of MSM and WSW vulnerability to HIV and STIs may mean that their needs might be better addressed through different sectors. For WSW that may require the need to reposition their agenda within the SANAC women's sector although they may face a variety of challenges therein which will be explored in the next sections.

6.2.2 Actor Power: through the lens of gender and sexuality

Some informants contended that in a patriarchal society such as South Africa, wherein men hold greater power than women, public health interventions for men tend to be prioritised. Informants cited recent examples of new funding which has been made available to roll out medical male circumcision programmes across South Africa as well as for social interventions working with men and boys to challenge harmful gender norms. Comparing this trend with the emergent focus on MSM is problematic though as gay and bisexual men continue to face stigma and discrimination in South African society to the extent that most of the interventions currently being made available for MSM are being delivered through siloed services. Nevertheless several informants expressed the growing concern that the rise in funding for men, including MSM, coincides with a decline in funding for programming to

address the burden of HIV among women, including WSW, and that this is an overarching feature of competition within SANAC.

Reflecting on the relative power of different actors involved in SANAC it is important to acknowledge that the LGBTI sector represents populations who are disempowered in South African society. The politics of sexuality were examined by Rubin who argued that many societies “appraise sex acts according to a hierarchical system of sexual value. Marital, reproductive heterosexuals are alone at the top erotic pyramid...as sexual behaviours...fall lower on the scale, the individuals who practice them are subjected to a presumption of mental illness, disreputability, criminality, restricted social and physical mobility, loss of institutional support and economic sanctions” (Rubin, 1989: 151). The reason why LGBTI people’s human rights, including their right health, have often been denied is because they reside lower down the scale of such an ‘erotic pyramid’ and thus hold less power. The framers of South Africa’s Constitution intended to erase discrimination on the basis of sexuality from society but hierarchal views have persisted. MSM may seem an anomaly to have emerged from among other powerless groups in South Africa, but their HIV incidence rates driven by greater biological susceptibility might not be as high if their social position was more equal. The results show that the power that advocates for MSM have wielded within SANAC correlates directly to the prominence public health actors have accorded to the evidence on the HIV risks experienced in the population.

The relative powerlessness of WSW seems to have been unshakable though as they continue to be invisible within SANAC processes. Moreover many public health actors seem to have been disinterested in female sexuality expressed through same-sex sexual behaviours. From the beginning of the AIDS epidemic in the US the Centers for Disease Control and Prevention (CDC) omitted an indicator to capture HIV infections among WSW in part due to misconceptions around female same-sex sexuality. Early in the US AIDS epidemic a CDC official explained that transmission risks were not being tracked because “lesbians don’t have much sex” (Montcalm and Myer, 2000: 132). Such biases are extended to the lack of consideration that particular sexual behaviours between two women might facilitate HIV and STI transmission. The literature reviewed supports the notion that female to female

transmission is possible and thus prevention programming for WSW in South Africa is necessary.

WSW do express personal power when exercising their sexual autonomy but the findings reveal that in the South African context WSW are often unable to maintain exclusively same-sex relationships. They may engage in transactional sex with men or experience sexual violence wherein men target WSW for abuse specifically because of their same-sex identity and/or behaviour. Thus efforts to address the sexual health needs of WSW requires a contestation of the power of patriarchal culture and institutions. Given what several informants shared regarding the misogynist and homophobic views expressed by South Africa's current President, which have been unchallenged by ANC leadership, resistance on behalf of WSW is unlikely to be expressed by vested interests, such as members of the SANAC women's sector aligned directly to the ANC or to other conservative institutions.

The results also show that the power of the SANAC women's sector has diminished due to: inconsistent and contested leadership; loss of active engagement linked to funding challenges among members; and diffused attention in the implementation of a variety of NSP priorities and key populations in which women are embedded. Advocates for the unrealised sexual health needs of WSW need to identify other allies within SANAC who come from a feminist standpoint whatever sector they are located within. Insights into how a women's rights based response to HIV/AIDS could be used to strengthen the agenda to improve WSW sexual health are explored in the next section.

6.3 Utilising ideas around women's vulnerability to HIV/AIDS in South Africa

A decade ago increasing attention to the feminisation of the AIDS pandemic in hyper endemic settings in sub Saharan Africa was central to global health policy on HIV/AIDS. Consequently technical agencies and donors involved in the response to HIV/AIDS introduced policies to action these commitments such as the Global Fund's *Gender Equality Strategy* (The Global Fund to Fight AIDS, 2008)and UNAIDS' *Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV* (Joint United Nations Programme on HIV/AIDS, 2010a). Initial implementation of such strategies was uneven and often poorly

translated to country level activities required to address national contexts of gender based vulnerabilities to HIV. I explored this concern in my Dr PH Organisational and Policy Analysis Project on the Gender Equality and Sexual Orientation and Gender Identity Strategies of the Global Fund. Subsequently, within in a few years high level attention to women affected by HIV/AIDS waned as other global health policy priorities and HIV prevention approaches took precedence. Particular groups of women at higher risk for HIV transmission, such as female sex workers and to a more limited extent women who inject drugs, maintained attention within interventions for key populations.

South African activists had utilised ideas around the feminisation of the HIV epidemic in strategies such as TAC's legal challenge to Government to introduce ARVs within PMTCT which served to overcome the first hurdle towards provision of ART in the public health system. The SANAC women's sector continued to state that their mission is "to address the feminised pandemic of HIV and AIDS, in order to holistically better the lives for women through women and human rights approaches" (SANAC Women's Sector, 2011: 1). But in South Africa, similar to global health policy shifts, ideas around focusing holistically on women's vulnerabilities to HIV seem to have been usurped by the targeting of certain women consider to be at greater risk.

Again of the fourteen key populations outlined in the 2012-2016 NSP ten ostensibly include women but only two specifically target women at greater risk: young (presumably heterosexual) women between the ages of 15 and 24; and female sex workers. Informants expressed concern that the kind of targeting of populations which might be pursued utilising the NSP's definition of key populations could result in many women falling through the cracks of HIV prevention efforts. This concern was underscored by low uptake of HCT throughout South Africa wherein many people do not know their HIV status, are unaware of how infectious they are, are not accessing ART and benefits of Treatment as Prevention in lowering viral load. In this context categorising any populations as 'at risk' is an inexact exercise. The results show that advocates did attempt to link WSW issues to other populations of women which SANAC prioritised as discussed in the next section.

6.3.1 Framing sexual violence against WSW

The findings revealed that in both NSP development processes some actors tried to utilise ideas around responding to GBV as a way to integrate WSW sexual health needs. The 2012-2016 NSP describes HIV vulnerability among adolescent and young women to be especially high among “survivors of physical and/or intimate partner violence” (Republic of South Africa, 2011: 25). There was some debate within SANAC about using the term ‘intimate partner violence’ (IPV) but the evidence employed to justify survivors of GBV for inclusion as a key population was a study on power inequality and violence within heterosexual relationships that showed that IPV was driving HIV incidence among young South African women. (Jewkes et al., 2010)

IPV resides in a heteronormative framing of relationships which does not capture violence within women’s intimate partnerships, an issue that was discussed in the findings of the multi country study on WSW (Sandfort et al., 2013). Moreover, IPV does not adequately capture sexual violence by men who are not the chosen partners of women, particularly within ‘corrective rape’ that targets WSW. Nor does the term GBV accurately capture the sexual violence perpetrated on the basis of non-heteronormative sexuality and/or gender non-conforming appearance. Thus GBV prevention or redress efforts may not serve WSW raped within hate crimes motivated by same-sex sexuality. There remains little scope for WSW programming to emerge from the pursuit of NSP objectives on IPV and/or GBV without considering how ‘corrective rape’ differs from other forms of sexual violence.

Regardless of how SANAC frames commitments to address sexual violence as a driver women’s vulnerability to HIV, the potential of effective leadership on the issue is not promising. The results revealed that while policies to combat GBV exist in South Africa they are not implemented, new initiatives are not adequately funded and overall this entrenched problem has suffered from a poor governance response. Informants bemoaned the lack of high level political leadership on GBV and the inexcusable silence from politicians regarding ‘corrective rape’ and violence against WSW. The 2012-2016 NSP implicates the Department of Women, Children and People with Disabilities in taking the lead to address “the intersection of gender-based violence and HIV”(Republic of South Africa, 2011: 32). Chapter

5 discussed the compromised position of this Department and following the general election of May 2014 the Department was disbanded and a new Minister for Women's Affairs was appointed. It will be some time before this change can be assessed for any impact on addressing the HIV threats of sexual violence experienced by WSW.

South African tabloid media's sensationalism of 'corrective rape' and murders of WSW could serve as an entry point for reflecting on factors which drive HIV vulnerability among WSW. The results suggest that one of the only ways currently available to justify addressing WSW in the context of HIV is through prevention or redress of 'corrective rape'. But advocates are wary of equating WSWs lived reality solely with the threat or perpetration of male violence. They would prefer that WSW programming could focus on a more holistic consideration of healthy relationships between women, their well-being, including safe sex within these relationships and among other partners, including potential male partners.

The results show that sexual violence is of the few concepts which correlate to the 'issue characteristics' which public health actors understand as a recognised HIV risk for WSW. Thus existing GBV/IPV interventions as well as research efforts must be utilised to the extent possible particularly given the context of a lack of funding for research on WSW. A heteronormative lens in the pursuit of building evidence on women within the response to HIV and STIs in South Africa will continue to make WSW needs invisible. Surveys which consider the sexual histories of women, including whether or not they have sex with other women, may not be salient to the outcomes of studies on the prevention of heterosexual HIV transmission but could provide data on WSW. Further reflections on reframing WSW vulnerabilities are provided within recommendations in the following section.

6.4 RECOMMENDATIONS

The following recommendations, informed by the results, provide an applicable output and fulfil study Objective Three: to suggest relevant recommendations which may provide insight to policy actors, particularly within SANAC, concerned with developing policy to address the sexual health of WSW. Particular suggestions about how to utilise reviews of the 2012-2016 NSP and prepare for the redevelopment of the NSP in 2016 are offered.

SANAC LGBTI SECTOR: Organisations implementing programming for MSM could set up a sub-forum for joint collaboration. Sector members implementing for other populations should rearticulate their agenda toward SANAC. Principally the sector should call on SANAC to initiate a research agenda on the epidemiological context of WSW in South Africa within the review of the 2012-2016 NSP and the redevelopment of the next NSP. Members concerned with WSW should draw lessons from the MSM research agenda and contribute toward an effective public health discourse around WSW STI and HIV risk behaviours whilst continuing to articulate rights based arguments about WSW sexual health. Service providers addressing WSW sexual health should publish programmatic outcomes which provide demographic and health data on the client base to be utilised in the research agenda.

SANAC WOMEN'S SECTOR: Through the review of the 2012-2016 NSP revise the argument that WSW sexual health needs are not vastly different from the needs of other women, including women living with HIV/AIDS. A return to a more holistic view of the vulnerability to HIV of women in all their diversity would strengthen the sector's advocacy overall and help to reposition its efforts on behalf of WSW in the formulation of the next NSP.

RESEARCHERS: A WSW research agenda must be pursued by universities and other research institutions and should tap into funding being made available for LGBT rights and/or health. Mapping exercises, size estimates and ultimately multi location prevalence and incidence studies are necessary. Quantitative surveys must take full sexual histories and pursue all possible STI and HIV transmission routes in order to identify specific WSW transmission risks. Encourage other domestic HIV and STI researchers considering ostensibly heterosexual women collects data on same sex behaviour. The timeline of such research should be well synched to NSP review and development opportunities so there is not an evidence gap when policy is being developed.

TECHNICAL AGENCIES: Building on the identification of key populations outlined in the 2012-2016 NSP UNAIDS and other development partners should support South Africa to rearticulate in the next NSP marginalised populations who may not be epidemic drivers but are vulnerable and continually underserved in programming. In conjunction with UNAIDS

agencies with a mandate to enhance human rights and social development, such as UNDP, and improve sexual health, such as UNFPA, should become more engaged in providing technical guidance to SANAC.

DEVELOPMENT PARTNERS: Bilateral, multilateral and private foundation donors must rationalise funding meant to improve the health of LGBT people by ensuring that all identified health problems within the LGBT community are addressed. Donors should consider how to utilise existing funding for MSM health as an entry point to support WSW health research and pilot targeted HIV and STI prevention services for WSW.

GOVERNMENT: The new Minister for Women's Affairs must deliver a national strategic plan on gender based violence which prioritises actions to address violence against WSW and the vulnerability to HIV of WSW survivors of sexual violence. Within reviews of the 2012-2016 NSP surmise how the DoH can increase efforts to sensitise health workers and ensure zero tolerance of discrimination against WSW. The DoH should provide further training for health workers on sexual health and same-sex sexual behaviour so that WSW can be accurately diagnosed and treated for STIs including HIV.

SANAC SECRETARIAT: Focus on coordination rather than implementation and ensure the timeline for the development of the next NSP development will ensure genuine and meaningful participation. Access technical assistance to enhance capacity for monitoring and evaluating the NSP. Ensure that evaluations of the 2012-2016 NSP does not eliminate objectives or change the policy content of NSP objectives. The effectiveness of the structure of 19 sectors of the SANAC civil society forum should be reassessed and the mandate and performance of the LGBTI sector should be reviewed.

CHAPTER 7: CONCLUSION

This study responds to a call for research (Sandfort et al., 2007) into the process through which the interests of WSW have been represented in South African HIV/AIDS policy considering the context of LGBT, as well as women's rights, organisations' engagement in policy processes and how research based advocacy might advance an agenda to enhance HIV prevention, treatment and care for and improve sexual health of WSW. The study has revealed multiple ways in which WSW are marginalised: in society, in the public health system and in policy processes. The findings support the argument (Johnson, 2007) that WSW vulnerability to STIs including HIV are not based solely on behavioural risks but due to the neglect of their right to health. Global and domestic research findings demonstrating the possibility of female to female transmission of STIs, including HIV, have been presented and triangulated with the kind of 'anecdotal' evidence of South African WSW affected by HIV which had been considered within SANAC discourse when these issues first emerged into the NSP policy process.

Some of the findings suggest that the false consciousness of WSW immunity to HIV and STIs is held among WSW themselves as well as among policy actors. By conducting the semi structured interviews that policy actors, including within SANAC's funding and implementing partners, were engaged one-on-one around the health concerns of WSW. These discussions sometimes lead to informants revealing their understanding of the structural and epidemiological drivers of poor sexual health among WSW although they reflected that these concerns could not be pursued robustly within the context of a generalised HIV epidemic. Thus there is a base of policy actors who hold a nuanced understanding of various vulnerabilities WSW face to HIV and STIs but taking action on the drivers is a low priority in NSP development and implementation, in part because there is not a strong evidence base, particularly from an epidemiological perspective.

I would hope that these findings could help inform advocates for WSW sexual health in two ways: firstly they maintain engagement with policy actors within SANAC and elsewhere, particularly utilising the existing quantitative and qualitative evidence as well as personal

testimony; secondly that they urge for investment in a research agenda that captures larger sample sizes to consider the epidemiological drivers of HIV and STIs within same sex relationships and the various structural drivers of WSW vulnerability to HIV and STIs related to factors such as sexuality, gender and social marginalisation.

The findings reveal that WSW interests have not been well served by the establishment of the SANAC LGBTI sector and that WSW needs are ignored among sector members and disregards the principle of solidarity in the face of discrimination due to sexual orientation and gender identity. Equally disconcerting is lack of critique around nominally addressing the health needs of the spectrum of LGBTI communities while only prioritising a response to the health of MSM. Additionally the results reflect a loss of influence by the SANAC women's sector which has negative implications for advancing policy discourse on all marginalised women. HIV incidence and prevalence data continues to demonstrate the impact on South African women underpinned by gendered power inequalities which have barely changed since the epidemic began. The pervasiveness of sexual violence is a stark example of the perilous position of women in the country yet the policy response has been poor. The health risks resulting from hate crimes against WSW have been inadequately addressed and not analysed from the perspective of sexuality based violence and the differences to GBV and/or IPV.

There are a range of insights from the application of the categories for a framework on determinants of political priority for WSW issues to be included in South Africa's NSP. In terms of the category of actor power there were a series of insights into the factor of policy community cohesion which coalesced around the importance of proving technical capacity by addressing a few 'game changers' and making evidence based policy influenced by global health policy and normative guidance particularly around the groups can be considered key populations. The role of policy entrepreneurs in bringing persuasive personal testimony on the impact of HIV among WSW to SANAC discourse did not translate into greater understanding among public health actors ability to deliver solutions. Lastly in terms of guiding institutions, while an important transfer of coordination of the NSP from the DoH occurred SANAC was not particularly well coordinated and its oversight role was

compromised due to involvement in implementation rather than maintaining focus on strategic guidance.

In the category of ideas, analysis of the factor of the internal frame showed that the policy community did not agree on the definition of, causes of, and solutions to WSW vulnerability to HIV and other STIs and that there were particular difficulties within WSW community in utilising public health discourse. Regarding the external frame the public 'outcry' in cases of 'corrective rape', particularly when attacks were fatal, drowns out more nuanced understanding of WSW lives and are not at all linked to highlighting HIV risks. Regardless, media sensationalism is not leading to policy action and there is impunity for perpetrators.

Within the political context and the politics stream the period analysed was very dynamic. Policy windows were open in 2007 but partially closed in 2011 as the NSP development process was more closely managed by SANAC, with unrealistically tight timelines, to ensure they would avoid producing another 'laundry list' that could not be implemented. Leadership changes over time at most levels of Government created some positive outcomes such as a more respected and capable MoH. But the sexist and heterosexist views expressed by President Zuma have problematized the ability to address the drivers of WSW vulnerabilities to poor sexual health. South Africa experienced resource constraints due to global recession and there was a massive loss of private foundation resources for the LGBT sector. While funding was available for men's interventions there was a contraction in resources for women's rights work. In the social context conservatism, including within faith communities, rose over time and compounded a loss of influence of women's movements and also underscores the surge in hate crimes against WSW.

Lastly, when reflecting on the issue characteristics and the problem stream there is no escaping the fact that the dearth of health metrics has impacted the ability of even the most passionate advocates to make the case on WSW sexual health within SANAC and other spaces. Poor dissemination and limited understanding of studies on WSW sexual health is compounded by a lack of resources to undertake further research. Furthermore since there is no available evidence from the implementation interventions that target or explicitly

include WSW set out in the 2007-2011 NSP there is no basis upon which to argue that WSW targeted activities have a positive impact, are cost effective and could be taken to scale.

I argue, along with several informants who are WSW living with HIV, that the possibility of female-to-female transmission of STIs including HIV has been demonstrated and can no longer be classed as 'no' risk in South Africa and other countries in Southern Africa including Botswana, Lesotho, Namibia and Zimbabwe. Samples among South African WSW suggest HIV transmission is occurring within exclusively same-sex relationships. Without targeted HIV prevention information and commodities WSW will continue behaviours which put them and their female partners at risk. Concurrently WSW living with HIV face multiple barriers to accessing health services in the public health system such as: misinformation, misdiagnosis, stigma and discrimination based on their sexuality and/or gender expression and outright refusal of care.

In the South African policy context, decision making around which health problems are prioritised must take into account issue characteristics without politicising or moralising aspects of them. . The framework of the Constitution and the results achieved through grassroots AIDS activism provide a strong basis for any population in South Africa to claim health as a human right. The NSPs, however, have not fully integrated the human right to health. The ability of the 2007-2011 NSP to address human rights was limited, in part because of the lack of a resourced action plan. The 2012-2016 NSP specified that rights based arguments could be utilised to highlight why an intervention, not well grounded in evidence, was necessary. However the findings reveal that poor 'grounding in evidence' and diminishing attention to the 'rights based arguments' were two important reasons that WSW vulnerabilities to HIV and STIs were not considered for inclusion in the 2012-2016 NSP.

In the next phase of NSP development advocates for WSW, including WSW living with HIV, must use the available platforms within SANAC, to reiterate the duties that Government must deliver in line with the Constitutional right to health. Engagement in both the SANAC LGBTI sector and the women's sector should be retained in order to further explore the potential of solidarity in approaches to Government to reflect the challenges facing WSW

within those facing the wider LGBTI community and the needs of women in all their diversity. There are significant intersections between both the structural and epidemiological drivers of poor sexual health among WSW and the vulnerabilities facing other South Africans in relation to: racism, gender inequality, poverty, unemployment, insecure housing, homophobia, HIV related stigma and discrimination, barriers to accessing health care and other forms of marginalisation. Thus multiple entry points can be pursued within SANAC policy discourse to bring attention to the health and social protection needs of WSW while underscoring the outstanding agenda for Government's response to HIV and STIs for all South Africans yet to benefit from improvements in HIV/AIDS policy management.

Appendix A: Topic Guide

Domain	Questions	Probes
<p>Opening</p> <p>Objective 2 iii</p>	<p>Please tell me what your current role is and how long you have held it?</p> <p>Please could you explain how your organisation was involved in the development of the NSP 2007-2011 and/or NSP 2012-2016 (and/or) implementation of the plans. (PS)</p> <p>or Has your organisation funded any programmes related to interventions for WSW outlined in the 2007-2011 or 2012-2016 NSP? (D)</p> <p>Did you/ your organisation make a submission to the 2011 consultation on the 2012-2016 NSP? (LGBT, CS)</p>	<p>If yes, why was your organisation involved?</p> <p>If not, why not?</p> <p>Who participated? Who was excluded?</p>
<p>Objective 1 i & iii</p>	<p>How would you explain the inclusion of WSW as a ‘high risk population’ in the 2007-2011 NSP?</p> <p>Do you think WSW are represented in a ‘lesser way’ than other issues?</p> <p>Why do you think the 2012-2016 NSP did not retain a focus on WSW (other than ensuring less discrimination in access to services)?</p>	
<p>Actor Power</p> <p>Objective 2 ii</p>	<p>Which organisations/individuals most influenced the 2007-11 NSP and 2012-16 NSP?</p> <p>What made them influential?(what was the source of their power)</p> <p>How did they demonstrate this power/influence?</p> <p>Was there a change between the 2 periods?</p> <p>Were there organisations/individuals supporting greater emphasis on WSW in (one or both) of the 2 plans?</p> <p>Which orgs/individuals? Why?</p>	<p>LGBT CSOs; other CSOs; government; donors etc.</p> <p>How?</p>

	<p>How did 'champions' use opportunities for the inclusion of WSW in this NSP(s)?</p> <p>Or opposing? Which ones? Why?</p> <p>Is there is cooperation among the individuals/and organisations that are involved with these issues? How did this change their influence over the policy?</p> <p>Was there any disagreement or competition among different organisations/individuals? How did this change their influence over the policy?</p>	<p>FBOs? Donors?</p> <p>Competition for scarce resources?</p>
<p>Ideas</p> <p>Objective 2 i&ii</p>	<p>What arguments on WSW were used to inform the 2007/11 and 2012/16 NSPs?</p> <p>How were they used, by who?</p> <p>Are WSW health issues, including violence against WSW, communicated to the public? How are these issues represented?</p>	<p>Do these messages resonate with decision makers who control resources?</p> <p>Positive or negative representations of WSW? Sensitive mass media?</p>
<p>Political Contexts</p> <p>Objective 1 i</p> <p>Objective 1 ii</p> <p>Objective 1 iii</p>	<p>During 2007 and 2011 were there changes in the national political climate?</p> <p>Did this make it easier or harder to get WSW issues on the policy agenda?</p> <p>Were there any economic challenges in 2007 and/or 2011?</p> <p>Were there changes in the social context?</p>	<p>Within South Africa? Global?</p> <p>Political events e.g. new MoH, elections?</p> <p>e.g. less resources resulting in more competition among advocates for different causes.</p> <p>e.g. improving/worsening tolerance, making space for new issues etc.</p>
<p>Issue Characteristics</p> <p>Objective 2 i&ii</p>	<p>Were the problems with the 'evidence' around the issue?</p> <p>Was it weak? Was it ambivalent? Was it not communicated effectively?</p> <p>Did particular type of actors use particular types of evidence?</p>	<p>e.g. 'evidence' personal testimony, people bearing witness, media reports, NGO reports</p> <p>If none, or few, what might you suggest to</p>

	<p>What interventions have been proposed to address the problem (HIV incidence among WSW, violence against WSW poor sexual health)?</p> <p>(are they clearly explained, have they been costed, are they backed by evidence, are they simple to implement?)</p>	respond to the problem?
<p>Accountability and Coordination</p> <p>Objective 1 ii</p>	<p>Are there reports which show attempts to implement the interventions for WSW from the 2007-2011 NSP?</p> <p>(Goals on reducing sexual transmission of HIV, mitigating the impact of HIV and AIDS and ensuring public knowledge of and adherence to the legal and policy provisions)</p> <p>Did previous implementation or the lack thereof impact the NSP 2012-16 process?</p> <p>(e.g. failure to implement the earlier policy may be a reason less attention was placed on WSW in 2011)</p> <p>How would you rate the effectiveness of SANAC as a coordinating mechanism to lead on the NSP?</p> <p>Was the NSP development process participatory?</p> <p>In 2007? In 2011?</p>	MTR, final evaluation, anything else from SANAC? LGBT org reports?
<p>Closing</p> <p>Objective 3</p>	<p>What would need to change/improve to enable greater attention on WSW in future policy documents?</p> <p>How would you suggest policies to address the needs of WSW in the context of HIV, VAW and poor sexual health be improved in the future?</p> <p>How to ensure better coordination in policy making, inclusion of a wide range of actors, stronger evidence etc.</p>	Could these issues potentially be reframed (more clearly, with greater emphasis) in the future?

Appendix B: Ethical Approval London School of Hygiene and Tropical Medicine
(follows on next page)

Appendix C: Ethical Approval University of Kwa Zulu Natal
(follows on next page)

You are being invited to take part in a research study. Please take time to read the following information carefully to decide whether or not you wish to take part.

Study title: Why and how did women who have sex with women (WSW) become a focus population of South Africa's National Strategic Plans on HIV, STIs and TB?

1. What is the purpose of the study?

To understand the policy process around the development of the National Strategic Plans on HIV, STIs and TB in South Africa and how interventions to improve sexual and reproductive health and enhance prevention of HIV among WSW were initially proposed and how they changed over time.

I hope to contribute this review of how WSW health issues emerged onto national policy and how attention to it evolved or depreciated over time to be useful resource within future processes for revising the national policy on HIV and STIs.

2. Why have I been chosen?

You have been identified by one or more colleagues as someone uniquely placed to contribute to an understanding of the NSP process and/or WSW issues and their place in national policy.

3. Do I have to take part?

If you agree to take part, I will ask you to sign a consent form. You are free to withdraw at any time but I would hope you could delegate or suggest another informant.

4. What will happen if I take part?

You are being asked to consent to a face to face interview to take place in your office or another location of your choosing. The interview is likely to last an hour – if longer is needed (up to 1.5 hours I will advise you in advance)

If a suitable date, selected based on your availability from 28 October - 12 December 2013 cannot be secured we will arrange for you to be interviewed over Skype or by phone. The study will involve audio recording. This is intended as a support to the notes I am taking of our interview.

5. Will my taking part in the study be kept confidential?

Yes. All information collected about you during the course of the research will be kept strictly confidential. I will not make the recordings available to any other party and the content of them and my notes will remain completely confidential.

6. What will happen to the results of the research study?

The results will be written up in a dissertation for submission for the degree of Doctor of Public Health at LSHTM. Subsequently the findings may be submitted for publication.

7. Who has reviewed the study?

This study was given a favourable ethical opinion by LSHTM and University of Kwa Zulu Natal Humanities and Social Sciences Research Ethics Committee.

8. Contact Details: My South African mobile number is 0603806926.

<p>Felicity Daly, MSc felicity.daly@lshtm.ac.uk Candidate, Doctorate in Public Health London School of Hygiene and Tropical Medicine Department of Global Health and Development 15-17 Tavistock Place, London, WC1H 9SH United Kingdom</p>	<p>Gender and HIV Programme Health Economics and HIV/AIDS Research Division University of KwaZulu-Natal Westville Campus Private Bag X54001 Durban, 4009 South Africa Telephone (Main Office): +27 (0)31 260-2592</p>
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INFORMED CONSENT FORM


Full Title of Project: Why and how did women who have sex with women become a focus population of South Africa's National Strategic Plans on HIV, STIs and TB?

Name of Principal Investigator:

M. Felicity Daly

**Please
initial box**

1. I confirm that I have read and understand the participant information sheet dated 15/10/13 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered fully.	
2. I understand that my participation is voluntary and I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.	
3. I understand that my identity will not be revealed in presentation of the report of this study and agree for a sound recording to be taken and used in preparation of the dissertation on this study.	
4. I agree to take part in the above study.	

Name of Participant <i>(printed)</i>	Signature 	Date 28-10-13
M. Felicity Daly	Signature	Date
Principle Investigator	Signature	Date

1 copy for participant; 1 copy for Principal Investigator

Appendix F Total Sample of Key Informants

Constituency	Number of informants	Informant interview number	Description of Institution	Location
Academia	2	#24; #25	Leading national research university	Cape Town and via Skype
Bilateral Donor	1	#16	Bilateral technical assistance provider	Pretoria
Bilateral Donor	1	#23	Bilateral development agency	Johannesburg
Civil Society/HIV	1	#9	National civil society network on HIV/AIDS	Johannesburg
Civil Society/HIV	1	#19	Non-governmental human rights organisation	Cape Town
Civil Society/HIV	1	#22	Non-governmental media outlet	Cape Town
Civil Society/HIV	1	#11	Non-governmental HIV prevention service provider	Johannesburg
Faith Based Organisation	1	#14	Network of faith based organisations	Johannesburg
Health Service Provider	1	#15	Medical HIV prevention service provider	Johannesburg
LGBT Organisation	1	#1	LGBT community organisation	Durban
LGBT Organisation	1	#13	LGBT community organisation	Johannesburg
LGBT Organisation	2	#7; #8	LGBT community organisation	Pretoria
Multilateral Donor	1	#12	Multilateral technical agency	Pretoria
Multilateral Donor	1	#6	Multilateral technical agency	Via Skype
Private Donor	2	#2; #5	Private foundation promoting democracy	Johannesburg and via Skype
Public Sector	2	#21	Government Department promoting health	Cape Town and Pretoria
Public Sector	1	#3	National Social Research Institution	Pretoria
Public Sector	4	#4; #10; #17; #20	Members of National Multisectoral Coordinating Platform	Durban, Johannesburg and Pretoria

Appendix G

Policy Content of the NSP 2007-2011 relevant to interventions for WSW

“Goal 2: Reduce Sexual Transmission of HIV. Objective 2.5: Increase roll out of prevention programmes for higher risk populations. Intervention: Incremental roll-out of comprehensive customised HIV prevention package for MSM, lesbians and transsexuals including promotion of VCT and access to male and female condoms, and STI symptom recognition” (Republic of South Africa, 2007: 69).

“Goal 8: Mitigate the Impact of HIV and AIDS and Create an Enabling Social Environment For Care, Treatment And Support. Objective 8.3: Strengthen the implementation of policies and services for marginalised communities affected by HIV and AIDS. Intervention: promote integration and equitable representation of LGBT people in care, treatment and support programmes” (ibid: 98).

“Goal 16: Ensure Public Knowledge of and Adherence to the Legal and Policy Provisions. Objective 16.3: Ensure a supportive legal environment for the provision of HIV and AIDS services to marginalised groups. Intervention: Develop and distribute information materials on rights to HIV prevention, treatment and support that responds to the special needs of groups including...MSM, gay and lesbian people” (ibid: 119).

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