A Survey on Alternative Sexual Reproductive Health services available for LGBTIQ in 3 districts of Malawi

Consultant
Chiwoza Bandawe, PhD

Centre for Human Rights and Rehabilitation (CHRR) and Unite for Body Rights (UFBR)

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## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>CAVWOC</td>
<td>Centre for Alternatives for Victimized Women and Children</td>
</tr>
<tr>
<td>CEDEP</td>
<td>Centre for Development of People</td>
</tr>
<tr>
<td>CHRR</td>
<td>Centre for Human Rights and Rehabilitation</td>
</tr>
<tr>
<td>FPAM</td>
<td>Family Planning Association of Malawi</td>
</tr>
<tr>
<td>HCSP</td>
<td>Health Care service provider</td>
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<tr>
<td>HIV</td>
<td>Human Immuno virus</td>
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<tr>
<td>HTC</td>
<td>HIV Testing and Counselling</td>
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<tr>
<td>LGBTIQ</td>
<td>Lesbian, Gay, Bisexual, Transgender, Intersex, Queer</td>
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<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
</tr>
<tr>
<td>NHP</td>
<td>National health policy</td>
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<tr>
<td>SRH</td>
<td>Sexual and reproductive health</td>
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<tr>
<td>STI</td>
<td>Sexual Transmitted Infection</td>
</tr>
<tr>
<td>UFBR</td>
<td>Unite for Body Rights</td>
</tr>
<tr>
<td>WSW</td>
<td>Women who have sex with women</td>
</tr>
<tr>
<td>YECE</td>
<td>Centre for Youth Empowerment and Civic Education</td>
</tr>
<tr>
<td>YONECO</td>
<td>Youth Net and Counselling</td>
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A Survey on Alternative Sexual Reproductive Health services available for the LGBTIQ when not provided by government facilities

Consultant
Chiwoza Bandawe, PhD

April 2015

Introduction

The right to health is a fundamental human right provided for in the 1966 International Covenant on Economic, Social and Cultural Rights adopted by the United Nations General Assembly (United Nations, 1966). The aim of the socio-economic rights is to ensure that all human beings have access to resources, opportunities and services needed for an adequate standard of living. These rights oblige the state and individuals to provide resources that people require.

However, given the stigma associated with sexual diversity and gender non-conformity in a conservative Malawian context, discriminatory policies and practices can also result in people being denied access to the information, support and services necessary to make informed decisions and to reduce their vulnerability and risk of infection. Gender non-conforming individuals and people involved in same sex relationships do not enjoy the right to health including “the highest attainable standard of health” because they lack access to treatment, care and support. Access to medical interventions creates serious challenges in addressing issues of HIV and AIDS among Lesbians, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ) persons. While many may argue that LGBTIQ persons are free to access medical services in Malawi, there is need of having friendly services that are tailored to LGBTIQ people's needs. LGBTIQ persons need to feel safe among medical practitioners to avoid the fear that they may be reported to police. Because of fear of stigma and discrimination coupled
with unfriendly laws, many LGBTIQ individuals operate underground, which makes it much harder to target them with sexual reproductive health (SRH) interventions.

There already are alarming statistics on HIV and AIDS in Malawi. Currently the HIV prevalence rate among the population remains at 10.6% whilst the prevalence rate among men having sex with men (MSM) is 21.4 %. It is important to note that most studies on LGBTIQ in Malawi have focused on MSM. The term MSM covers a diverse group of people, including people who see themselves as gay, bisexual and others. The need for LGBTIQ friendly and accessible health care services is crucial both from an HIV/Aids perspective as well as from a human rights perspective. The Malawi National HIV/AIDS policy of 2003 recognises that an effective response to HIV/AIDS requires the active involvement of all sectors of society. It identifies sex workers and ‘persons engaged in same sex sexual relations’ in groups of people suffering from discrimination which makes them vulnerable in the context of HIV/AIDS (Government of Malawi, 2003).

In a 2012 needs assessment survey of men who have sex (MSM) and Women who have sex with women (WSW), nineteen respondents (28%) admitted to have ever felt afraid of seeking health care services because of their sexual orientation. All of them feared being harassed by the health care provider or arrested by the police. It was found that 12 respondents (18%) have ever heard the health care services providers (HCSP) gossiping about them because of their sexual orientation. Nine respondents (13%) reported having been denied or given a low quality health care because of their sexual orientation (1 respondent was denied treatment but it was later given to him when he was accompanied by a peer educator of the Centre for Development of people (CEDEP) (Bandawe &Mambulasa, 2012).

There is hesitancy and concern amongst many HCSPs, including HIV service implementers, that if they serve the LGBTIQ population, they may be acting illegally, since the Penal Code criminalises same-sex activity, widely understood
to mean sodomy, which is anal sex (Sec 153-156 & 137A of the Penal Code (Amendment) Act No.1 of 2011 as read with Penal Code Cap.7:01 of the Laws of Malawi). Consequently, the LGBTIQ community lack information and resources to make sexual activity easier and non-risky. Information on availability and accessibility of barrier methods like condoms, lubricants, dental dams, and female condoms is not readily available (MSM GF & COC, 2012). A recent report by CEDEP shows that a large number of MSM and WSW engage in unsafe sex and use paraphilia which is risky like non-water based lubricants (Baral et al., 2009).

As pointed out earlier, most of the studies done on LGBTIQ in Malawi have focussed primarily on MSM. Most HCSPs are not aware of the distinctions between the different groups within the LGBTIQ community. As such, even amongst the LGBTIQ community, the distinctions between them are not fully and properly understood. Malawi has only recently begun to open up to the realisation of the existence of lesbians and gays within the country, let alone embrace the intersex and transgender persons. Most interventions have targeted MSM and a few are now starting to target WSW. The TIQ have been much marginalised (within the marginalised group) and very few have openly identified as such. Hence, in this report, whilst TIQ are recognised as part of the community needing intervention, there is practically on the ground very limited information on gender identity, transgender, intersex and queer members of the LGBTIQ community. Bandawe and Meerkotter’s book chapter launched in March 2015 is amongst the few publications trying to raise awareness of the need to give attention to issues of gender identity (Bandawe & Meerkotter, 2015). Given this background, it is important to realise therefore that whilst the differences amongst the LGBTIQ group exists, most respondents in this survey grouped them into one group, having LGB in their mind.

This survey is the result of a collaboration between The Centre for Human Rights and Rehabilitation (CHRR), one of Malawi’s leading human rights non-governmental organizations, and the Unite for Body Rights (UFBR) programme, a five year (2011-2015) youth reproductive health and rights programme funded by the Dutch Ministry of Foreign Affairs through the Dutch Sexual and Reproductive
Health and Rights Alliance, with Rutgers WPF as lead agent in the Netherlands. CHRR’s mission statement is to contribute towards the protection, promotion and consolidation of good governance by empowering rural and urban communities in Malawi to become aware of and exercise their rights through research, advocacy and networking in order to realize human development.

The UFBR programme targets young people (10-24), women, people from marginalised groups and community members with the overall objective of improving the sexual and reproductive health and rights of these targeted groups in three Malawian districts, Dedza, Mangochi and Chikwawa.

Purpose and Objectives

The main purpose of the survey was to explore alternatives available for lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) persons if sexual reproductive (SRH) health services are not provided by government facilities. Specifically, the survey sought to assess the level of access of LGBTIQ individuals to SRH services in the selected districts of the UFBR programme in Malawi, explore alternative health services available for LGBTIQ individuals and make recommendations on the role that the UFBR can play to promote access to services for LGBTIQ individuals.

Methodology

Study Design
This is mainly a qualitative research design used primarily to obtain perceptions and views of LGBTIQ health care users and HCSPs of the current availability of services for this population as well as their perception of the level of access to SRH individuals. It is also a descriptive design that will obtain some quantitative data from healthcare providers about current services and user needs of LGBTIQ.
Study Place
The study was carried out in 3 districts where the UFBR programme is implemented in Malawi. Implementing the programme are the Centre for Alternatives for Victimized Women and Children (CAVWOC), the Centre for Youth Empowerment and Civic Education (YECE), the Family Planning Association of Malawi (FPAM) and Youth Net and Counselling (YONECO) and the Centre for Human Rights and Rehabilitation (CHRR). The districts were Chikwawa, Dedza and Mangochi. The health facilities were selected to provide a representative mix of health care settings, including private and public clinics and hospitals that are active in the provision of reproductive healthcare services.

Study Population
A total of 41 LGBTIQ respondents were identified through snowball sampling and participated in focus group discussions in the three districts sampled. The specific break down was 15 in Chikwawa, 3 in Dedza and 23 in Mangochi. In Chikwawa, 6 identified as gay, 8 as bisexual men and 1 as intersex. In Dedza, 2 respondents identified as gay while 1 identified as bisexual. In Mangochi, 7 identified as lesbian, 10 as gay, 5 as bisexual and 1 as transgender. There were two separate focus groups in Mangochi, one with the Lesbian identified and the other with the rest. Along gender lines, 32 were male, 7 were female, 1 transgender male and 1 was intersex. All respondents averaged 24 years of age.

Individual interviews were conducted with the HCSPs. A total of 24HCSPs were identified in the three districts. The specific breakdown was Chikwawa5, Dedza9 and Mangochi10. They were identified through convenience sampling in which the consultant made preliminary visits to the health centers and hospitals and identified potential respondents in line with the criteria. Their availability and minimal disruption to the service delivery was an important aspect of the selection. Selection of HCSPs included individuals working in specialized public and private clinics, STI control programmes, VCT centres and NGOs implementing HIV/STI programmes. Personnel interviewed included medical
and non-medical staff at these programs. Of the 24 respondents, 2 were qualified medical doctors, 8 were clinical officers, 4 were nurses, 5 were HTC counsellors, 3 were a medical assistant, 1 was a laboratory technician (STI clinic) and 1 was an STI care provider. The HCSP respondents were 11 female and 13 males all with an average age of 37 years.

Inclusion criteria: All HCSP selected were those who provide a range of SRH services. We targeted two different types of HCSPs: those whose institutions offered services to LGBTIQ and those who would be hesitant to offer such services. The hesitant health centres were identified following a CHRR workshop conducted in April 2013 where participants were asked if their centres would be open or hesitant to serve LGBTIQ individuals. Those who responded “hesitant” were put into the hesitant group for this investigation. Hence, when being interviewed for this survey, the question was again put to the individual respondent who confirmed the position of the service centre. The focus here was on the health service provider organisation primarily because in line with the objectives of the study we were looking to see which potential alternative health service organisations would be available to provide services to LGBTIQ clients.

Sample size
In qualitative research the concept of saturation is the guiding principle in determining sample size. Saturation occurs when no new information emerges from the interviews and the researcher finds the same information with each progressing interview or focus group discussion (Mason, 2010).

Despite much debate on qualitative research sample size (e.g. O’Reilly & Parker, 2013), an agreed standard that has stood the test of time is 30 respondents. This is well summarized in Peter de Paulo’s article in which he argues: “Until the definitive answer is provided, perhaps an N of 30 respondents is a reasonable starting point for deciding the qualitative sample size that can reveal the full range (or nearly the full range) of potentially important customer perceptions” (De Paulo, 2000). In view of this we took 30 people as the minimum sample size for our users focus group discussions with LGBTIQ individuals.
Data Collection
Research instruments were developed to assist in data collection and are in Appendices 1-3. The focus group discussions were recorded and transcribed. Following transcription, the discussion was interpreted from Chichewa into English.

Data Analysis
Thematic analysis was used guided by the topics of the focus group discussion. Most of the interviews had their responses written straight into the interview schedule although some were recorded. The recorded ones were transcribed.
Findings & Discussion

The findings and discussion are presented in two sections. The first section is drawn from the focus group discussions with members of the LGBTIQ community whilst the second section is drawn from the interviews with HCSPs.

LGBTIQ Responses

There are SRH services available on the ground in all three districts. In terms of actual services available, respondents mentioned the supply of condoms, HTC and STI clinics were available. The healthcare providers in all three districts confirmed the availability of the SRH services. In Chikwawa, all LGBTIQ respondents said condoms were available in shops and at Chikwawa district hospital and private clinics, all of which are located within walking distance. However, in the shops and private clinics they have to purchase condoms while in the government hospitals they are provided for free. But in the hospital condoms are not always available, so respondents rely mostly on shops and private clinics where they are sold. In Mangochi, it was pointed out that only CHRR and CEDEP are distributing free condoms and lubricants.

Whilst condoms are available, lubricants in general are not available. One respondent in Chikwawa pointed out:

"It’s easy to find condoms. But lubricants are hard to find. In fact we don’t know of any clinic or shop in Chikwawa where one can get lubricants (water-based). People just use Vaseline or even saliva to have sex”.

For the lesbian community there are no dental dams and other protective measures available anywhere in Malawi and most of them were unaware of such risk reducing products.
In terms of services specifically for LGBTIQ, there are no specific services. The LGBTIQ use the services that are available. These services are mainly targeted at heterosexual persons. One respondent in Dedza said:

“Information about STIs is only targeting straight people. It’s like they don’t recognise our existence”.

Asked whether there were specific incidents of prejudice experienced when accessing the SRH services, only two respondents reported this to be the case, one in Chikwawa and the other in Dedza. The rest of the respondents had not experienced such prejudice. A respondent in Dedza reported:

“I once went to the hospital at Kasina where I asked a clinician if I could get some lubricants. He looked at me suspiciously and seemed to have noted something in me. I left the room quickly and went out of the hospital. I have not returned to the hospital after that. I am afraid that if he sees me again, he is going to ask me difficult questions.”

In Chikwawa the specific incident reported was:

“I once read on the internet about lubricants. After reading I went to Banja La Mtsogolo clinic at Nchalo to ask if I could buy some. The clinician said they don’t stock them. Then he looked at me and said, I hope you are not gay. I didn’t answer and simply left the clinic.”

Although only two reported such experiences, most respondents in all three districts were of the view that health care service providers are homophobic. “People treat you like a dog when they know or suspect you are a homo”, said a Dedza respondent. Mangochi respondents mentioned the cold shoulder treatment from some clinicians after the gay patients declared their sexual orientation during clinical history taking. One of the health care providers in Dedza, a clinical officer admitted:
“I see them as abnormal people; but I have no problem helping them. They are shy; they mostly come for curative, not preventive services.”

Most respondents disclosed however that they deliberately do not disclose their sexual orientation when they seek medical care. They generally do not hide health related information from the service provider when interviewed unless it will expose their sexual orientation. One respondent in Dedza disclosed that he once suffered a terrible stomach-ache and pain in the lower extremities. This happened a week after he had slept with another man. Suspecting an STI, he went to a local clinic where the clinician did some tests and gave him an injection. He then gave him a notification saying that he should bring his partner to get treated as well. He lied that he had slept with a female prostitute and that he could not trace her. Such stories illustrate that LGBTIQ people think that sharing their sexual orientation would compromise the quality of care they receive if health care providers know of their sexual orientation. A Mangochi respondent stated:

“I went to a hospital where a doctor kept asking me why I wore earrings like a woman. It was clear he didn’t like me. He gave me paracetamol and told me to get the rest of the medication from the pharmacy.”

Nevertheless, Mangochi respondents have benefitted from earlier programmes from CHRR and CEDEP which have targeted HCSPs and sensitised them to LGBTIQ issues. Respondents in Mangochi acknowledged that health care services used to be difficult especially for LGBTIQs with STIs, but there are now some clinicians in the hospitals who know about the LGBTIQ communities and they directly go to them for help (citing Mangochi district hospital as the most helpful).

Respondents were unanimous in recommending the provision of LGBTIQ health information such as issues pertaining to understanding issues of sexuality and prevention of STIs. In addition they wanted a space where there would get a constant supply of condoms and lubricants. What further emerged amongst the LGBTIQ respondents was the need for specialist training to be provided to health
service providers to enable them effectively service the LGBTIQ community. Such training would expose the HCSPs to issues pertaining to LGBTIQ issues such as the coming out process. In particular, respondents were keen for the health care providers to change their attitudes towards LGBTIQ persons. Many HCSPs see the LGBTIQ as “abnormal” and good rapport would not be established when an LGBTIQ person goes for health care provision. Although HCSPs have professional ethics of non-discrimination, their negative attitude towards LGBTIQ is off putting to the members of this community. LGBTIQ respondents mentioned that at times they were humiliated or made the object of ridicule when HCSP would “lecture” them to change their behaviour or call other HCSP to come and look at the clients.

The need for a space where LGBTIQ specific information can be provided is highlighted by the fact that there are no spaces in these districts where such information can be obtained:

“We have no access to information about sexual orientation or practice. Sometimes we hear it on the radio, but such programmes do not come regularly and usually do not provide much information”.

Most LGBTIQ obtain information from radio. However the information is not LGBTIQ specific. They would want to know more about safe sex practices for LGBTIQ persons.

When asked to identify specific clinics that could potentially service the LGBTIQ group in their area, they all pointed to private clinics such as Banja La Mtsogolo. They were uncomfortable with government hospital or clinics providing such services because given the large crowds that attend they were afraid they could be easily identified. Furthermore they prefer such clinics because Private clinics can service the LGBTIQ group since their interest is to make money. Hence they would not be so prejudiced against LGBTIQ because they would not want to lose customers. They would therefore hold their negative attitudes in check. However, the HCSPs were not of the same view that the fee-paying hospitals
were more tolerant of LGBTIQ. One private health care provider said even though he would be hesitant to offer services to the LGBTIQ community for religious reasons as a clinician he has a moral obligation to meet the needs of all of his clients, regardless of their lifestyle. Another said much as they are in business, they have the right to turn away patients if treating such patients would mean going against God's will. A third respondent said that because they are paying "clients", LGBTIQ patients have the right to "take their business elsewhere" if they were dissatisfied with their treatment in a certain facility.

One of the clinical officers said since his health center is run by the Catholic Church he would turn away patients if the treatment they are seeking is not in line with church teachings. He gave the example of contraceptives, saying if someone came asking for contraceptives the hospital would turn him or her away because the health facility does not provide such services.

"These people don't seek services in government hospitals when they contract STIs because of the requirement to bring a partner, so they go to private clinics where such questions are never asked. Private clinics are money-oriented."

Besides they are owned by an individual, so are not subjected to stringent rules like mission or government facilities. If such private clinics became LGBTIQ service clinics, respondents recommended that UFBR should provide training for the staff to understand sexual orientation issues and appreciate the dynamics of gender identity:

"First sensitize them about these issues so that they can understand and accept us as human beings"

In order to effectively promote such services in the areas, respondents recommended that the UFBR programme set up an office in Dedza to be closer to
the LGBTIQ community there. Chikwawa respondents recommended a specific LGBTIQ drop in centre. They did not specify a particular location as long as it was accessible. What also emerged was the need for mental health issues to be addressed. Many members of the LGBTIQ community live with the stress of being stigmatised, rejected by their families if discovered and being treated as outcasts by their communities. There are no designated mental health service facilities available for LGBTIQ anywhere in Malawi and such a service provision would be very supportive. Respondents in Mangochi for example spoke of the trauma of being victims of homophobic attacks and having to constantly live with the fear of being beaten up.

The LGBTIQ wanted the following range of services to be provided for them:

<table>
<thead>
<tr>
<th>Alternative services requested</th>
<th>Numbers requesting</th>
<th>LGBTIQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific trainings on issues to do with understanding sexuality and self-awareness.</td>
<td>38</td>
<td>LGBI</td>
</tr>
<tr>
<td>Counselling services, a space where they can be counselled on the issues and challenges they are facing (Mental Health)</td>
<td>36</td>
<td>LGI</td>
</tr>
<tr>
<td>Provision of STI education and treatment.</td>
<td>41</td>
<td>LGBI</td>
</tr>
<tr>
<td>Provision of condoms, lubricants, dental dams and other aids that promote safe sex.</td>
<td>33</td>
<td>LGBI</td>
</tr>
<tr>
<td>Group counselling</td>
<td>21</td>
<td>LG</td>
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Table 1: LGBTIQ Specific services requested

**Health Care Service Providers (HCSP)**

An important component of the survey was getting the views of the health care service providers (HCSP). Personnel from the three government district hospitals were interviewed as they were seen as centres offering services which the LGBTIQ has accessed. We also interviewed HCSP from 4 private clinics and health centres. Some of the private clinics were members of the Blue Star Alliance, a network of health care providers focussed on reproductive health in rural areas, which means they provide the services that all other alliance members provide such as reproductive health services (family planning), palliative & preventive care, STI screening, treatment & counselling provide. One of the health care centres was a missionary based one. In total, 3 of the 4 private clinics were “hesitant” to service the LGBTIQ community. The private clinics that
would be hesitant to offer LGBTIQ services said this is the case mainly for religious reasons. All government facilities indicated that they would be willing to service the needs of the LGBTIQ community only if government came up with a clear policy and guidelines.

Most service providers had In-patient, Out patient, Maternity, Mental health care services, under 5, outreach activities, HTC and Post abortal care (Lobi health centre). There were also some offering Youth-friendly health services, NRU (Nutritional Rehabilitation Unit)(Chikwawa), TB screening and treatment, laboratory, dental, eye, X-ray and Orthopaedics. (See Appendix 1 for a detailed breakdown of the services offered by each health provider organisation).

When asked: Do you sometimes receive or have clients who are LGBTIQ? 15 responded that they do not know for sure since they are hidden and the topic is taboo. A HCSP from a private clinic in Dedza responded:

“It’s difficult to know for sure because we normally don’t ask our clients about their sex life. And even if we asked I don’t think anyone would be free to tell us that they are homosexual. As you know homosexuality is still considered taboo in our society. But as a private clinic we receive everyone. I am sure among our clients there are some who are homosexual. But as I said this is not something we normally ask.”

This made it difficult for HCSP to ascertain the characteristics of their LGBTIQ clients:

“They don’t reveal. But as a clinician sometimes you just suspect. I have treated a few people who looked suspicious to me, but I treated them without asking questions. I remember treating one young man whom I strongly suspected to be homosexual, the way he talked, the way he moved and the fact that he had an anal STI. I don’t remember his exact age, but he must have been in his twenties or early thirties.”
The healthcare workers admitted that they have negative feelings and opinions towards LGBTIQ. Only two of the 24 healthcare workers said they don’t have negative opinions of the LGBTIQ, they don’t judge them.

LGBTIQ persons receive all services available as anyone else both Preventive and Curative, though most receive curative services as there are no specific programmes for preventative services to LGBTIQ.

Given that no specific services for LGBTIQ exist, they are serviced through the same processes everyone goes through:

“We don’t follow specific steps for LGBTIQ people. But I remember for the gay people that I met and treated, I treated them well. Thereafter I counselled them; I asked them why they were gay. They told me they were born like that. I advised them on measures they could take to protect themselves from HIV and other STIs.”

Health care service providers felt that LGBTIQ access all general medical services when they need to, but acknowledged that it might be difficult for LGBTIQ to have quality medical attention supplied for specific health conditions that may give away their sexual orientation due to the negative attitudes the HCSPs may have. The HCSPs therefore acknowledged the difficulty LGBTIQ may go through due to the prejudices.

Specific training to HCSPs to effectively service the LGBTIQ community is limited. 15 of the 24 HCSP respondents did not receive any training and those who had some training said LGBTIQ issues were mentioned in passing:

“Not even at school but some guide documents I see mention MSM, but we don’t know how to work in this issue. But I am willing to be trained if a chance comes.”
HCSPs recognised the importance of their ethics in not discriminating against LGBTIQ. Their prejudices are however quite entrenched as in this example from a Dedza health care worker:

“Health job ethics include helping everyone even criminals or sinners so health workers should be reminded of this through trainings.”

When asked: “What additional services do you feel you would have the potential to offer to service the LGBTIQ community?” the responses can be summarised as:

“Supplying lubricants as our hospital doesn’t have this may be other health workers don’t know or see lubricants.”

Some looked at the issue from a wider angle,

“Government should remove all laws criminalising same-sex sexual behaviour and come up with a clear policy on this issue. Only then are we going to be able to be free to adequately service this group. NGOs should intensify advocacy to urge government to do this.”

All of the health care providers were aware of the existence of the National HIV Policy (NHP) however no respondent was aware that the NHP contains information about HIV prevention and HIV/AIDS treatment in people who are in same sex sexual relationships.

Most of the service providers from “hesitant” clinics had little or no exposure in servicing LGBTIQ clients. Several spoke of “suspecting” some clients may be gay. A Dedza “Hesitant” clinic service provider:

“I remember meeting some people who looked suspicious. None of them said openly that they were gay, but I suspected they were.”
Another offered:

“Since I started working here in 2011, I have met three people whom I suspected were gay. They presented anal infections and I referred them to the STI clinic.”

Most health care service providers who had had little exposure to LGBTIQ reported negative opinions feelings about this group of clients:

“I am a Christian and I believe it’s a sin for people of the same sex to engage in sexual intercourse.” Dedza Health care worker

“I take them as human beings, however according to my faith I consider them as sinners. I ask myself, why do they do this? Is it habit or what?”

The role culture and especially religion plays in shaping attitudes of the health care providers is enormous. The healthcare workers struggle to juxtapose their professional training and ethics to service all persons versus their religious faith that is usually interpreted to mean they have to condemn and judge LGBTIQ. When asked what they would do if an LGBTIQ person came for SRH services, one summarised well the response of many health care providers:

“I would treat that person just as I would treat any criminal or a prostitute. Otherwise as a person I don’t approve of these things.”

The HCSP was demonstrating that in the same way he would provide care to criminals and prostitutes, he would do the same for LGBTIQ. He therefore groups LGBTIQ in the same category as criminals. When asked: “Could your premises be used to provide interventions for LGBTIQ, e.g., creating awareness about HIV/AIDS and distribution of condoms?” most of the hesitant clinics said no:

“I don’t think so. This is a Catholic facility and the position of the Church on these matters is well known; it’s strongly against; so I don’t think these premises can be used to provide interventions for this group. However, as individual health workers,
realising our responsibility to serve all people without discrimination, we sometimes provide these services discreetly. For instance, we are not allowed to provide contraceptives, but some of us do clandestinely.”

Interestingly though, the responses from the government clinics were more accommodating of LGBTIQ individuals. However, what was clearly expressed was the need for government to take a firm and clear policy stand on the issue:

“This is a government hospital. It’s not possible to provide interventions unless government comes out with a clear policy on this issue.” Dedza Health care worker

“[Health care workers] find it difficult because this issue is not clear. Government’s position is also not clear, that’s why many people hesitate to work with this group.” Mangochi health care worker

The HCSPs were specifically asked: “Do you believe your hesitation [to service LGBTIQ] is in line with your code of ethics as a health care provider? Why or why not? If contradicting, how do you explain?” One respondent from Chikwawa said:

“It’s difficult; we all have our personal attitudes and beliefs. Of course my ethics require that I treat all people, so I guess I would help him.”

A Dedza service provider said:

“I would not hesitate. It’s my job to serve all people. But all I am saying is that I would treat them just like I would treat a murderer who came for help.”

The HCSP here is indicating he would go ahead and treat as fairly as possible even though his personal attitude towards such persons is negative.
Another Dedza clinician seemed more liberal:

*As a clinician it’s none of my business what people do in the privacy. If they have a problem that needs to be fixed, I try to fix it. I don’t judge my clients. Homosexuality is nothing new.* “Izi sizinthu zachilendo.” [Nothing new here]

HCSP were asked what they thought were the reasons why HCSPs find it difficult or challenging to serve LGBTIQ people. There were numerous reasons offered. The key themes emerging were to do with people’s perceptions. The first perception is that the issue of homosexuality was “forced” on the people of Malawi by the donor community. The issue thus becomes seen as a symbol of the will for self-determination and cultural identity. This feeds into the belief that “naturally” no Malawian would engage in same sex sexual activities unless they are doing so due to external influence and money.

The perceived government silence on the issue especially with regard to clearly articulated guidelines on how to service LGBTIQ people has led to HCSPs justifying their refusal to service LGBTIQ with the quality of care they deserve. Whilst there are ethical demands on the HCSP, 16 HCSP indicated that they allowed their personal opinions to supersede their ethical duty to serve all without discrimination.

Health workers also find it difficult to work with LGBTIQ because of religious reasons. A large part of the discourse against LGBTIQ was that Malawi is a “God-fearing nation”. As one health care worker put it:

*“There are many sins, but this sin is considered the worst.”*

The healthcare workers recommend:

Government should also put measures to help LGBTIQ persons – especially in relation to HIV. The government needs to introduce clear guidelines for healthcare workers to know how to service LGBTIQ. However, the 2003 National HIV and AIDS Policy specifically acknowledges that there are persons who engage in same sex
relationships and that if these are not accorded access to prevention, education, treatment, care and support, they may in fact endanger others. In addition, the report goes on to state that the Malawi Government undertakes to 'put in place mechanisms to ensure that HIV and STI prevention, treatment, care and support can be accessed by all without discrimination, including people engaged in same sex sexual relations'.

The health care service providers were clearly not conversant with the contents of the HIV policy on same sex relationships.

One healthcare worker in Mangochi said:

“I would not offer specific services for this group, unless government provides clear guidelines on this issue. For example, I would not provide lubricants to gay people because homosexuality is illegal in this country. However, as a health worker I would provide general services that are provided to everyone else.”

Healthcare workers need specific training to understand specific issues related to LGBTIQ.

Since mission hospitals have policies against contraceptives, and even homosexuality, NGOs need to encourage the church to change these policies.

**Conclusion**

Most health workers find it difficult or challenging to work with the LGBTIQ community because of cultural and religious reasons. The HCSPs have very limited understanding of LGBTIQ nomenclature and the differences between them. To them LGBTIQ is grouped into one and the only picture most have is of LGB. To even get HCSP to accept that LGB exist has been a struggle for human rights advocates amongst HCSP. Those with limited exposure to LGBTIQ clients bring their own conservative attitudes to their work. The situation is further hampered by the difficulty of access to LGBTIQ individuals given that they are a
discreet community because of fear of arrest or people's homophobic attitudes. The HCSP perceive the government to be silent on the issue and are unaware of the guidelines for servicing people in same sex relationships. This further compromises the potential for quality LGBTIQ service provision.

It was interesting to note that there were no differences in how hesitant service providers are in relation to their level of education and/or their gender. The determining factor of how the HCSP saw and related with LGBTIQ was overwhelmingly determined by their religious beliefs. A respondent may have been serving in a government hospital which is not a “hesitant” space but may still personally be uncomfortable servicing LGBTIQ.

With regard to the level of access of LGBTIQ individuals to SRH services in the three districts of the UFBR programme in Malawi, LGBTIQ persons do have access to reproductive health services available for the general population. There is no access to specific LGBTIQ services except in Mangochi district where HCSPs that were trained by CHRR and CEDEP can offer such services. Condoms are readily available but other needs such as lubricants, dental dams are more difficult to access. The current access to SRH is conditional on the LGBTIQ not disclosing their sexual orientation as there is so much negativity on the part of the health care providers towards LGBTIQ. This, as well as the community’s negative stigma towards LGBTIQ, takes an emotional toll on the LGBTIQ community.
Recommendations

Based on the above conclusions the following are the recommendations of the study:

- LGBTIQ need specific health care services that are currently not available in Malawi. The services would include LGBTIQ related health education, sexual and reproductive health services and STI treatment. Provision of lubricants and other low risk sexual aids would be essential.

- There would therefore be the need for setting up mental health services to run individual counselling as well as provide group therapy to strengthen the mental well-being of the LGBTIQ persons. Such services are currently non-existent throughout Malawi. With regard to transgender for example, the counselling service would liaise with hormonal therapists or endocrinologists to ensure adequate therapies are available to service such clients. Counsellors would have to be very familiar and conversant with the different needs and issues within the LGBTIQ community.

- Alternative health services available for LGBTIQ would best be done through private clinics given that they appear more receptive to servicing these clients. Mission hospitals would be reluctant to service such clients given their perception that homosexuality is “sin”.

- What would be required to effectively service the LGBTIQ community would be for the health care personnel to be trained in servicing LGBTIQ. The training would need to go beyond the provision of materials to encompass the HCSPs own attitudes and prejudices. The training would have to address the fears that people have of learning to handle and accept those who have different sexual orientation from them and to be comfortable with such difference. It would also need to challenge their world view that that LGBTIQ is against their religious belief.
• The UFBR can play an important role in the training of health care personnel; identifying clinics that can serve the LGBTIQ community as well as help provide spaces where LGBTIQ can meet and receive more information about LGBTIQ issues such as orientation and sexuality issues. This would address the much needed preventative aspects of SRH for LGBTIQ.
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APPENDIX 1

HEALTH CARE PROVIDER ORGANISATIONS SERVICES PROVIDED

Mangochi Hospital (Government)

Antenatal care
Postnatal care
Kangaroo mother care
Nursery
STIs
Counselling of STIs
Trauma care
Condom distribution.
OPD
HTC

Source: Nurse, Female, Aged 32
Orthopaedic Clinical Officer, Male, 36
Clinical Officer, Male, 36
Clinical Officer, Male, 44
Medical Assistant, Male, 39
Medical Assistant, Female, 27
Laboratory Technician, male, 38
HTC Counsellor, female, 52
HTC Counsellor, Female 37
Medical Doctor, Female 29

Dedza District Hospital (Government)

In-patient services
Out patient
Family planning
Maternity
Mental health care services

Sources: Clinical Officer, Male, Aged 26
Nurse & Midwife Technician, Female, 29
STI Care Provider, Female, Aged 53
HTC Counsellor, Female, Aged 34
Medical Doctor, Female, Aged 24
Mtendere Mission Health Centre, Dedza. (Hesitant)

ART
Maternity
HTC Services
OPD
In-patients
STI clinic
Youth-friendly health services
Outreach
Source: Medical Assistant, Male, Aged 31
TC Counsellor, Male, Aged 29

Lobi Rural Health Centre, Dedza (Hesitant)

OPD
Family planning
VIA
Under 5
Outreach activities
HTC
Post-abortal care
Sources: Nurse, Male, Aged 28
Clinical Officer, Male, Aged 58

Chikwawa District Hospital (Government)

OPD
In-patient services
Under 5 clinic
Ante-natal and delivery
NRU (Nutritional Rehabilitation Unit)
TB screening and treatment
ART
STI
PMTCT
HTC
Laboratory
Dental,
Eye,
X-ray,
Orthopaedics

Sources: Clinical Officer, Male, Aged 32
Nurse, Female, Aged 26
HTC Counsellor, Female, Aged 30
Chinyanje Private Clinic, Chikwawa

Palliative care
Preventive
Under 5
STI,
Family planning

Source: Clinical Officer, Male, Aged 72

Tachira Private Clinic, Chikwawa

Reproductive health services (family planning)
Palliative & preventive care,
STI screening, treatment & counselling.

Source: Clinical Officer, Male, aged 64
APPENDIX 2

CHRR/ UFBR FGD QUESTION GUIDE TO LGBTIQ COMMUNITY

Procedure:
1. Introduce yourself and describe the study to respondents.
2. Obtain informed consent from potential respondents and give them a chance to ask any questions they may have about the study.
3. Obtain oral consent to tape-record the discussion from the respondents who consent to take part in the study.
4. To encourage openness, remind the respondent that whatever is discussed is confidential.
5. Record the discussion verbatim noting the sex and occupation of the person talking.
6. Check the tape periodically to make sure it is recording properly. Use new batteries for each discussion to avoid disruption in recording.
7. Record any unusual/unexpected circumstances that may have influenced the discussion.
8. When the discussion is over, thank the respondent for their participation.

Questions:
1. What are the SRH services available in your area?
2. Please describe the accessibility of the service in terms of location, how to get there, opening hours and affordability.
3. What are some of the services you receive?
4. What is your experience accessing condom and lubricants at these service points?
5. What are your experiences accessing other SRH services at these health points? Have you encountered any specific prejudices?
6. Have you ever withheld information from a health care provider because of fear of their response to your sexual orientation or practice? What information? Why? What did you then do about it?
7. Have you felt that you have received lower quality of care as result of your sexual orientation or practice?
8. Are you aware of any STI related services in the area where you live?
9. Have you or anyone you know ever sought STI treatment? Where did you/they get treated? Why did you/they go to that facility to seek treatment services? What influenced you/them to make the decision?
10. What would you recommend to improve the quality of those services?
11. What are LGBTIQ related services available in your area?
12. Describe which services are offered in the facility? What motivates you to seek health care services in that facility?
13. What would you want to suggest for improving the care and support at the service providers for LGBTIQ group?
14. Where do you currently get information about general health related issues?
15. Where do you currently get information about health related issues concerning sexual orientation or practice?
16. What other health care services would you like to see made available?
17. What health information would you like to receive pertaining to sexual orientation or practice?
18. Are there specific clinics that you believe could potentially service the LGBTIQ group in your area?
19. Why do you think they are a potential place for servicing the LGBTIQ community?
20. What would you recommend if these potential clinics become LGBTIQ service clinics?
21. What would you advise the UFBR do to promote such services on your area?
APPENDIX 3

UFBR CHRR Health Care Providers’ Key Informant Interview Guide for those offering services to LGBTIQ

Demographic Data

Age:

Highest level of your education:

Current Occupation:

Gender:

Health care providers may include individuals working in specialized public and private clinics, STI control programmes, VCT centres and NGOs implementing HIV/STI programmes. Personnel interviewed will include medical and non-medical staff at these programs.

1. Describe your facility generally, the types of service offered etc.
2. Do you sometimes receive or have clients who are LGBTIQ? Probe for frequency and specific times when the sexual minorities’ seek services.
3. What are the characteristics of your LGBTIQ clients (age, nationality, etc.)?
4. What are your opinions feelings about this group of clients? And what perceptions do your colleagues have about this groups of clients?
5. Have you observed any differences between LGBTIQ clients and other clients? Probe for behaviour while seeking services.
6. What services do you provide to the LGBTIQ clients? Probe for types of services - preventive, curative or both, specific details of service provided, e.g., ARV treatment, condom availability and types provided to the sexual minorities.
7. (IF health care provider) What are the different steps do you follow if the client is an LGBTIQ? (Probe: look for oral/anal STI; give different safe sex advices; make referral etc)
8. Did you receive any specific training to effectively service the LGBTIQ community?
9. Are your services tailored to meet the needs of the LGBTIQ clients? What happens when you can't solve problems specific to their sexual orientation?
10. How do you ensure privacy and confidentiality of the clients and their partners?
11. Could your premises be used to provide interventions for LGBTIQ, e.g., creating awareness about HIV/AIDS and distribution of condoms?

12. What support (supplies, training) do you need to meet the needs of LGBTIQ?

13. What additional services do you feel you would have the potential to offer to service the LGBTIQ community?

14. Generally why do health care workers find it difficult or challenging to work with LGBTIQ people? How can some of these challenges be addressed?

End of Interview, thank you for your time.
APPENDIX 4

UFBR CHRR Health Care Providers’ Key Informant Interview Guide for those HESITANT to offer services to LGBTIQ

Demographic Data
Age:
Highest level of your education:
Current Occupation:
Gender:

Health care providers may include individuals working in specialized public and private clinics, STI control programmes, VCT centres and NGOs implementing HIV/STI programmes. Personnel interviewed will include medical and non-medical staff in areas where UFBR is operating but may not be offering such services to LGBTIQ.

1. Describe your facility generally, the types of service offered etc.
2. Do you sometimes receive or have clients who are LGBTIQ? Probe for frequency and specific times when the sexual minorities’ seek services.
3. What are the characteristics of your LGBTIQ clients (age, nationality, etc.)?
4. What are your opinions feelings about this group of clients? And what perceptions do your colleagues have about this groups of clients?
5. Have you observed any differences between LGBTIQ clients and other clients? Probe for behaviour while seeking services
6. Why might you be hesitant to provide services to the LGBTIQ clients? Probe for beliefs, perceptions, fears.
7. Do you believe or think that your attitude may change? Why or why not?
8. What would you do if an LGBTIQ person came for SRH services?
9. Do you believe your hesitation is in line with your code of ethics as a health care provider? Why or why not? If contradicting, how do you explain?
10. Did you receive any specific training to effectively service the LGBTIQ community?
11. Would you be willing to receive such training to understand the issues better?
12. What services do you feel you would have the potential to offer to service the LGBTIQ community?
13. Generally why do health care workers find it difficult or challenging to work with LGBTIQ people? How can some of these challenges be addressed?

End of Interview, thank you for your time.
To: Rutgers WPF

From: Centre for Human Rights and Rehabilitation

Date: 30th April 2015

SUBJECT: REACTION TO THE SURVEY REPORT

We write this note to present our response to the report on the survey on Alternative Sexual Reproductive Health Services available for the LGBTIQ when not provided by government facilities. Indeed, the study was commissioned by CHRR in collaboration with the Unite for Body Rights (UFBR) programme. We, at CHRR, are very grateful to Rutgers WPF, UFBR partners, the consultant, the respondents and everyone who participated for making this survey a success.

Our response to this survey is that the findings as well as the conclusions and recommendations to a large extent do meet our expectations. Of course, there are a few ‘surprising’ results. Our assumption –and the assumption of many of our LGBTIQ clients –was that private clinics would be more accommodating of LGBTIQ persons’ health needs considering that they are “in business”. But this study has shown us that this may not always be the case. Some health providers within private clinics may refuse to treat a patient in the LGBTIQ category because of personal or religious beliefs. In such situations, a refusal can simply leave the patient without access to necessary care, which is very unfortunate.

Another important finding for us is the revelation that most health care providers have very limited understanding of LGBTIQ terminology and the differences between them. This perhaps is not very surprising considering that these things are never taught in schools or training colleges. But it cannot be disputed that ignorance of these things affects how health service providers will render services to LGBTIQ individuals. Therefore, we find the recommendation for training health service providers, particularly those in private clinics, to be very much in order and doable. We agree that the training would need to go beyond the provision of materials to encompass the providers’ own attitudes and prejudices. This would go a long way in addressing the ‘negativity’ on the part of the health care providers towards LGBTIQs and the misconceptions regarding the promotion of LGBTIQ rights in Malawi.
The recommendation for setting up mental health services to run individual counselling as well as provide group therapy to strengthen the mental well-being of the LGBTIQ persons is welcome. However, since CHRR currently does not have capacity to provide such services, this is something that may best be done with the help of external facilitators preferably those from the Malawi College of Medicine.

This survey is, therefore, extremely important to CHRR and the UFBR programme. The findings will help CHRR to effectively contribute to the UFBR programme’s objective of creating an enabling environment for SRHR (Result Area 2 –MDGs & SRHR services). Therefore, based on the conclusions and recommendations of this report, it is the wish of CHRR to provide specialist training for the targeted health service providers to enable them understand the reality of sexual diversity, sexual orientation, gender identity and the unique sexual and reproductive health needs of the LGBTIQ community. The aim of this training will be to improve the capacity of the service providers to deliver tailor-made SRH services to the LGBTIQ community. It will be expected that at the end of the training workshop, participating clinics would be willing to become LGBTIQ-friendly clinics –i.e. clinics where LGBTIQ individuals can go and access SRH services (lubricants, condoms, relevant SRH information etc.) and where they can expect to be treated in a non-judgmental and non-discriminatory manner.

Funds permitting, CHRR would also like to consider provision of mental health services through workshops designed to address often neglected issues such as self-esteem, relationships and the coming out process.

In brief, the above is our reaction to the survey’s findings, conclusions and recommendations. Once again thank you all for your contribution.

Sincerely,

Timothy Mtambo

Executive Director

Email: chrr@chrrmw.org