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Health, violence and sexuality in the accounts of sexually and gender non-normative users of public health services in South Africa.

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Declaration

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Abstract

The constitutional protection afforded to the LGBT/queer community in South Africa has not effectively eradicated discrimination. Queerness continues to be violently "othered" in important public spaces and institutions. One such critical space, is the over-burdened and under-resourced public health care system, which remains particularly unresponsive to the needs of sexually and gendered non-normative persons. Research in this area tends to focus on queer identity as a risk-factor for wellbeing without appreciating the complex constitution of queer subjectivity produced through the very interaction with the public health system in South Africa. Through the use of a narrative-discursive design, this research aims to explore the subjectivity of queer consumers of public health and their interface with social, structural and symbolic violence/s. Using stories of experiencing healthcare as an entry point, this study troubles the notion of queerness as merely a category at the receiving end of prejudice in the public health system. Rather, the study focuses on how this very health system produces queerness as an instrument and effect of biopower. The data collected via semi-structured interviews with 10 volunteer LGBT participants who make regular use of public health services was wed to discourse analysis to explore the nexus between being queer and being a public health consumer in South Africa. This study is of particular relevance for stakeholders within the sector, providing experiential accounts of how violence centres the use of healthcare for LGBT consumers which may provide a response that could inform future health services policy.

Keywords: Biopolitics, Disciplinary Power, LGBT, Microaggression, Public Health, Sexuality, South Africa, Violence.

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Chapter 1: Introduction

The recognition of sexual orientation as a source for discrimination in South Africa, granted constitutional protection in the equality clause of section 9(3), has not eradicated discrimination against LGBT people (Ilyayambwa, 2012) with this group remaining vulnerable to prejudice in South Africa (Minister of Justice and Correctional Services, 2016). The marked increase in violent crimes against this minority group has generated a body of research into how stigma manifests against non-normative sexual identities and primes hate-based assaults (Mahomed & Trangoš, 2016; Wells & Polders, 2006). However, the violence faced by queer bodies in heterosexist societies is not limited to the physical harm mainly highlighted in the social psychological literature (Nadal & Griffin, 2011). Further, studies of violence in the LGBT community have not paid sufficient attention to the way discrimination reproduces the very difference it targets (Ferim, 2016; Koraan & Geduld, 2016). In order to investigate the changing face of heteronormativity, structural and symbolic forms of violence need to be accounted for to provide conceptual insight into how queer bodies are regulated, constrained and produced in view of violence.

The visibility of the LGBT community exists due to broader discourses of traditional gender roles and sexuality in South Africa fuelling homophobia and marking these subjects as deviant (Morrissey, 2013). The moral trend in South African queer studies often halts ideological engagement with identity and public health, as the lack of access to fundamental services, is treated (rightfully) as an injustice (Cloete, Simbayi, Kalichman, Strebel, & Henda, 2008; Rispel, Metcalf, Cloete, Moorman, & Reddy, 2011; Skinner & Mfecane, 2004). However, engagement with how the queer subject position is treated during healthcare encounters and fixed upon users of public health can be furthered. Although research has shown that 10% of an LGBT South

African sample felt discriminated against during healthcare visits, such insight into the pervasiveness of prejudice neglects the underlying social discourse which propagates the statistic **(**Love Not Hate Campaign, 2016). The context of this study may point to an under-reporting in this sector, or singular understanding of violence as deeply entrenched homophobia remains an important issue for LGBT people in South Africa (Ferim, 2016). Violence often co-occurs with anti-LGBT beliefs whether this is socially between individuals as physical altercations (Lloyd, 2013), structural in the form of practiced exclusion of the LGBT community in certain spaces (Logie & Gibson, 2013) or prejudice and bias in common interactions (Sue et al., 2007). How violence is accounted for by the LGBT community in accessing healthcare has practical and theoretical value for the study of violence.

With a proximity to power, Foucault (1973) shows how religious, moral and biological discourses of health and hygiene coincide and have been incorporated into understandings of the queer body. With this cultural authority of medicine, discrimination based on sexual orientation and gender have been incorporated into the operation of public health institutions by placing religious constraints on the body (Foucault, 1973). Although religion was slowly replaced by science in the clinic, it's knowledge of a binary gender system and reproductive focus on the body still othered non-conforming individuals (Foucault, 1973). With the turn to current modernity, moral-religious restrictions on queer sexuality have transferred to a bio-politics driven by the optimisation of the population (Foucault, Davidson, & Burchell, 2008). This biopolitical power works in public health to re-medicalise queerness and streamline disease management which can essentialise the LGBT community to illness as seen in the wake of the AIDS crisis (Dennis, 1997). This population-level health security is important to try understand in South Africa with an ongoing HIV and sexual health epidemic (Lane, Mogale, Struthers,

McIntyre, & Kegeles, 2008). Studying how queer users account for violence in public health needs to also inspect the discourses attached to these clinics.

1.1 Research Rationale

Research on LGBT health has a tendency within the growing literature to focus on understanding factors that drive health inclusion or equitable health for this population (Mulé et al., 2009). This important area of study examines the ways that constrained health access to the LGBT community is often shaped by homophobia. However, very few studies have explored exactly how such constraints construct the queer health consumer. Modern health provision studies often emphasise the discrepancies in levels of care and treatment between heterosexual conforming individuals and projected similarities within the queer community (McDermott, Roen, & Scourfield, 2008). By focusing on the LGBT community solely as a disadvantaged population in terms of access, the individual experience of public health consumption has been ignored. The homogenisation of queer people inherent in these works (Bowleg, 2012) can also render invisible the discrete differences between sexually non-normative and gender non-conforming people. The different discourses around moral sexuality and gender transgression within the healthcare sector require further study to explore how these diverse identities interconnect to systems of power in the South African context. An important exception to this body of research is the recent work by Meer and Müller (2017) which provides a description of how queerness and healthcare spaces are co-produced within social interactions. However, this work uses Lefebvre's triad of social space to explore the heteronormative practices of healthcare providers and the symbolic deviance assigned to queerness and does not account for other forms

of violence (Meer & Müller, 2017). A further account of how queer users shape and are shaped through specific violence/s in South African healthcare facilities is required.

As a result, the current study attempts to address the oversight in ignoring violent practices within the healthcare system as well as account for the macro-level discourses which produce the subjectivities and medical experiences of queer people. Violence is a broad analytic term in this study which following the World Health Organisation (WHO) definition can be seen as the "intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation" (WHO, 2019). In relation to public health, this overarching definition focuses on distinguishing violence from accidental injury by emphasising the intended use of force or collective power which harms an individual. The glossary of violence for this report is extended to define interpersonal violence as acts of harm or intimidation that occur between individual members of society where structural violence is defined as harm embedded into macrosocial systems as institutional inequalities which disenfranchise individuals or groups of people (Rutherford, Zwi, Grove, & Butchart, 2007). Another analytic category of violence in this study is symbolic violence which refers to the instrumental use of concealed social domination by an individual against a group identity (Sue, 2010).

Interpersonal violence is often attended to as a public health concern for the LGBT community given its social visibility and the moral imposition of victimisation (Potter, Fountain, & Stapleton, 2012). However, restrictive anti-queer violence is not the only form of power exerted during the healthcare moment. As work by Padilla, del Aguila and Parker (2007) points out sexual and gender minorities experience violence within the structures of social institutions

as these identities are seen as maladaptive and outside of doctors' traditional skills. This structural violence infringes on the LGBT person to meet their basic healthcare needs, and identity assertion can lead to sanctioning or link back to physical altercations (Padilla et al., 2007). Health encounters are not confined to broad political systems as they also occur as a form of rehearsed social interaction in everyday life (Peräkylä, 2011). This allows for micro-level violence to occur in which LGBT identities are invalidated or annihilated by concealed forms of prejudice (Sue & Capodilupo, 2008). These microaggressions as a form of innocuous violence in interactions can isolate the LGBT community and render their subjectivities invisible (Nadal & Griffin, 2011). Exploring the formation of the queer subject in public healthcare requires a better understanding of how violence is accounted for by LGBT users of public health.

Lastly, Daley and MacDonnell (2011) show that heterosexist discourses are institutionalised into healthcare which produces the queer subject as a specific kind of healthcare user focused on their sexual and reproductive health. This study attempts to move past the common research objective of documenting barriers to access and equity for the LGBT community and investigate how these differences are structured through and come to exist by violence. As such, studying how violence is enacted on the queer body represents an entry point into understanding the way sex, sexuality, gender and non-normative subjectivities are not only a mode of social contravention but produced as instruments and effects of power. By using Foucault's and more contemporary conceptualisations on the role of sovereign, disciplinary and biopower in shaping the individual, this study attempts to track how queerness is produced in reports by LGBT healthcare users in South Africa.

1.2 Research Aim

The primary aim of this study was to explore constructions of violence in the accounts of queer users of public health. This was accomplished through narrative interviews with self-identified members of the LGBT community who have used public health facilities and reported violence in their use. The interviews were analysed using a Foucauldian-style Discourse Analysis (FDA) to explore the constructions of violence in these accounts (Wodak & Meyer, 2009) following the steps proposed by Parker (2014). This style of analysis allows dominant and counter discourses to be studied which aims to show how queer users understand their subjectivity within the clinic (Arribas-Ayllon & Walkerdine, 2008). Foucault (1981) understands discourse as an effect of power which through language of inclusion, exclusion and selection informs which practices are seen as permissible in any social context. By constituting knowledge of the body, people, and places discourse acts through language to produce subjects (Foucault, 1981). This understanding of discourse as the power relations and political meaning of language is carried through in Parker's (2014) instructions for analysing text.

With the purpose of studying the discourses of queerness attached to government health facilities, this study provides a framework of understanding on how violence is accounted for by queer users of health. This research undertakes to show how spectacular, structural and symbolic violence in the health system are points of disciplinary and productive power for queer subject positions. By targeting three kinds of violence this study is guided by an overarching research question: How has violence shaped the accounts and experiences of LGBT users of public health services in South Africa?

1.3 Structure and Outline of the Report

Chapter 2 provides a comprehensive review of the literature in order to situate the study within a context of power and its operationalization on sexuality and gender to other queerness. A comprehensive theoretical framework on the typology of violence/s under scrutiny in this study is also provided specifically outlining Foucault's work on discipline, Galtung's interdependent understanding of structural violence as well as borrowing from Sue's conceptualization of microaggressions. This discussion considers queer users of health to be products of the discourses available to them through the violent exercise of modern power. Included in this is a review of previous works which have isolated sexual and gender identity as social determinants to health and attempts to understand the omission of subjectivity in this interaction. This review is followed by arguing that LGBT health encounters relate to both disciplinary power of making the body docile, and biopolitical power to essentialise biology which may have coinciding and contradicting projects for the individual user.

Chapter 3 describes the data collection and analytic methods used to implement this research project and supportive arguments are provided for the sampling technique, ethical considerations and use of a narrative method. This section also contains an analysis of positionality and the dialogue in the text, specifically highlighting how the researcher's own subjectivity may have rebounded in the interviews.

Chapter 4 presents the results of the analysis structured as a discussion of the discourses produced in the interviews and the specific sample who generated the data for this study are also

described. In view of the sourced literature and participant productions, discourses of sexuality, gender, religion, collective identity, biological ordering and rights were analysed.

Chapter 5 concludes the report by summarising the arguments in the discussion. The practical and theoretical strengths and constraints are outlined as well as an acknowledgment of the potential academic and real-world recommendations found in the study.

Chapter 2: Literature Review

Queerness is often violently sanctioned in South African society. Theoretically, it will be argued that LGBT bodies are sites upon which power is exerted for disciplinary and biopolitical functions. The subjectification of queerness, or the process through which human subjects are produced discursively as 'queer' in the public healthcare system has not been fully explored in this context. According to a limited set of surveys, this subjectification is often accompanied or in fact constituted through various forms of violence. Yet, accounts of experiences of violence by queer users of the South Africa's public health system have not been adequately examined.

2.1 What or Who is a 'Subject': A Theoretical Premise

Framed by constructionism, this research shows how discourses around the LGBT community in the health sector form part of their individual sense-making of their subjectivity. The overarching assumption of this intended study is that gender and sexuality are discursive constructs arising out of, located in, and manifested through the regulatory function of society (Foucault, 1978). Premised on the work of Foucault (1977) discourses are not dormant categorisations or processes of speech, but provide regulation through technologies of the self. As Foucault's (1977, 1978) work is important to this study, it aligns with his central idea that power is not purely a resistive force brought by another but is inherent in all interactions and holds the capacity within discourse to constitute subjects and their practices. Under this guise, being queer is foremost a subject position which is undetachable from the realities which shape it (Foucault, 1978). So, the LGBT/queer label in this study is referent to non-normative sexual and gender identities, not as universal or enduring categories, but as established subject positions which challenge the heteronormative order (Warner, 1993).

Although some queer theorists often call for a clean distinction between queerness and the stability suggested in LGBT as separate social identities, this contested academic terminology has the potential to homogenise non-normative experiences and erase the nuances within these varied identities (Lovaas, Elia, & Yep, 2006; Slagle, 2006). Disaggregating queerness from the LGBT community is also practically contentious for health research as this can prevent an accurate exploration into the interconnectedness and oppositions between sex and gender (Peel & Thomson, 2009). Despite the strong anti-identity stake which often prefaces the epistemology of queer research (Stein & Plummer, 1994), forcing a self-emancipated 'queer' title on the set of practices used by participants asserts a position of knowledge over their own ability to self-identify and removes the determined field of normalisation which shapes their identity (Green, 2010). The word queer also carries negative social connotation outside of academia as Butler (2011a) rightly suggests:

> The term "queer" has operated as one linguistic practice whose purpose has been the shaming of the subject it names or, rather, the producing of a subject through that shaming interpellation. 'Queer' derives its force precisely through the repeated invocation by which it has become linked to accusation, pathologization, insult. This is an invocation by which a social bond among homophobic communities is formed through time. The interpellation echoes past interpellations, and binds the speakers, as if they spoke in unison across time. In this sense, it is always an imaginary chorus that taunts "queer!". (p. 172)

While acknowledging the important political distinctions that have been made between the label "queer" and those used by self-identified members of the LGBT community, the two

were used interchangeably in this study as participant, and not analytic categories, to not force participants into debates around academic language and follow their own sense-making.

Sexuality is taken to refer to the culturally and historically bounded knowledge about an individual's sexual orientation which is reduced to a binary between homosexuality and heterosexuality (Foucault, 1978). Sexuality presents as a codification of sexual behaviour as its everyday performance and construction is enforced by power relations (Foucault, 1978). Similarly, gender can be seen as the historical dichotomy in society where sex distinctions have carried into activities aligned to the socially accepted categories of men and women (McNay, 2013). Although Foucault's own work does not assert an analysis of gender, other constructionist authors highlight gender identity as a process of interpretation and performance under discourse (McNay, 2013). McNay (2013) continues to suggest that a sex/gender distinction is a means of bypassing the theoretical problems of addressing both in tandem, however they carry interrelated meanings for how the queer body is treated.

For ease of understanding, definitions of the sexualities and genders which the participants self-identified with are provided. Gay is seen as the default understanding of homosexuality, where an individual experiences attraction solely to members of the same gender identity with lesbian referring specifically to a gay woman (Killermann, 2013). In terms of sexual orientation, some participants identified as queer which in this light is an umbrella term to describe individuals who do not identify in the straight/gay binary or can experience attraction to all gender identities (Killermann, 2013). In terms of gender, a transgender woman refers to an individual whose gender identity as a woman is incongruent with their male sex assigned at birth (Killermann, 2013). By comparison, gender non-conforming refers to a gender identity outside of the gender binary with non-traditional gender expression (Killermann, 2013). Lastly, one

participant in this study also identified as demi-sexual which refers to a person who does not experience sexual attraction until a strong emotional connection is formed (Killermann, 2013).

2.2 Hetero: The Norm of (Violent) Activity in Queer Health

The dominant oppositional discourse surrounding the queer community is that of heteronormativity. The most basic conceptualisation of this notion is that heterosexual sex and conformist gender roles are the taken for granted expressions of humanity (Oswald, Blume, & Marks, 2005). Heterosexist discourses emerge to demonise homosexuality, to isolate these bodies, and hold them up as a spectre which dignifies heterosexuality (Warner, 1993). Heteronormativity becomes a model which structures the possibilities of actions available to all social members regardless of how they situate themselves to it, as heterosexuality remains "something that we are oriented around, even if it disappears from view" (Ahmed, 2006, p. 560). This structure of governance assists not only in the regulation of bodies, according to normative accounts of sexuality and gender, but creates non-normative subjectivities in the moment of speaking about queer subjects (Lloyd, 2013).

This ideal has further taken root in South African society by binding itself to narratives of culture and context with the categorisation of non-normative sexual identities as "un-African" leading to various forms of violent consequences (Morrissey, 2013, p. 81), such as corrective rape (Brown, 2012), marginalisation by traditional leaders (Epprecht, 2013), and hate crimes (Luyt, 2012) for the queer community. The rhetoric of heteronormativity is differentially configured but nonetheless ubiquitous across intersecting social categories such as class and race. Heteronormativity is tied to tradition, as echoed by Msibi (2009, 2012) as homophobic violence is often argued as necessary by perpetrators to maintain the social order. Spectacular

forms of violence like these – which physically assault or harm the body within view of society – relate to Foucault's understanding of sovereign power. Heterosexuality here takes the place of rule-based authority, where any dissent through the performance of homosexuality faces violent punishment and dramatic shows of force (Foucault, 1977).

Homophobic violence creates the queer subject as visible and the "art of punishing" in such instances operates by providing a threshold for expected behaviour (Foucault, 1977, p. 182). Research conducted in Gauteng by Nel and Judge (2008) clearly shows how prejudicial hate speech and violence against queer bodies in South Africa is common. Nel and Judge (2008) found that 44% of LGBT people experienced some form of prejudice in using healthcare, and further that 62% of the sample experienced hate crimes more generally. This indication that anti-LGBT discrimination permeates all aspects of everyday life is compounded with the Love Not Hate Campaign's (2016) finding that 41% of those surveyed knew of someone who had been murdered because of their identity and 55% expressed fear they would be discriminated against in the future, reflecting the consciousness of violence for this community. Similarly, participatory action research by Graziano (2004) found that challenging everyday heterosexism led to physical and sexual violence for black homosexual men and women in South Africa. In these ways, sovereign power held up by heteronormativity acts to limit queer behaviour and stop it through socially visible violence enacted by another subject. Hate crimes and physical acts of violence easily align with Foucault's (1977) understanding of persecution as a means of making the exercise of authority visible. Within a heterosexist society, sovereign acts of power like this mark the body and repress the non-conforming subject. Verbal hostility, physical altercations and sexual abuse form a "spectacle of violence" for the LGBT community where violence can be seen as permissible to maintain the social order of heterosexuality (Mason, 2002, p. 180).

Physical violence has been well conceptualised through Foucault's gaze to underscore the manifestation of gendered (McNay, 2013), racial and ethnic (Moore, 2005), and sexual orientation based violence as sovereign acts of power (Martino, 2000). Although imperfectly, by virtue of their observability these acts of homophobic violence materialise as a process of social domination as the queer body is marked as a site to be controlled through force and allows these sovereign acts of violence to give way to modern discipline (Foucault, 1977). Through reading the shift in the penal system from acts of torture to imprisonment, Foucault (1977) introduces the idea of discipline as a new productive force in society. In this genealogy, Foucault (1977) indicates how social control in prisons develops into a highly structured regulation of the body aimed at producing docility and a rhetorical correction of the soul. Within this modern regime of power, violence and discipline are drawn together in order to "punish with more universality and necessity; to insert the power to punish more deeply into the social body" (Foucault, 1977, p. 82). In these ways, disciplinary power acts as a system of knowledge that knows of the queer subject as an 'other' in relation to heterosexuality.

Forms of regulatory punishment pervade society beyond the prison taking hold in interactions of the clinic. To Foucault (1977) although the body is a privileged place for the application of punishment, this "bearer of forces" acts as a mediator for discipline to maintain itself and train the individual into norming this conduct as the desired outcome (p. 166). Modern disciplinary power acts through routine, structure and the organisation of space to train the subject (Foucault, 1977). Through the authority of medical practitioners and the systemisation of the professional consult, the clinic emphasises the observability of the patient (Foucault, 1973). This institutionalisation of categorising disease, bodies and their subjects acts as a form of panopticon which seeks out compliance (Foucault, 1973).

Queerness has a unique relationship within health due to historical connotations of illness. Beginning with Foucault's (1978) writings on development, as modern Western society turned toward socialising procreative behaviour homosexuality was seen as abnormality. Knowledge from rates of birth, fertility and death motivated reproduction as a matter of public importance and conversely, disciplined non-procreative or pleasurable sex (Foucault, 1978). In tandem, an observable shift towards understanding human motivation through the psychiatrist made them the authority figure of confession. This substitution away from religion bore the science of sexuality, where the authority of medical practitioners to classify and elaborate on sexual conditions established a divide between non/normalized sexualities (Foucault, 1978).

Within this Victorian period, doctors studying sexuality created two strategic categories: the gender conforming heterosexual, and the deviant counter position of homosexuality (Foucault, 1978). In the language of normal against pathological, and health against sickness sexuality became rooted in the practices of health and hygiene as sexual deviance was seen as a form of contamination (Foucault, 1978). The formulation of a hygienic discourse was mutually constituted by the illegality of non-heterosexuality which charged medical practitioners with finding a cure and so "sexual irregularity was annexed to mental illness" (Foucault, 1978, p. 36). Through the organising of medical treatments alongside a moral value, the practice of medicine branded all deviations from heterosexuality within an "emphatic vocabulary of abomination" and so sexuality was treated as a biomedical phenomenon (Foucault, 1978, p. 36).

Within this framework, sex and gender are less about their action but symptomatic of power's operation to diagnose and correct deviance. As Drescher (2015) points out the depathologisation of homosexuality (which only occurred in 1973) from the DSM led to a shift in cultural attitudes around homosexuality within the West as this normalising view was

gradually accepted from a scientific authority. Currently, the DSM-5 saw a change from gender identity disorder (GID) to gender dysphoria (GD) in a bid to represent the distress queer people experience when their assigned gender is incongruent with their own identity (Davy, 2015). However, Davy (2015) continues to argue that this inversion re-stigmatises gender expression as pathological and could reduce access to legal recognition and medical transition by installing a psychiatric threshold for gender expression. Importantly, Foucault (1978) emphasises that this medicalisation does not repress sexuality, but forces the individual to internalise the examination and monitoring of their own thoughts and feelings in relation to heterosexuality. How medical encounters, then, inform queer subjectivity and are informed by the creation of a medical sexuality in South Africa can be further explored.

2.3 Structural Violence: Another Link to Institutions and Queerness

Physical acts of violence and the link to power may be clear, but power relations are neither this simplistic or within the control of any one individual. Under the scrutiny of discourses of queerness as maladaptive, this judgement forms into self-examination which acts as a "normalizing gaze, a surveillance that makes it possible to qualify, to classify and to punish" (Foucault, 1977, p. 184). Unlike sovereign punishment which directly violates the body, disciplinary power tries to make the body docile and produce confession of new sexualities if they do not align to the norm (Wilchins, 2004). Linking to the discussion on heterosexist discipline in the clinic, queer health has its discursive roots in the pathologising of non-normative sexualities illustrating that the very architecture of the clinic is violently positioned against LGBT subjects.

Although healthcare is embedded in historical processes which locate the LGBT community within a global system, individual health is contextually situated and shaped by local interpretations of the queer body (Padilla et al., 2007). As a state apparatus, the public healthcare system in South Africa is socially over-burdened and economically under resourced (Mayosi & Benatar, 2014), making it largely unresponsive to the needs of sexually non-normative persons, with current policies treating minority identity as a risk factor for wellbeing (Reddy, Sandfort, & Rispel, 2009; Rispel & Metcalf, 2009). Studies into the health-seeking behaviour of queer people have an implicit bias of overrepresentation towards homosexual men, and a stringent focus on the HIV epidemic (Burrell, Mark, Grant, Wood, & Bekker, 2010; Cloete et al., 2008; Lane et al., 2011; Skinner & Mfecane, 2004). This research provides specific insight into the health-seeking behaviours of this sub-group of the queer population, with Rispel et al. (2011) showing that only 6.8% of their sample would even willingly use government facilities. The fear of victimisation and perception of violence with a public practitioner can act as a barrier to care for the LGBT community (Rispel et al., 2011). However, these practical concerns are used to equate homosexuality to all queer subjectivities and ignore non-sexual reasons for the uptake of care in the LGBT community. Queer health consumers are marked by not only availability of care, but access to it and the acceptability of their bodies within clinics and how this seemingly operates alongside violence/s can be further explored.

Another formation of power is found in structural violence, where the authority granted to social institutions such as hospitals can harm the individual by creating a barrier to accessing their basic needs or structuring their experiences of health (Galtung, 1969). This distinction from personal spectacular violence is determined by the presence of an acting subject, in that the origins of structural violence are not formed from an individual agent but are institutional,

economic or political in character (Galtung, 1969). Social structures can still marginalise the oppressed even with a missing subject of action by sustaining unbalanced power relations (Galtung & Höivik, 1971). This process of social exclusion in health is found through the normalising of heterosexual bodies who are given preferential treatment making queer health inorganic to the hospital (Padilla et al., 2007). Structural violence within health may be indirect in its shape with no identifiable agent of harm (Galtung & Höivik, 1971), but as a form of systematic oppression constructs the queer health user as a particular kind of un/healthy subject.

With queer affirming treatment an oddity (Mayer et al., 2008), pathological language remaining in international health guidelines (Hollenbach, Eckstrand, & Dreger, 2014), and separate services a necessity to find tailored care (Fredriksen-Goldsen et al., 2014) structural violence acts as an opportunity for discipline to permeate the queer healthcare engagement. Smith (2015) found that lesbian and bisexual health consumers in Cape Town used specific strategies such as non-disclosure to protect their access to healthcare. Structural violence in these cases creates subjectivities for the self, as disciplinary power performs on the mind, what it enacted on the body, through "conscious and permanent visibility" on queer bodies whose subjectivities are proposed as sites to exercise social control (Foucault, 1977, p. 201). A study conducted by Müller (2018) highlights that although queer patients' needs are not outside the expected competencies of a trained professional, due to the unintelligibility of homosexual bodies, they are seen as beyond the scope of mainstream medical care in South Africa. By being institutionally invisible, such interactions either force patients to re-assert their subjectivity and challenge the heteronormative attitudes of service providers at the risk of not accessing care or to conceal their self-identification (Müller, 2018). These structural barriers form queerness as a specific 'other' outside of the normal operations of the clinic.

Identifying as queer structures healthcare in specific ways, creating an affective barrier to targeted treatment as the fear of harassment can lead to non-disclosure of identity (Lane et al., 2008; Rispel & Metcalf, 2009). One of the few studies on gender non-conforming and transgender people in South Africa by Stevens (2012) found that participants routinely expressed being held responsible for acquiring ill-health, such as HIV infection, due to their gender identity. As such the finding by Wells and Polders (2006) that 16% of LGBT people in their sample delayed or did not seek treatment for fear of violent discrimination speaks to queerness as sanctionable within the structures of public health due to discourses of health and hygiene. These studies suggest in line with Foucault (1977) that the hospital can carry panoptic technologies, using it as a privileged site for training queer bodies to monitor their subjectivity against the norm. Structural violence is built into the disciplinary function of the clinic and how queer users account for the violence endorsed by the very institution charged with their care can potentially add a new layer of understanding in the formation of queerness in relation to power.

2.4 Microaggressive Violence: A New frontier for Subjectivity

Part of going to a clinic is the interaction with the staff, and these interactions may be better apprehended as forms of discipline that, to varying degrees are enacted along a continuum from physical to symbolic violence – as a form of concealed social domination at the level of the micro-interaction (Sue, 2010). The everyday labour of sense making for queer people during healthcare engagements has yet to target microaggressions as a form of symbolic violence in the South African context. These “stunning, automatic acts of disregard” are conceived of as subtle, commonplace and everyday acts of discrimination (Davis, 1989, p. 1576; Pierce, 1974, 1995). Microaggressive acts are considered to be brief structural and behavioural indignities expressed

through language (Devos & Banaji, 2005; Nadal, 2008). Sue et al. (2007) further suggests that microaggressions are the systemic transformation of overt prejudice into a concealed form and as such are part of the exercise of mis/recognition and invisibility of symbolic violence. As such it is possible that these covert acts can become a relational task which, although constructed externally from the perpetrated, forces the queer subject position to the fore.

The current typology of microaggressions divides these acts into: microassaults, microinsults and microinvalidations (Capodilupo et al., 2010; Sue & Capodilupo, 2008). Under these labels, the microassault is conceptualised as the most explicit form of discrimination where a direct derogation is enacted upon an intended victim (Sue et al., 2007). These malicious acts are socially visible to both parties, and implemented as an intended form of sanctioning against the victim for their, claimed or unclaimed, subject position (Solorzano, Ceja, & Yosso, 2000). Comparatively, the microinsult is seen as a subtle communicative action of insensitivity which demeans the identity of the perpetrated (Sue & Capodilupo, 2008). As such, these acts can be unintended by the perpetrator but nonetheless create an antagonistic interaction which maligns the victim's identity (Dunbar, 2006). The microinvalidation is seen as an innocuous act which indirectly serves to minimise, nullify or negate the social realities faced by oppressed groups (Burdsey, 2011; Capodilupo et al., 2010). These cues are taken to socially exclude individuals whose identities are being sanctioned (Nadal & Griffin, 2011), and even further to nefariously protect the subject position of the perpetrator from inspection. Where Nadal and Griffin (2011) found that denying heterosexism, pathologising queerness, and endorsing social conformity were the most perpetrated microaggressions for LGBT American youth seeking mental health care, Smith and Shin (2014) found that these tropes can be taken as queer blindfolding aligned with the erasure and yet awareness of, the queer subject position as an abnormality. The innocuous

microaggressive acts of invalidation and insult appear as symbolic violence which extend beyond a stigmatising function and act as discursive tools to discipline queer subjectivity.

A compelling study by Subramani (2018) into Chennai state and private hospitals argues that micro-inequities build and maintain the asymmetrical power relationships found in society. Through in-depth interviews and ethnographic work, it was observed that patients on the bottom of an asymmetry (be it class, caste or gender) were often met with avoidance, eye-rolling and dismissal. This micro-messaging was most profound in state institutions, where power dynamics were heightened due to the higher volume of patients without access to alternate treatment. This dependency becomes key in the transfer of the violence of social norms into the medical setting as Subramani (2018) found that these inequities were normalised by the disempowered victims and treated as a necessary part of securing healthcare. By legitimising these acts and treating them as part of the process, patients' subjectivities are produced by this "discrimination woven into the everyday" (p. 138). Although with a focus on practitioners, this instance shows how the public hospital setting can mirror society and the potential microaggressions have to create queer health care users in South Africa as unique.

Institutional assumptions found in healthcare settings can also carry symbolic violence as they invalidate, and indexically subjectify, queer lives. Material communication of health as exclusively heterosexual, in pamphlets and posters displayed in reproductive health care centres, clinics and waiting rooms are symbolic gestures which align with the microinvalidation as this queer exclusion constructs these subjects as deviant to the normal functioning of the clinic (Goldberg, 2005; McDonald, McIntyre, & Anderson, 2003; Röndahl, Innala, & Carlsson, 2006). The cases presented by Heyes, Dean, and Goldberg (2016) highlight instances such as a lesbian patient having their partner listed as a friend on her intake forms, to the child of a lesbian mother

having treatment delayed due to the absence of a father on paperwork. Such engagements speak not only to the pre-established erasure of queer identities in the healthcare setting, but to the resonance microaggressive acts have in the momentary constitution of the queer subject which has not been targeted in the South African landscape.

Power, in such exchanges, exerts itself not simply through disciplinary correction but in fact produces subjects and produces particular knowledge about those subjects (Rose, 1998). This formulation of power as a regime of the self which instructs the level of identity, and what can or cannot be done with that identity, evolves queer subjectivity into a product of microaggressive acts. As set out by Butler (2011a) identity is formed through the conditions of possibility and impossibility available to the individual, and microaggressions form part of the range of (im)possibilities for the LGBT community. The theoretical progression therein is that power in this form is productive and scripts queer subjectivities as opposed to being a purely negativising force seen in the other networks of power.

The most persistent limitation in bridging the theoretical gap from microaggressive violence and discourse is in measurement. These studies are often thwarted by the use of scales (Balsam, Molina, Beadnell, Simoni, & Walters, 2011; Forrest-Bank & Jenson, 2015), which create the microaggressions under investigation instead of allowing participants to speak about them. The conceptual intent and the practical contributions possible from items such as “I saw people holding signs with religiously based anti-LGBT messages (e.g., “Faggots are going to hell.”) are neither nuanced, or able to prevent the reification of the target of analysis (Woodford, Chonody, Kulick, Brennan, & Renn, 2015, p. 15). Similarly, the scrutiny of microaggressive acts tends to be unimaginative, with authors committing only to basic thematic analyses (Galupo, Henise, & Davis, 2014; Nadal et al., 2011; Nadal, Skolnik, & Wong, 2012). Although fruitful in

critiquing the experiences of queer bodies under heteronormativity, such approaches leave the very discourses which inform this subject position unexamined and thus fail to show how microaggressions constitute queerness. With the salience to not simply act as assaults against marginalised bodies, but be constructive of them, these violent acts need to be studied through a discursive lens.

2.5 The Needle and the Thread: Biopower as a conduit for Disciplinary Violence.

As aforementioned, disciplinary power and its reach through violence co-create subjectivity and so need to be linked to the range of possibilities available through biopolitical power. Foucault first opened lengthy discussion about biopolitics at his lectures at Collège de France which initially spoke on the growth of liberalism and how governments use this order of rationality to blur the boundary between biological existence and existing in a political community (Foucault, 2007). This claim suggests that power, and its exertion, takes biology as its primary object (Foucault, 2007). Where Foucault (1977) suggests that sovereign power in its classic form represses the individual and acts deductively, biopower exerts a productive influence to manage bodies (Oksala, 2010).

By suggesting that "the anchor points for exercises of power are always bodies" biopower regulates, is practiced by and is reproduced upon the body and life (McWhorter, 2004, p. 42). This understanding suggests biopower is individualising and collectivising; it intervenes through disciplinary mechanisms to control the individual body and it exercises control at the level of populations (Foucault, 2007). This theoretical understanding links to the practicalities of LGBT health with the example of "surgical management" of medical transition for transgender patients through the orchidectomy or hysterectomy (Feldman, 2008, p. 365). In this exchange,

biology is physically operated on to align with the sex binary and this instructs the transgender community of the channels, procedures and cost of transition. As such, anatomopolitics as the disciplinary arm of biopower which Foucault (1978) speaks about targets actions onto the body as a system of efficient social control.

An important aspect of biopower is that it does not replace sovereign or disciplinary mechanisms of power and violence against the body, but rather they co-exist to manage the population (Oksala, 2010). Where Foucault (2003) undoubtedly draws a distinction between discipline and biopolitics as two related technologies of the self, they are both drawn on to form biopower. Violence is used within a biopolitical regime to take bodies as objects of active intervention, constituting individuals as populations which must be made to live within specific parameters (Wilcox, 2015). Heteronormativity forms part of the biopolitical agenda where reproductive sex is exalted as a biological imperative which reciprocally produces the queer community as against this ideal population (Qi, 2016). When this biopolitical order appears in jeopardy, violence may serve as a corrective and instructive influence (Wilcox, 2015).

As Foucault (2003) explains when the biopolitical order is threatened by an individual and their actions, “regulatory mechanisms must be established to establish an equilibrium, maintain an average, establish a sort of homeostasis and compensate for variations within this general population and its aleatory field.” (p. 246). The work by Holmes, Rudge and Perron (2011) on the medical field similarly emphasises that contemporary practices of violence, be they spectacular, structural or symbolic, are constituted not only within sovereign power but with reference to biopower. A discrete example of violence being used as the exertion of power for the LGBT community in the medical setting is seen in the HIV/AIDS crisis. Van Doorn's (2013) analysis of viral containment programmes in the United States, or the ‘Test and Treat’ strategy,

indicates how the previously neglected LGBT community became responsible for the protection of all queer bodies. Conversely, this emphasis placed on healthcare rights and responsibilities for HIV positive people renders government's role in the crisis through prevention strategies and the uninfected invisible to view (Van Doorn, 2013). In this situation, violence is woven into the biopolitical programme as these mechanisms of structural harm through government neglect and harassment when using testing facilities are used to create responsible sexual citizens (Van Doorn, 2013) which simultaneously sanctions and creates knowledge about the queer individually and community.

Further, the changing nature of HIV prevention programmes from behavioural to pharmaceutical and current surgical strategies illustrates the symbolic shift towards the biomedicalisation of sexuality (Giami & Perrey, 2012). The authors (2012) argue that unclear outcomes are found in surgical and medical approaches (such as male circumcision and chemoprevention) and these technologies modify strategies of disciplining sexual behaviour to intervening on how health is consumed by the individual body (Giami & Perrey, 2012). As such these instances of biopolitical violence provide the possibilities and parameters for how bodies can exist, and how subjectivity is embodied for the LGBT health user (Mason, 2002). Critically, this form of power operates to prolong queer life in some form and productively constitutes the subject along the continuum of human rights. How this project works in South African healthcare alongside forms of spectacular violence and discipline can show new insights into queer subjectivity.

Drawing on these ideas of the body as politics, Rose and Novas (2005) suggest the current project of power resides in biological citizenship which "links conceptions of citizens to beliefs about the biological existence of human beings (p. 440). As a project of governance, this

biomedical belief is enforced through state health infrastructure to patient-citizens who re- and co-produce these beliefs amongst themselves as a common knowledge (Rose & Novas, 2005). Thus, citizens are held individually responsible for their own health and the health of future generations in their communities (Rose & Novas, 2005). This post-Foucauldian scholarship suggests this form of citizenship is an effect of biopower as biological citizens actively engage in their own governance, relating their health to the state and science either in alliance or resistance (Rose & Novas, 2005). As indicated by Paparini and Rhodes (2016) HIV treatment for the LGBT community targeting viral suppression adds to prevention outcomes and represents significant cost saving efforts of public expenditure. However, this goal is projected as an objective measure for success and of hope which obscures the moral and economic obligation imposed by health systems (Paparini & Rhodes, 2016). Queer health users who fall in this cascade of care become increasingly responsible for more than their own health and curate their own patient rights by mobilising to a greater biosocial community (Paparini & Rhodes, 2016).

In assessing how the response to HIV in West Africa was modelled on gay activism in the United States, Nguyen (2013) deploys a further link between Foucault's biopolitical power and health citizenship. This research shows how local support groups in this resource scarce context are fashioned into the confessional technologies of the self as patients who attend counselling script stories of sexual misdeeds and shame (Nguyen, 2013). Those who are seen as valuable to forging solidarity and positive support in their personal networks are triaged into scarcely available antiretroviral treatment (Nguyen, 2013). This work shows that the technologies of the disciplined self, visible in discourses of health and sexuality, can accrue into the management of populations with specific health care needs.

Power works through violence as a tool for individualisation, making subjects visible to monitoring whilst simultaneously treating bodies as sites for social correction. As such, queer health sits at a particular tension point between sustaining life and sanctioning these subjectivities for non-compliance to the heterosexist norm. Even as new discourses of citizenship, rights and access to care emerge to provide opportunities for the queer subject in the health system, simultaneous acts of violence emerge to add dis/order at all points in this state apparatus. This review and study offer a theoretical platform that violence can take many forms ranging from sovereign displays of physical violence through to structural and symbolic violence in microaggressions. All of these violent interactions are potential mechanisms for the production of non-normative sexual and gender identity during health use. This study asks, then, how have experiences of violence shaped the way queer people have thought of themselves (and sexualities) in the context of the health system? The aim here is to add insight into the connections between disciplinary and biopower in shaping queer health subjectivities and whether or how these technologies are unique to the LGBT community in South Africa.

Chapter 3: Method

The method of this study made use of highly experiential accounts of the healthcare system to explore how queer subjects construct and maintain violence in their reporting. The hybrid design and sampling considerations linked to this analytic project are highlighted here, as well as considerations for reflexivity and research ethics.

3.1 Research Design

This study was firmly a qualitative work focusing on the language used by participants so as to not reduce their lives to numbers (or four letters). Particularly, a hybrid narrative-discursive approach as outlined by Taylor and Littleton (2006) was implemented. The focus of this approach is to allow participants to create their own biographical accounts of an experience as a resource to unpack prevalent societal meanings (Taylor & Littleton, 2006). By fusing the narrative collection with a critically informed discourse analysis which can pivot on the constructions of social life, the analysis aims to provide insight into how power is infused into the accounts of violence for LGBT users of public health. By bringing forth personal understandings of an event, participants' self-identity can be studied through their own talk without an overly directed influence. The autobiographical nature of the narrative provides attention to the speaker's own reflexive work, and the origins or constraints they fix to their subjectivity (Taylor & Littleton, 2006). Thus, the analytic emphasis of this approach for the current study was to use the participant narratives of health consumption as a way to better understand violence as a mean of subjectification for LGBT people using public health systems.

By creating an open-space for individual reflections, Tamboukou (2008) suggests that narrative research applies neatly to the Foucauldian sense of power as it isolates the participant's

discursive formation of the self. The chosen hybrid method provided the ability to reveal how participants constitute their queerness in this space through their own practices in the narrative, however the relationship to power cannot be ignored in these texts (Tamboukou, 2008). Doing discursive work around subjectivity and power relations means issues of reflexivity with the research are necessary to consider. Essentially, the dialogue between the researcher's own sexuality can provide meaning in the interviews (Atkinson, Delamont, & Housley, 2008). This bias from personal subjectivity during the interviews must be noted and understanding this positionality is valuable to the design of the study. This analytic strategy has been justified in previous research showing that this hybridised method which adapts the traditional designs can provide new insights into the how the structure of stories informs how social power is concealed in everyday life in theorising a complex subject (Morison & Macleod, 2013; Taylor, 2015).

3.2 Participants and Sampling

Given the specificity of the participants required for this study, namely self-identified LGBT people who have used the public health system, a non-probability and purposive sampling technique was used. After ethical clearance was obtained from the University of the Witwatersrand this certificate accompanied by the research proposal were sent to activist and support groups affiliated with the LGBT community. A total of five sites were contacted, with null responses from Gay and Lesbian Memory in Action (GALA) and Amnesty International WITS. Multiple attempts to find volunteers were made through WITS Safe Zones although no participants were recruited from this organisation. Out of these sites, two engaged in the gatekeeping process namely the ANOVA health institute and OUT-LGBT Well-Being where the

others declined to assist. Both these organisations offer supplementary health services such as safe-sex services and support groups for queer people.

Once put in contact with the relevant gatekeepers the researcher presented the study on multiple occasions to members of the LGBT community after a support group at the attached Health4Men clinic in Yeoville and TEN81 clinic in Hatfield. After which participants who were over the age of 18, had a level of proficiency in English and experienced public healthcare were asked to volunteer. It must be noted that this linguistic criterion is not an attempt to exclude certain narratives, but rather due to the researcher's own inabilities as a monolingual English speaker. Potential participants were given a pamphlet with the researcher's contact details, as well as providing their own to the researcher so that they could be contacted at their convenience. The final sample consisted of 10 self-identified LGBT people. Within this group, 5 gay males of colour, 1 gay woman/lesbian of colour, 2 gender non-binary people and 2 transgender women participated in the study. Importantly, the output of this work does not claim to fully represent or provide the typical case of a queer health user but a pronounced look into this subjectivity (Fossey, Harvey, McDermott, & Davidson, 2002).

3.3 Data Collection

Given that the healthcare system is the primary site of exploration into broader discourses, the narratives collected were anchored through a conversation around public health consumption. A semi-structured interview schedule with story-type prompts (Appendix A) was used in order to centre talk around the healthcare engagement but did not foreclose discussion of other experiences constructed in participant's narratives. The questions were planned to discuss two topic areas, a life-history and understanding of participant's identity and either a story or

stories of using public healthcare and how these tracked in the narrative. Violence was topicalised by the researcher who asked broadly if the participant had any stories or experiences regarding violence in healthcare to share.

With the interviews being participant driven and focused on the types of violence occurring in the healthcare engagement not all the prompts were used in each interview or followed a pre-determined plot. In practice, two broad strategies were employed by participants who either tried to follow precise thematic scripts which focused on memory specificity or using self-stories to centre on meaning-making (Singer, Blagov, Berry, & Oost, 2013). Some participants chose to directly respond to the prompts with short stories rather than speak about a grand narrative and the average interview length was 40 minutes across all 10 interviews. This fluid style of data gathering was necessary to balance between the subtlety in exploring, and not creating, microaggressions as well as gaining rapport to speak about violence and its discursive impact on queerness.

Procedurally, once participants got into direct contact with the researcher a date, time and place for the interview was agreed upon based on their convenience. Two data collection sites were used in this study. Three interviews took place in the offices of the TEN81 clinic in Hatfield for convenience of participants located around Tshwane with the remaining interviews occurring in a therapy room in the University's Emthonjeni Centre. Both of these locations were private and secure. The researcher also kept a reflexive journal in which instances of positionality or visible participant reaction were recorded. These reflections consisted of the researcher's own personal impression of the discussion with the participant, which were used during the reflexive analysis, to track the rebounding effects of subjectivity in the co-creation of

the final texts. Data was collected using an audio recorder and uploaded onto a password protected drive which only the researcher and his supervisor had access to.

3.4 Data Analysis

Data was transcribed using Microsoft word with a basic level of detail. Once the transcripts were finalised, the audio files were replayed to see if participant meaning was lost. The data was then manually coded to reduce the amount of information in the transcripts for analysis of the violent interactions.

The narrative-discursive approach allows for a layered study into the meanings attributed to identities and focuses on subjectivity as the product of talk. In the spirit of a participatory project, an introduction to each participants story and events of violence is given to provide context for each case. These life stories provide an important backdrop to describe the ways that institutionalised forms of power systematically shape the health system and violence LGBT people are subjected to. With a narrative form of interview, parts of a narrative analysis will shape the discourse analysis as the main analytic strategy. The analysis starts with participant cases to ensure that the individuals attached to the narratives are brought forth and to provide a guiding narrative architecture to the consequent discourse analysis as necessary with the chosen hybrid method, but are not intended as a full narratology of these accounts. Tamboukou (2008) makes the case that as participants centre themselves in their plot, the canonical narrative focuses on subjectivity. This means that narratives provide opportunity for studying the nature and functions of discourse on the plot, sequencing of events, and linguistic choices in each text (Tamboukou, 2008). The narrative form is important to how violence is accounted for by queer users of public health as this can provide insight into the effects of discourse within their

contexts of generation (Kohler Riessman, 2000). In this way, the episode of violence is inseparable to its discursive structure and should be analysed alongside each other.

Within the narrative structure of violence, a Foucauldian-style Discourse Analysis (FDA) was performed following the steps outlined by Parker (2014). This type of inspection focuses on the effects of language as a form of action and isolates the subjects and object relations found in talk before exploring the implications invoked by the text (Parker, 2014). Further, Parker's (2014) approach to analysis is best suited to this study as it aligns with Foucault's (1972) understanding of discourse, as a system of statements which forms the objects of which they speak. Applying Parker's (2014) criteria for discursive analysis allowed the oppositions created through power, the historical location, and ideological effects of speaking to be seen in the narratives. This style of discursive analysis works for this report as Parker (2014) emphasises that his criteria should serve as a loose guide to understand social power and not as regimented steps which allows the narrative structure to co-exist with the unpacking of discursive regimes of the subject.

Taylor and Littleton (2006) indicate how the content and arrangement of narratives provide enough room to study discursive objects such as violence and microaggressions without creating these as storytelling objects for participants. By superimposing the narration of violence onto the discourse analysis the ways in which participant subjectivity and positionality are defined can be understood as discursive resources (Edley, 2001b). The purpose of which will be to provide analytical insight into how discourses around queer subjectivities relate to being objects of power regulated through violence in the clinic (Foucault, 1978).

3.5 Self-Reflexivity and Textual Dialogue

The data collection for this study rebounded against the researcher's own sexuality and as Macbeth (2001) argues positional reflexivity can influence data. The initial interest to study healthcare and its violent occurrences for the LGBT community stemmed from personal self-identification as a gay man and from doing community work in healthcare as a naïve assurance that there was analytic value in this topic (Macbeth, 2001). Even though narrative productions of text may prevent reifying the target of analysis, the data remains a contrived production in a research interview (Speer, 2002). Without naturalised data, then, queer identity and the shared methods of doing social life anchor the speech produced in the interviews.

Shared queer identity was used as a taken for granted assurance of mutual understanding with participants often stating the researcher would know or understand their struggles. However, the use of common queer identity for story-building was not unanimous throughout the interviews. When trying to establish whether a participant openly identified as queer during their healthcare visits, the researcher asked whether the participant was "out" at this time. This term used to describe those who openly self-identify as queer in all spheres of their lives (Leap, 1996) was misunderstood by two participants as noted in the reflexive journal. These instances disrupts the notion that forming part of the same community can be used as a reliable means for a shared sub-cultural vocabulary (Peräkylä & Vehvil*ƒ*inen, 2003) which had consequences for a fluent narrative production in these interview. With a topic based on violence and sexuality there were moments in the interviews where jarring microaggressions were used, such as participants using labels like "moffie" or "istabane" (which are derogatory terms for queer people in South Africa) which directly create and sanction queerness. Acting as a mediator between the data and its

collection became a task of setting the researcher's own interpellation aside and focusing on how the participants narrated these constructions (Berger, 2015).

As the interviews proceeded it became clear that participants were aware of the researcher as a specific audience with potential access to other stakeholders. Noted in a reflexive journal, the participants from Pretoria asked during the debrief whether this work would be published or sent to government. As a student research psychologist and working with gatekeepers in the LGBT community, some participants presumed the researcher had the authority to channel their own advocacy or change the healthcare system. The power dynamics from a proximity to psychology was not uniform in the interviews, as some participants situated themselves as experts in the topic due to their lived experience (Parker, 1994). Grounded in their life history, these participants own thoughts and uninterrupted speech were produced without many additional prompts. Textual reflexivity put forth by Macbeth (2001) was useful during the transcription process to force attention to the details of the interactions, and see how these dynamics added to the narrative form without writing the researcher into the data.

Whether through disaffiliation to a category, rapport building through the use of shared social resources or shifting power relations, the dialogical nature of these narratives is important to track. In some instances, the narrative collection acted as a negotiation between participant and researcher subjectivities insofar as sexuality was not just a category in the interviews, but was used as tool to try gain a shared apprehension of society (Schegloff, 1999). This position of the researcher inside the transcripts is important in understanding how discourses which were analysed may have uniquely emerged.

3.6 Ethical Considerations

Due to the status of the LGBT community as a potentially vulnerable group in the South African context, this study only included participants who openly self-identify as LGBT/queer. In order to mitigate adverse effects of participating in the study, distance was created between the specific provider of and the experience of the public healthcare system by not directly asking for institutions to be named and focusing solely on recollected accounts. As such participants who were currently dependent on treatment were not included in this study to not unintentionally compromise their care. By focusing the study on the discursive impact of identity during the healthcare engagement, and not the institution itself, clearance was not required from the facilities mentioned by participants. Given the use of face-to-face interviews for this study, anonymity cannot be guaranteed to participants. However, confidentiality can be assured by the researcher and through the removal of all participant particulars from the final transcripts through a pseudonym and this data has been stored on a password protected computer. Basic ethical procedures such as informed consent and the right to withdraw without prejudice were upheld up until this publication of the final report.

There were no direct incentives for participating in this study. However, an ethics amendment was requested and approved for (Appendix F) to allow for transport compensation which was given to a single participant upon request to secure their attendance. Although the topic of discriminatory violence may be psychologically sensitive, in line with the thought of De Gruchy and Lewin (2001) ethical discourse should not render marginalised subject positions invisible to study. To account for this a short debriefing process, in which participants are made aware of available support groups and crises hotlines was added to the interviews.

Chapter 4: Results and Discussion

This study aimed to unpack the discourses and violence/s which constitute LGBT people as specific kinds of healthcare users. This chapter examines how violence informs queer self-knowledge of using public health using an FDA as the main analysis. In unpacking encounters with staff, patients, clinicians and the public this analysis investigates how differing forms of violence are restrictive in terms of access to, but productive for queer subjectivity.

4.1 Participant Cases

With the narrative technique of this study, many participant's reported life experiences to help make sense of their episodes of violence. Whilst not the direct target of analysis, this context for each case shows how participants position themselves in relation to their queer identity and health needs. Although edited by the researcher, this sketch of the data can provide some level of voice to those who participated in this study and importantly provide a narrative architecture to appreciate the discourses analysed later. For reference, descriptive information about the participants is below in Table 1.

Table 1.

Descriptive Information of the Sample.

Participant Pseudonym	Gender Identity	Sexual Identity	Age	Racial Identification
Kholofelo	Gender Fluid	Gay	20	Black African
Zoliswa	Cisgender Man	Gay	33	Black African
Lucky	Cisgender Man	Gay	29	Black African
Akanyang	Cisgender Man	Gay	26	Black African

Jacob	Cisgender Man	Gay	38	Black African
Cleo	Transgender Woman	Queer	24	White
Priya	Cisgender Woman	Gay	25	Indian
Alex	Gender Non-Binary	Queer/Demisexual	31	White
Zaha	Transgender Woman	Heterosexual	40	Coloured
Lwazi	Cisgender Man	Gay	27	Black African

4.1.1 Kholofelo's Story: A narrative of sex and health.

Growing up in a small isolated town in the Eastern Cape, Kholofelo shares that culture and the interconnectedness of their rural community constrained their gender expression. Although, they see themselves as gender fluid – moving between feminine and masculine expressions – Kholofelo presents as a man, preferring to be "sort of straight presenting in the binary system" whilst using gender neutral pronouns. The first time Kholofelo made use of public health coincided with their first sexual experience where they were groomed by an older male into performing oral sex. As a self-oriented "straight A-student", Kholofelo was aware of the risks of unsafe sex and feeling at risk for an STI went to their local clinic for help. In this account, Kholofelo plays into common myths and tropes regarding sexual health that promiscuity itself is a violation against the body constantly stating HIV infection is a curse.

Trying to access care in their rural community meant playing into the heteronormative story of the first sexual experience. With the awareness that the nursing staff share stories about the patients they see, and knowing that the nurse charged with their care had told their mother about their sister's hidden pregnancy, Kholofelo chose to hide their identity. By producing an emotional narrative, about a fictional girlfriend with promiscuous sexual habits, Kholofelo

managed to align with the nurse who then faked documentation to say she had been pricked during an injection and needed Post-Exposure Prophylactics (PEP) for herself. In this instance, identity concealment is used as a necessary means to secure an HIV test and medication indicating that the fear of violence is productive for how gender is portrayed in Kholofelo's story.

Moving to Johannesburg to begin their tertiary education represented a transition to sexual freedom and newly found autonomy for Kholofelo. After having sex at a party, Kholofelo believed again that they were at risk for an STD despite using protection. When seeking care at a clinic in inner-city Hillbrow Kholofelo indicates how the organisation of the triage, where separate queues are created for TB or HIV related concerns, immediately prioritised sex in health. Kholofelo was met with verbal abuse from the nurse who publicly shamed them and tried to include those in the ward to witness her display when asked about their identity. Having failed to secure their desired medication, Kholofelo flagged down a student doctor who prescribed the medication without verbal harassment. These interactions with medical personnel exemplify how violence within this setting is situational, and highly dependent on the individual and the broader discourses of gender, sexuality, and morality which attenuate whether it will be enacted upon or not. This temporally coherent narrative also indicates the power of language in its everyday operation, and how claiming subject positions through the words of gender and sexuality have material consequences for LGBT people when trying to access medicine.

4.1.2 Zoliswa's Story: A story about sport and violence

In his interview, Zoliswa was consistent in trying to produce a counter-narrative of queerness – emerging without sanctioning or production from the margins of power (Andrews, Squire, &

Tamboukou, 2013). Zoliswa begins his story with a statement that he does not always disclose his identity publicly, but that he also does not care about other's opinions. This opening up the text with an awareness of the social monitoring queerness faces whilst also foreclosing its ability to alter his behaviour shows an attempt to rearrange the power relations which permeate his life. Situating himself as the active agent is a central genre in his story, continued when Zoliswa details his school years and states the violence he faced was multi-dimensional where "it can be physical it can be emotional or vocally" but then disjunctively turns to suggest he was protected from this by being "much more into sport". This re-assertion of his own agency through his athletic ability, however provides two outlets of violence with the one being that his physical fitness created a barrier to violence for this masculine body. On the other hand, Zoliswa goes on to share that his body was treated as a sexualised object because of his physique which led to unwanted sexual conduct, mostly catcalling used to symbolically invalidate his homosexuality. Zoliswa in turn juxtaposes these experiences against his own definition of violence, where he suggests he faced, "nothing much more that was much more bigger than that" focusing on physical violence as central to conceptualising harm. This awareness of traditional forms of violence is strategically compared with witnessing symbolic forms of violence in order to de-escalate how these microaggressive acts informed his own subjectivity. In this way, Zoliswa tries to move his narrative away from a story of victimhood and project himself as empowered.

4.1.3 Lucky's Story: A narrative of transforming the township

Lucky dedicated a considerable portion of his narrative to speaking from a township perspective, relaying how this urban and impoverished setting constrained his sexual expression. He starts tracking his story of healthcare use in his teenage years where he became aware of the

difference in his sexuality. In school, students would openly mock him for being gay and teachers, who he believed where meant to protect students, would use this word as an insult "whenever you've done something wrong they will want to associate your behaviour with being gay". This indexing of homosexuality through deviance is central to Lucky's lived experience. Similarly, he uses the community as an antagonist throughout his story suggesting that his life was made harder by virtue of being raised in a socio-economically deprived township. Lucky's story is mainly one of transformation, and self-empowerment against abuse he faced for being a gay man as he focuses on comparing this systemic violence to the volunteer work he does for the LGBT community. However, part of his process of queer subject formation includes actively engaging the social world and asserting his position in the face of violent consequences. He continues by placing significance on his human rights, and uses this to dismiss violence he has faced from nursing staff at his local clinic. By creating a point of tension, where the sanctioning of his homosexuality rebounded against the language of protection under the constitution, Lucky's narrative suggests that queer healthcare is not only constrained through violence but by not being a product of normal discipline.

4.1.4 Akanyang's Story: A narrative of resisting heterosexuality

Akanyang begins his narration by depicting himself as resolved in his sexuality. He follows that although he faced some discrimination during school, which he describes as boys having "tantrums" playing into the discourse of anti-gay as anti-developed (Wells & Polders, 2006), he was able to manage it. This observation of his sexuality coming from his male peers speaks neatly to Foucault's (1977) examination of group monitoring which made his exercise of difference noticeable. However, Akanyang sees himself as a "vocal person" who always defends

himself, setting up homosexuality as a form of resistant subject. Similarly, Akanyang disaffiliates from the narrative of difficulty with being gay reportedly having always been comfortable with his sexuality because of how feminine he is. As such, Akanyang indicates that his close assimilation to femininity made identifying as gay easier, as if the weight of destroying the masculine assumption was removed (Warner, 2000). By setting up this counter-discourse of proximity to femininity as beneficial to being gay, Akanyang positions himself in a powerful position which in turn, however, also works to cement homosexuality within its current construct as a mystification of womanhood (Warner, 2000). This transfers into the clinic, where Akanyang narrates having verbal altercations with nursing staff who try to speak about his sexuality and performance of masculinity instead of his health concerns at the time. As such, his narration shows a conflict between using gendered discourse to combat the norm or reinstating its authority to disempower the queer subject.

4.1.5 Jacob's Story: A narrative of biblical proportions

Soliciting a narrative from Jacob was difficult. He chose to answer each prompt as a direct question, rather than opening up about experiences he has been through. This may be attributable to his prior experience with the research process as he responded to the debriefing questions with, "Um, it's not the first time I'm doing this. There was the other lady she was also doing her Masters in University of Pretoria, we did an interview I think 2 or 3 months back she was here". Answering to prompts as if they were closed questions, despite reassurance to speak freely and create a story, makes sense with this familiarity with a specific kind of highly structured interview (Andrews et al., 2013). Fortunately, Jacob spoke about enjoying this style of interview even if he did not fully conform to the narrative style as he stated "I was hoping you weren't

going to ask me these thousand million difficult questions but the interview was good and proper". Although Jacob did not create a comprehensive plotline, his responses provide valuable insights as he shared small stories which Georgakopoulou (2006) argues can neaten subject analysis. After building rapport a notable incident where religion became the focus of his health was spoken about. Jacob sees violence as dependent on the clinician in front of him throughout his story and believes anti-homosexual attitudes are fixed to the healthcare sector due to religion. He states that, "you can't be free you have to adjust and look at the situation at first and that whether this is a gay friendly or not". For his own convenience in accessing these services, then, he chooses to operate within the margins prescribed to his male gender by feigning heterosexuality.

4.1.6 Cleo's Story: A narrative of a transgressing body

As a transgender woman, Cleo is hyper-aware of her gender performance within her narrative and focuses on how her body is responded to in everyday life. She opens by speaking about the recent problems she has faced at a STEM (Science, Technology, Engineering, Math) student symposium and the conscious decisions she has to make regarding her oration, dress and even make-up as she reportedly has to "work at like how are people going to see me and then, you know, make value statements about my work before I've even opened my mouth". In this way, Cleo speaks to gender discourses having a corporeal effect on her body and the way she moves through the world as she constantly has to monitor and challenge heteronormative restrictions on her subjectivity (Andrews et al., 2013).

Cleo continues by sharing an incident of microaggressive violence which happened at this symposium, "when I was like getting my little tag thing, they called me. Mr. and I was like,

girl! It says ‘miss’ on the tag, like what? I had like lipstick the same colour as your blood leave me alone.” This act of misgendering, despite her gender marker being displayed on her tag, shows the common delegitimisation of transgender people’s designations of their own genders (McLemore, 2015). As McLemore (2015) argues this symbolic violence represents a disruption of her subjectivity which Cleo resists by reinforcing normative gender role expectations as seen through her focusing on her lipstick as a sign of femininity.

This genre of the individual against the system continued in Cleo’s narrative of health as she details how doctors “didn't know what to do with [her]” when going for a hormone replacement therapy (HRT) consult at a teaching hospital in outer Johannesburg. Throughout her narrative Cleo presents herself as a passive agent being acted upon by her social world and rarely reports claiming her gendered subjectivity. In her narrative, violence is given a close proximity to men as she details feeling unsafe when sitting in the line “next to a man who’s trying to hit on [her]”. Similarly, when walking through the halls of this large public hospital Cleo speaks about being followed by a man and when he tried to accost her she had to “whip out [her] student card and look like a med student instead of a patient to try and like take advantage of some kind of power dynamic”. Whether through symbolic, structural or social forms Cleo constructs a narrative which places storied significance on how her subjectivity is surrounded by violence.

4.1.7 Priya’s Story: A narrative of family, faith and dress

Priya chose to centre her speech around her family struggles, providing insights into the everyday violence of growing up queer. Religion was endemic to her storytelling as she prefaced that her parents observe conservative Christian values each time the plot of her narrative turned. Priya states that she faced verbal abuse, mostly from her mother and aunt, on a daily basis with

her even choosing to identify as gay because she does not “like to use the word lesbian because [her] mum and the way like families try to project things on words.” Priya uses microaggressive violence to even define her subjectivity, as the constant maligning of lesbianism with negative traits such as being dirty has led to her to disaffiliate from this word. For Priya, her story of coming out was also characterised by ubiquitous modes of silencing around her sexuality. In her account although her father was accepting, her mother instructed her to pretend she was heterosexual and hide her sexuality from the extended family. As Brown (2009) suggests the politics of silence around non-normative sexualities is in itself a politics of articulation as the coerced erasure of this subjectivity mediates the conditions of its existence.

Following this genre of being constrained by her family Priya emphasises that she felt constantly “policed” for her choices of dress especially when she wanted to wear male clothing, such as suits, which she prefers. By visibly transgressing heteronormative dress, Priya marks her body as deviant and so it becomes an expression of disciplinary power through correction (Dwyer, 2009). Priya continues by sharing a story of going to a Sabbath service and when she decided to wear a dress, “my dad said something to the effect of ‘there's my little girl’ and I got so angry with him like you say absolutely nothing like when I wear anything else.” Important to this exchange is the use of the microinsult where her father chooses to actively praise her gender conforming dress which acts to indignify her queerness. What these stories show is that microaggressive violence creates discursive knowledge about sexualised subjects. Priya uses these stories to understand her healthcare decisions, creating a reflexive narrative where she considers her subjectivity in relation to these social contexts (Andrews et al., 2013).

4.1.8 Alex's Story: A story to map mental health

Alex engages with their queer identity in a particularly localised and nuanced way, indicating the situational nature and shift over time of their self-expression. Alex first came out as a lesbian woman, and now identifies as a gender non-binary and demisexual person. This change in subject position is important to Alex's account of using healthcare as they create a temporally scattered narrative, moving between incidents to make sense of each other, and juxtaposing their experiences as they move through these different categories. Alex's story begins in school as they began to realize they were sexually non-normative. Alex recalls being told they were a lesbian by their peers and "at that point [they] didn't know what that word meant" and they started Googling "how to be a lesbian?". Alex narrates the lack of knowledge about being queer, and the domestic violence in their family as reasons they began to self-harm and as points of articulation for their struggles with mental health.

By orienting to the story-arc of challenges with self-identification and the family in the coming-out story, Alex situates themselves as acted upon by their social world (Zimman, 2009). The use of this genre in Alex's case does not serve to authenticate their belonging and self-autonomy (Zimman, 2009), but as a way to contest the denaturalisation of their queerness which forces her to disclose their identity in the first place. Alex draws comparisons between using a public psychiatric hospital in Johannesburg where they faced shame, stigma and sexual harm to their local clinic in Randburg which freely dispenses their psychiatric medication because of their gender expression. These instances draw together violence as a resource to legitimise discrimination against the LGBT community in health.

4.1.9 Zaha's Story: An advocacy tale

Zaha contextualizes her narrative through her current work, activism and desire to operate in organisations linked to the National Department of Health. With this sense of authority, a significant portion of her speech focused on collective tropes and metaphors of LGBT health infused into her own story (Andrews et al., 2013). In Zaha's narrative, asserting her identity as a transgender woman is seen as important to changing the space around her by making her gender identity visible to transform her social world. She states that she "cannot be bothered or phased about how people see [her] and identify [her]" whilst immediately juxtaposing this with her need to be "very conscientious of a lot of things and [her] surroundings, especially when it comes to big crowds." This heightened awareness of the spatial location of her body was represented in her stating she had faced microaggressions when we walked to the interview room, "I noticed a lot of people who looked at me and I noticed a lot of snickering and laughing about 'oh okay, you can see you know, that's the kind of dude'." As Halberstam (2005) suggests transgender people operate with a "postmodern geography" of space as their body represents a multitude of discourses in every location (p. 5). Zaha places a point of discontinuity between using her body as an opportunity to produce cultural change (Halberstam, 2005) and the imminence of restrictive violence in producing her narrative.

This sparks a continuation into a story of a verbal attack Zaha faced near her home in central Johannesburg. A group of young men, who Zaha labels as "drunk outsiders" to her community, "decided that they just wanted to start calling [her] names" by calling to her through "hey wena, istabane! Voetsek halala!". Istabane is a specific word of hate speech for the LGBT community in South Africa which essentially calls out Zaha's gender performance by naming her as a hermaphroditic figure (Francis, 2017). With her boyfriend about to assault them, Zaha

states she “thought to [herself] you know what you need to take power, so [she] turned around and just said fuck you.” The cascade of violent actions and reactions indicates the power relations inherit in gender expressions, as well as the ability to reclaim power through language (Green, 2007).

Growing up in Durban, Zaha makes reference to her racial identification as coloured and her tight-knit family as both constraining and supportive for her gender expression. Even when dressed as a boy to use the local clinic, she emphasises her effeminacy and emotional vulnerability as indicators that she was transgender. By creating a historical account of her gender identity, Zaha naturalises her self-representation and binds her narrative to the archetypal transgender story of being trapped in their body (Zimman, 2009). At this point in her narrative, Zaha returns to speaking through generalised themes as if playing to a wider audience than just the researcher (Andrews et al., 2013).

De-centring herself within general themes, Zaha suggests that structural violence such as the process of psychoanalysis for medical transition are part of the reason the transgender community choose to self-medicate. Zaha uses a short story of a friend who has a cisgender woman get contraception pills from a local clinic as a form of HRT to invoke these struggles. She further cites this collective identity by citing that she currently does not use formal HRT but rather buys them from a friend in Thailand. This subcultural strategies for the hyper-consumption of health place the body front and centre in gender work and uses this biological essentialism to subvert the medical system’s authority over it (Anderson, 2012).

4.1.10 Lwazi's Story: A case of Beyoncé in the bay

Culture and religion focalise Lwazi's story of growing up gay in the Eastern Cape. As a Xhosa man, he shares that his sexuality was considered a taboo and "something that was shameful, that was done in secrecy" which rebounded against his family's strong Christian ties making it hard for him to identify as gay. Attending a Catholic school, Lwazi speaks about the displacement he felt with his sexuality and that he is absolved from religion as "god cannot punish [him] for that because there's no place for [him] there". Similarly, when he had to go to initiation school, Lwazi saw it as a way to pay his "debt" that he owed to his culture and that now he should be allowed to live his life freely. Lwazi consistently co-constructs meaning and his subject position from these institutions (Andrews et al., 2013).

Although he sees buying into the cultural rites of his immediate family as a buffer to the social world, they also act as inflows for symbolic violence. As he remembers, in the middle of a trivial argument about a ritual his cousin shouted at him "you'll never have kids, you have anal sex like it's wrong, you're gonna burn in hell, you should be ashamed of yourself, you will never be a woman. I should give you my pussy like you're so pathetic." This verbal assault shows how discourses of sexuality and gender collide to make the body a primary site of discursive violence against the LGBT community (Galupo et al., 2014).

Lwazi's storytelling centres this format of using short stories, drawn from his own life or others, to create a layered narrative through multiple linked experiences (Georgakopoulou, 2006). Lwazi recalls being sent to a public hospital in Nelson Mandela Bay to see a psychologist when he transgressed heterosexual norms as a child by playing with Barbie dolls. After this clinician assured his family that he would either grow out of it or "if he is like that, accept it" and with this medical authority Lwazi was able to transgress norms, and date other boys with less

resistance. This exchange also has consequences for Lwazi's narrative, as thereafter he begins to situate himself as a passive agent in his own text identifying how he is acted upon by his social world rather than how he interacts with it (Tamboukou, 2008).

Lwazi follows with a story of helping his transgender friend enquire about her self-medicated hormone therapy. Similar to Zaha's story, Lwazi's friend also uses contraception as a form of gender-affirming medicine to develop breasts and become more feminine, but she was experiencing cardiovascular issues. When they arrived, Lwazi felt hyper-visible and conscious of their identities due to the microaggressions and glares around them from patients, janitors and the admin staff (Nadal & Griffin, 2011). Lwazi compares this heightened social visibility to being like "Beyoncé" as "everyone is going to like take notice but that's a positive whereas ours was negative". These short stories and life history contextualisation indicate that the queer subject is a particular kind of health user who is understandable and created in the clinic through the spectacle of violence/s.

4.2 Discursive Analysis of Subjectivity

This analysis focuses on how violence is accounted for by queer users of health within South African public hospitals. By concentrating on the episodes of violence within the narratives, the discourses which participants use to make sense of themselves and violent encounters are studied. With the account of violence as the target of analysis, discourses of heterosexuality such as the gender binary, religion and collective identities operate alongside understandings of healthcare as a right. To differing extents symbolic, structural and physical violence appeared in the narratives. These forms of violence were also accounted for through understandings of sovereign, disciplinary and biopower as indicated in the theoretical

framework. By superimposing the narrative structure of the interviews onto the functions of discourse, this analysis shows how violence can be understood as a sense-making tool.

4.2.1 The Medicalisation of Sexuality

Healthcare for the LGBT community relates to the historical discourse of sexuality as illness (Foucault, 1973). In their accounts, participants spoke about how forms of homophobic violence make the clinical interaction about their sexuality and obscures their health concerns. Priya reports a steady narrative describing events of violence, the family and health as ordinary to her everyday life (Lieblich, Tuval-Mashiach, & Zilber, 1998). This plot style constructs violence in health as a pattern and normalised extension of queer subjectivity. After seeing a gynaecologist for a yeast infection – a common and non-sexually transmitted build-up of bacteria – Priya faced verbal abuse from her mother who "wanted to crucify [her] for potentially being sexually active." Priya places significance on how there is a "very immediate connection to sex rather than health, perhaps, with the LGBTQIA everything community". The sexing of queer health, where all illness and healthcare seeking behaviour is viewed in relation to sexual activity (Martos, Wilson, & Meyer, 2017), forms a knowledge base which reproduces the body as othered connected to symbolic violence through misrecognising queer health as only a matter of sex.

The discourse of sexuality and health also produced specific accounts of the body as an object of violence. After having sex, Lwazi developed an anal cut and tried to source treatment from his local clinic in Nelson Mandela Bay. However, the nurse he was seeking care from used this cut as a means to sanction his sexuality. The nurse asked, "'why do you have a cut in your anus? Like are you queer, are you gay?'" and this example of the microassault tries to malign his

sexuality and uses the discourse of homosexuality as deviant to construct his need for care as invalid given his sexual practices. At this point in the story, Lwazi noticed “whilst [he] was sitting there, [he] saw all these other registered nurses checking [him] out and everything like she was discussing me.” This account of symbolic violence acts as a form of discipline, marking his sexuality as deviant and trying to correct it through social visibility (Foucault, 1977).

In his account, Lwazi tried to re-position the nurses’ comments by speaking to the universality of the body arguing “‘but no a woman can get cuts from vaginal sex if they like, it's not because of me’”. The nurse countered with another microassault remarking that “you see like this is wrong, you’re not supposed to have this sex, hence, you have such things’.” These interactions in the narrative indicate the body is produced as an object of common knowledge through sexuality (Green, 2007). The reported emphasis placed on “this” kind of sex being “wrong” shows how symbolic violence from the discourse of sexuality can exercise power over the queer subject. Where discipline is enacted through the treatment of health itself, the LGBT community are dually disciplined as unordered health and sexual subjects (Foucault, 1978). Further, this attempt at discipline also makes use of ideas surrounding biopolitics. The nurse here positions queer sexuality as antithetical to the body by suggesting it is being harmed solely because of Lwazi’s sexuality (Giami & Perrey, 2012). Lwazi reports that the nurse stated, “you must take these pills, these condoms and go”. Even though in this specific account homosexuality is regarded as unhealthy, it is not always, as the idea of safe sex is used to promote the sanctity of life and the body itself for the queer subject.

The discursive link between sexuality violence against the LGBT community was most apparent in Alex’s narrative. As a gender non-binary and queer person, Alex uses the genre of the coming-out story such as metaphors of the individual versus society to make sense of their

stigmatised identity (Zimman, 2009). These community-specific metaphors are central to their account of violence to contest the denaturalisation of their subjectivity (Zimman, 2009). Following from this, Alex speaks how they started taking anti-depressants following domestic violence at home. When their suicidal ideation became unmanageable, they were admitted into a public Johannesburg psychiatric clinic for a 6-week in-patient programme. During the admissions process, Alex details telling a nurse about their then same-sex lesbian relationship:

> ***R:*** **So, then can you sort of tell me what the admission process was like on a whole?**
>
> *P: I was assigned a nurse. You know who I was like-like I have to talk to about stuff and I really didn't trust her because she had said to me, um you know that 'gay people are sick' and I'm like, well, yeah, I'm gay and I'm sick. I would talk to them about for example like the relationship that I had you know with my partner at that time and um they would say to me things like, 'yeah, that's not normal' and that for me was super hard because it was from that, that I took that I couldn't trust them and talk to them about where I was at.*

In this story, the microassault from the nurse uses the language of illness and normalisation to not only other Alex's subjectivity, but validate their admission into a psychiatric clinic. The history between sexuality and mental health constructed in the symbolic violence from the nurse targets Alex as the ideal clinical subject (Flanders, Robinson, Legge, & Tarasoff, 2016). This act of correction continued in the in-take process where Alex was reportedly singled out and made to change into a gown separate from the ward. Alex used this strict regimen of disciplinary acts as a technology for the self by no longer speaking about their sexuality and inauthentically presenting as heterosexual (Foucault, 1977). The medicalisation of sexuality here in Alex's narrative was used to account for the next act of violence they faced which centred their story:

So I didn't feel that I could talk to the people who were working there. It was really kind of like a space where I didn't feel safe. And then I think in my second last week people had started to talk about me being queer. I was finally like, yeah well it is what it is, I had this partner last year whatever um and there was this day when I was I was getting ready to go to breakfast, because the whole hospital goes to the same place for breakfast. And so I was getting ready and there was one of the patients who was on the male ward. We didn't really get to know him. He was kind of like very quiet and so I was wondering off and he grabbed me and he pushed me against the wall and he started sexually assaulting me. I was like really freaked out. I didn't know what to do. And I mean he was, you know, really really inappropriate he was like, 'Oh okay. Well, let's try fix you'. Um, and it was something that basically left a huge scar in my life around accessing support. And subsequently I didn't feel like I could tell people about it or report it because it would also mean disclosing that I was queer.

In this account of a physical assault, the collapsing of expectations of sexuality due to the gendered body can be used to incite violence against the queer health user (Galupo et al., 2014). This exercise of sovereign power over Alex's autonomy is rationalised as an attempt to cure them through heterosexualising their body (Logie & Gibson, 2013). Alex's reporting of this account suggests that the clinic was not incidental to the violence but instructive of it. Alex assigns a temporal link in their narration stressing that they "didn't feel safe" because of the annihilation of queerness in this clinic and once it was addressed towards the end of their stay, the assault happened. The traditional set up of the psychiatric clinic with single-sex wards due to constructions of gender which see men as violent and women as vulnerable appears in Alex's reporting to create their victimhood inside the clinic (Mezey, Hassell, & Bartlett, 2005). Alex

points to how this sexual violence borrows from the discourse of homosexuality as correctable as her attacker's statement, "let's try fix you" allows this exercise of power over Alex's queerly 'broken' body (Morrissey, 2013). These power relations between genders manifested from the clinic, using violence to discursively heal Alex by performing heteronormatively gendered sex. Alex reports not telling nurses about the assault because they feared having to 'out' themselves for being queer due to the repetitive symbolic violence (Youdell, 2010). As such, this overt sexual violence is tuned in to the symbolic erasure of their queer identity within the structure of this clinic. To Alex's account, then, the discourses of sexuality and correction connect violence in producing their subjectivity in specific ways in the clinic.

4.2.2 Practicing Gender in Care

Gender and its traditional practices were included in most of the narrations of violence in this study. Violence was accounted for through heterosexual assumptions of what men and women are, and can be, in relation to biology and to make sense of ill health. Following their story of sexual assault, Alex recalls one of the female patients in her ward who "randomly woke up and started making out with [them]". Critically, Alex did not describe this as an assault playing into gendered discourse of who can and cannot perpetrate sexual violence in a heterosexist society (Kramer, 2017). Gender has an important architecture in Alex's own reporting of violence in the clinic, by surfacing particular power relations between gendered subjects and how violence is accounted for. Jacob also narrates gender as a source for violence in his account of securing treatment for an STI from a nurse:

> ***R: So, in that initial instance with the nurse and throughout the process of admissions did anyone in particular ever ask you directly about your sexual orientation?***

> *P: Immediately when you start talking, being free, being yourself, they'll be like 'No, no there's something wrong? Why are you talking, doing that? Your hands? What's wrong with you? You're a man. Dude! You are a guy. Are you okay?'. They'll want to correct you*.

With a deviant performance of masculinity, Jacob narrates how trying to access care became about his gender. These microassaults levelled against him function out of cultural norms for men to be heterosexual and this masculinity is positioned to reportedly constrain him from "being [himself]" (Msibi, 2009). Jacob positions his queer subjectivity as constrained by these norms which do not allow him to be "free" and act how he would like. By showing how the microaggression shapes the presentation of sexuality and how a gendered subject position is forced on the individual, cultural norms of masculinity allow for disciplinary power to exercise itself within the medical system (Foucault, 1977). The repetition of masculine imagery such as "dude" and "you are a guy" alongside asking if he is okay emphasise that Jacob's performance of sexuality is marked as deviant for the kind of body he has. Jacob also reports clearly that these assertions were a means to correct his behaviour and make him align to the norm of his gender (Warner, 2000).

The violence gender can carry in the clinic was most evident, and obvious, for transgender participants who spoke about trying to access gender-affirming treatment. However, gender also appeared when it was inconsequential to the need for care as evidenced in Zaha's case. By creating a historical account of her gender identity in talking about violence, Zaha creates her narrative within the trope of the coming-out story of disclosing subjectivity despite consequences and this self-representation allows her to naturalise her gender expression and assign blame onto the clinicians in her reporting (Zimman, 2009). When she had the flu, Zaha

tried to see a doctor at a clinic in Hillbrow where the nurses shouted, to a point where patients were watching and laughing, at her “but you are man. Why are you acting like a woman?”. By making the exercise of authority visible, the symbolic violence from the nurse in this case moves away from discipline through surveillance and to spectacular verbal violence, meant to include the other patients in Zaha’s reporting, which ensures her gender is targeted for non-conformance (Foucault, 1977).

Similarly, Cleo created a layered narrative around her healthcare use, borrowing from her experience as a diabetic to stage her story of HRT which she got from a large teaching hospital in Soweto. The narrative strategy of using events to make sense of others also shows how the discursive function of violence is un/ordinary and systemic for queer health care users (Georgakopoulou, 2006). To access this medication, Cleo had to apply through the neuropsychology ward and undergo 6 months of psychological evaluations where she believed they tried “to determine if [she] was really trans”. This account of structural violence through gatekeeping is built on a wide narrative of the medical system restricting direct access to gender-affirming care by providing anchors for ‘correct’ gender performance (Dubov & Fraenkel, 2018; Sevelius, 2013).

In Cleo’s account this structural violence acts a way to create a binary in transgender subjectivity of either being a site of mental health or biology. Being immediately processed through the discourse of psychology, Cleo’s gender is seen as a form of psychiatric problem and her uptake of this care is blocked by considerations for her mental health with questions such as “is it okay for you to transition? Are you doing okay?” centring her narration of this process despite her assertion she “would reach out if [she] needed that.” The use of psychology to understand her gender identity elicits her confession, and disciplinary power works to transmit

and reinforce norms of gender as Cleo defines her own subjectivity as abnormal (Foucault, 1978). However, in Cleo's account she has to constantly reiterate that her physical health and quality of life is the target of treatment as she states "I just need to go on HRT for my health – this is something I require". By promoting being transgender as biologically based, Cleo constructs her body as relevant to the control and practice of biomedicine. Emphasising her need for biomedical intervention does not push-back against the discourse of psychology, but Cleo's account illustrates self-discipline and the making of her gender identity as the target of biomedical science (Rose, 1998). In using essentialist medical discourse, Cleo's account uses structural violence as not only a form of regimented surveillance but to create avenues of access to health through biopower (Bauer et al., 2009).

Cleo continues her temporally incoherent narrative by speaking about completing her intake forms, and structurally uses this account to attune to discipline as a technology for subjectivity:

> *At one point I was handing in a form and the nurse was like 'which one do you want me to tick? on the like gender thing and it was very sweet to me because I actually never had a problem with the nursing staff, they were never like gross to me.*

Bauer et al. (2009) emphasises how documents and the legal framework of the clinic can create avenues for structural and symbolic violence through the misgendering of the trans user. However, Cleo's case saw these forms as an opportunity for gendered subjectivity. The personal significance placed in this moment of the narrative indicates how structural violence and symbolic cues act as a discursive regime to constitute the transgender body through processes of objectification as a certain kind of gendered body (Green, 2007). By being accommodated through these procedures of social control, Cleo acts as an ordered subject aligning to the

gendered categorisation in the clinic (Foucault, 1982). The clinic, then, acts to discipline queerness and its authority can be used by queer users to provide legitimate possibilities for their gendered constitution.

4.2.3 Infiltration of Religion

Work on the relationship between health and religion in the West by Chibnall and Brooks (2001) found that physicians did not initiate religious discussions and felt uncomfortable when having to address it in a consult. However, this study identified the inverse in South Africa. Clinic workers would insert a religious discourse when engaging with LGBT patients to denaturalise their healthcare choices. Participants drew on religion as a meddling force, seeing it as a discourse used by practitioners to try compromise their care in their reports. Kholofelo's narration was devoid of religion making no mention of it until they decided to start on PrEP (Pre-Exposure Prophylaxis) after a risky sexual encounter. In an exchange, a nurse told them, "No, you shouldn't take like that medication you should go to church, we'll pray for you". This act of symbolic violence in the form of the microassault (Sue, 2010) constructs homosexuality as the actual source of Kholofelo's ill-health which can be corrected through spiritual, rather than clinical, intervention.

As Wilcox (2002) puts it religion operates as a moral argument for conformist gender roles and homophobia leaving queerness as a "'stigmatized' or 'spoiled' identity" (p. 500). Kholofelo was aware of the implication of this microassault, as they responded, "next thing you tell me that your pastor is going to help cure my sexuality and I'm not feeling it". In this incident, religion is used strategically to call on the historical discourse of sexuality as chosen deviance as an attempt to make Kholofelo docile and 'correct' their orientation (Foucault, 1978).

However, Kholofelo was able to draw on the biopolitical goals of the clinic to access care, arguing to the nurse that they "don't go there for like religion, I go there to access healthcare and I feel like we should all stick to healthcare". Although religion may intrude on these aims and be used as a form of symbolic discipline, its corrective influence can be obscured through prefacing the medical management of the population as the function of the clinic.

The silence of religion in Kholofelo's general narrative, compared to its prominence in their story of clinic points to religious discourse as primary to this violence. This narrative form has an ideological effect, presenting religion as an antagonist to Kholofelo's story but also in trying to use healthcare. However, Kholofelo also uses religion to reinforce the institution of medicine counterintuitively drawing on these metaphors to promote their own health. After acquiring medication following their sexual assault Kholofelo states, "I went there, got the PEP, took it like religiously. I used to pray." Using practices of faith highlights how medicine can be constituted alongside religious knowledge, with Kremer, Ironson, and Porr (2009) finding that this discourse is used as a motivator for pharmaceutical adherence during HIV treatment. Kholofelo's narrative form points to religion as an important discourse during healthcare for the LGBT community, as a form of violence which can bind the body to immorality and as a way to care for the body.

Religion was also inserted into an experience Jacob had with a nurse when seeking treatment for an STD. However, Jacob positions himself as a passive character in his story, seeing violence as something which plays out around him because of practitioners. By structuring his narrative in this way, Jacob is able to assign blame for violent encounters and see nurses as antagonists to his sexuality. When asked about how he caught the STD, the attending nurse made a point to mention to "use condoms when you penetrate the girl" when he has sex in

future. This form of microinvalidation renders his homosexuality invisible, symbolically removing it as even a possibility for male sex (Sue, 2010). Once engaged into an account of violence, Jacob asserted that he was “the one being penetrated”. This claiming of his subjectivity through a sex act was followed by the nurse stating he was ill because he was doing “a satanic thing” and quoting bible scriptures to him.

This insertion is an attempt to construct homosexuality as the reason for his STD to delegitimise his need for care. Religious discourse filters into this violent encounter to shift focus away from the functional role of the clinic, and towards correcting sexuality (Ellingson & Green, 2014). Once this violence started Jacob tried to discontinue his treatment in his account “I was like ‘you know what I think I’m getting uncomfortable, then I will leave’. Then she was saying ‘No! It’s okay lets, okay let’s continue’”. This narration of violence in a traditional form of disciplinary power is seemingly stopped by Jacob focusing back on the services of the clinic. In this account leveraging biopolitical power through his right to care provides possibilities to remove the moral supervision of his sexuality.

The closeness between religion and stigmatising discourse was also used as a justification for choosing specific doctors. In Priya’s case religion featured as an important genre throughout her narrative. When she moved to Johannesburg, Priya struggled to find a doctor as the clinic closest to her only had a Muslim doctor. Priya specifically inserts religion as a discourse to prevent violence, “I'm not assuming that because she's a Muslim woman that she's conservative. But, like I don't know whether I can say something and then she's going to react differently to me and I don't want that experience”. Islam is produced as a specific religious discourse which can be used as a proxy for misogyny and homophobia in her account (Hasan, 2012).

Priya structures this non-account of actual violence as an important plot point in her narrative as a newcomer to the city and points to this religious subjectivity as a way to decide on a doctor. Without occurring, violence is accounted for in Priya's narrative to make her responsible for her own healthcare choices. This language sees religion as something to avoid, and can be used to pose a limit on the reach of sovereign and disciplinary power. To these participants, religion was constructed into their accounts of violence and in some ways as inseparable from the clinic.

4.2.4 Local Structure of Clinics

Participants spoke about South African clinics as inattentive to the specific health needs of the LGBT community and solely focused on health for heterosexual people rather than being inclusive. This matches with Galtung and Höivik's (1971) concept of structural violence as these create conditions for social injustice not caused by a clearly identifiable individual actor, but the clinic as an institution. When probed about why he feels unsafe disclosing his sexual orientation in the clinic, Lucky states:

> ***R: Is it a deliberate choice to remain silent whilst you're in the queue waiting for the consult?***
>
> *P: Usually we'll be quiet because actually our clinics don't have anything about same-sex, even the IC [intensive care] material in the clinic, the posters and even when they do hold talks, they don't even get to that point. Everything, it's still heterosexual.*

Lucky emphasises that queer health is treated on the periphery of traditional care as he states that when his local clinic holds health talks they fail to extend the content into the LGBT community. Padilla et al. (2007) state that exclusively displaying conformist genders and sexualities is central

to the functioning of structural violence in health systems. By constructing the clinic as exclusively heterosexual, LGBT subjectivity is dismissed from view. This expression of violence connects to the form of Lucky's story, as he positions himself as a hero for his community in his plot. This stress emphasises the oppositional discursive position between the queer subject and the clinic as a potentially hostile object of care.

Participants narrations of structural violence in public clinics also carried specific meanings in the context of South Africa. As the starting point of their narrative, Kholofelo speaks about going to a clinic after their first sexual encounter as they were worried about the risk of STDs. The only clinic in their rural home town had a reputation for breaking patient confidentiality and gossiping with community members. With this, Kholofelo "knew okay if I am going to the doctor, I have to lie about what happened. So, I told him that 'no, I was making out with a girl and then the condom broke'". Knowledge about the running of this clinic was used as a resource for Kholofelo to perform heterosexuality through their speech to safeguard their safety and privacy whilst accessing care. Structuring this as the beginning to their story of violence also stresses structural violence as a means of disciplining subjectivity by creating continued self-surveillance (Foucault, 1977).

However, unlike Galtung's (1969) position that just access prevents structural violence this study found that differential access by tailoring services for the LGBT community can create new opportunities for violence. Many of the participants in this study made use of a clinic in inner-city Johannesburg which has a small unit dedicated to assistive services for the LGBT community, although it mostly emphasises gay men. Zoliswa's story follows with going to this clinic after a condom broke whilst having sex. In a reported exchange with a male nurse, Zoliswa narrates himself as an informed patient and decided to, "just be straight on the point as [he's] the

one that's got a problem that needs some help so I don't have to hide anything" and highlight his sexuality in order to get the treatment he wanted. Daley and MacDonnell (2011) argue that such discursive representations of queer health can make clinics safe for sexual minorities and improve access. Initially, Zoliswa constructs the practices of his sexuality as vital to his specific health needs and that he advocates online for LGBT people to use this clinic, "because, I'm the one who's got a problem that needs some help so I don't have to hide open anything to you guys because I've got a problem" seeing the practices of his sexuality as central to sexual health.

However, this affirming discourse was not carried through Zoliswa's story as he continues by showing how this clinic displaced structural violence instead of removing it. Given the low resources in South African public health, some government facilities have tried to bridge access concerns for the LGBT community through this integrative model in established clinics (Müller, 2014). With a separate queue for the queer part of the clinic which sits alongside a maternity ward Zoliswa was aware of himself as visibly othered to these fellow patients:

> *I was so deurmekaar because it's like there's ladies here and its like oh okay but there's a section whereby it's only the mens. It was like its a public service, so I cannot expect much more than anything anything else because I'm not paying anything, so far, actually for that service. Basically you know with the gay, for instance, on a gay perspective with the gay people there in one place they kinda like to be laid back trying to see who's going to start because we sit in a one line and in one chair because we not many as the other people as they come and do other facilities. So it's a matter of you go you much more interested on the people that are sitting on the same benches as you. For the ones that are sitting behind you, for me personally I didn't even care. I treat them as if they don't even exist actually. Basically, when I when I go to that clinic, what I normally do, because*

> *there's a Wi-Fi, and its either I'll put headphones and then-then just be on Twitter and read what is around or grab some pamphlets. Whoever that is sitting next to me, if you don't make any conversation, just mind on business and then I'll mind mine too.*

The specific layout of the clinic, where the LGBT health needs are adjoined to a maternity ward forces queer patients to claim this subjectivity because of the queue they wait in. Kholofelo similarly expressed that:

> *Because its situated next to a maternity ward sometimes when you're sitting there those ladies they are pointing fingers at people like 'Okay, that one is probably gay, this one is gay' and I think its okay that the clinic is-is there like that in Yeoville, but maybe-maybe if that door was on the outside so you just go in that side but it's in the same facility there wouldn't be issues of people getting attacked when they go in.*

Placing female reproductive health next to the LGBT section of the clinic uses the politics of life as a vehicle for violence by institutionalising the oppositional discourse between heterosexuality and queerness (Petchesky, 2016). In both these narratives, the participants see the structure of the clinic as having a discursive function on their sexuality. The physical binary in the wards between reproductive and sexual health concerns enforces structural violence. Importantly, Kholofelo's account links this to alleged homophobic attacks outside the clinic and to common microassaults where patients try to malign queer subjectivity by guessing who is gay due to the spatial planning of the clinic. As Galtung (1969) believes, structural violence interacts with other kinds of violence and this systematic oppression connects to the roots of violence and not just the visible effects. Bowman et al. (2015) mobilise behind an understanding that the variability of violent outcomes are best explained through links which interrogate these patterns of violence/s.

As such, accounting for physical and symbolic violence through structural maltreatment of the clinic makes an important contribution to understanding violence/s as interconnected.

In his narration, Zoliswa shows how he treats his sexuality with flexibility providing a situational account for the conditions in which structural violence provides possibility for homosexuality to emerge. Zoliswa tries to move his narrative away from a story of victimhood and project himself as empowered. When asked to speak more about these experiences, Zoliswa suggests that "sometimes certain things you experience about your lifestyle" are attached to "the areas that you go to". Structural violence is used in Zoliswa's narrative of health to counter the discourse of sexuality as biologically fixed used by human rights campaigners (Terry, 1999), and stages space as central to how violence and sexuality play out within his story. Zoliswa only makes this comment in this episode of violence, and not throughout his narration, and so the significance he places here shows how this plot and queer subjectivity are connected to space through structural violence (Heyes et al., 2016).

4.2.5 Accounting for Violence through Collective Identities

An important part of the process of accounting for queerness was using strategies of collective identities to make sense of violence in the clinic. Race was a constant discourse in Lucky's stories of using health, and he sees his community as an antagonist throughout suggesting that his life was made harder by virtue of "growing up black in the township where its actually not, it's not, it's not okay according to the community to be different." This co-creation of a racial community in speaking on the marginalisation he experiences as a gay man is akin to Judge's (2017) work on blackwashing homophobia where the intersection between these

subjectivities creates black sexuality as a specific object of violence. This racialised subjectivity appeared in the clinic when Lucky was consulting with a doctor about the side effects of PrEP:

> *I was taking PrEP and all that and so he thought I have a girlfriend and all that so it was almost like the same one when I – the same one when I was still in the closet when they thought, they always think because when you tell them you're gay they go 'Oh, but you don't look gay' and I'm like, 'Like how does a gay look like?' And that's when they'll start telling you all the features they have in their head because you can't be gay and be black and all that.*

In this microinvalidation, the doctor dismisses Lucky's claim to homosexuality through the discourse of race. Lucky's narration constructs homosexuality and blackness as mutually exclusive, and that by virtue of his race his sexuality becomes a target for symbolic violence. This policing of the performance of homosexuality speaks to the discursive roots of homosexuality as a desired assimilation to womanhood (Tapinc, 2002) and Lucky's masculinity is challenged because it simultaneously re-scripts the knowledge of what it means to be gay and to be black.

As seen in her case, when trying to use a public clinic a nurse referred to Zaha as an "istabane" which translates to a hermaphrodite figure and represents a derogatory way of stating that an individual's gender expression and biology do not match (Francis, 2017). In response to this report, Zaha extends a metaphor of the collective racial identity in relation to violence to explain the systematic discrimination faced by the LGBT community:

> *We've got to understand one thing what we are facing as an LGBTI is what our black people faced during Apartheid. So what we are doing what-what we what society is doing to us as LGBTI is Apartheid. And that is what I think we need to start doing as an LGBT*

community start looking at society and say to- and say to them, you see how you get upset when people use the K word? It's how we feel when you use the moffie word, the istabane word. That to us is the K word.

Having particular power in South Africa, the invocation of Apartheid as a comparative tool elaborates on the role of everyday violence in creating queer subjects. This account links the kind of violence that is easily associated with Apartheid to how queer subjectivity is surfaced in public health referring to how this sort of discrimination is institutionally validated. This comparison draws on systematic power imbalances and separation of services and uses a racialised discourse to suggest the LGBT community are oppressed as black people were during Apartheid. This use of discourse is related to the structure of Zaha's narrative, as she contextualizes her stories with her activism. In this way, collective violence discursively emerges in her narrative to validate her reporting of oppression and empower her towards social change.

HIV is a recurrent theme in studying LGBT heath, however this study also suggests that it can be used as an object to collectively understand queer subjectivity in South African hospitals. Akanyang's narrative of violence begins with trying to consult a doctor at his local clinic in Pretoria to get flu medicine, however a nurse intervened in his treatment:

R: So, this time that you did go and you had this encounter with the nurse, what was your reason for going to the facility?

P: So, that time I was a volunteer at that clinic, so then I decided no let me just consult since I'm having flu that's when this whole thing started she said to me like, 'you have to get tested' this and that. But, no testing is volunteering don't tell me what to do.

In this account, the nurse inserts HIV as a way to malign Akanyang's homosexuality and co-construct the meaning of his body through the disease. The microinsult of diagnosing from

sexuality acts as an attempt to exercise authority over Akanyang and make him take an HIV test even though he had not come to be tested. Functionally, this discourse of HIV as a biopolitical concern for gay men is used to make the individual accountable for the gay population and to coerce confession (Nguyen, 2013).

However, Akanyang disaffiliates from the narrative of struggle with his sexuality reinforcing a position where "I don't think I have ever struggled with being gay 'cause I am more feminine". This staging of himself is important in showing how HIV can be used as an attempt to incite discourses of shame in violent encounters and also incites a necessary defense for queerness:

> *Even though I was so pissed, because I remember I just went to consult and then a nurse really said to me,'you must also test, you know, you gay people are the one in higher risk of getting infected with HIV. Actually, you're the victim of HIV'. I was like, 'Why? Why would you say so?'. I just told you that I am not sexually active, um, other than that's I got so annoyed, I was so bored so that's why actually I prefer going to a private doctor or private clinic.*

By asserting his sexuality, Akanyang's subjectivity within the AIDS crisis becomes a hallmark for health as it creates specific knowledge about what his needs could be to clinicians and as something to be answered for prior to using the services (Rispel et al., 2011). As indicated in Andrews et al. (2013) turning "stories of HIV into morality tales" is a common genre used to provide ethical force to a narrative (p. 61). In this interaction, the nurse uses the discourse of victimhood to try and assert a moral boundary on Akanyang's sexuality despite him not orienting towards sexual activity. Akanyang's reporting also creates violence as an object of public hospitals emphasizing that these impasses are why he prefers privatised health. This discourse of

service views public hospitals as oppositional to the queer subject, where the binary of private care would allow for more collective agency.

4.2.6 Queer Bodies as Unwieldy Targets of Care.

The accounts of violence and discourses which frame them carry consequences for the queer subject and their uptake of health services. In some of the participant narratives, claiming a queer subject position was seen as something to be averted from in the clinic. Specifically, participants created these instances through the knowledge that identifying with the LGBT community was likely to lead to violent outcomes. And so, some participants used the heterosexual norm to secure care. Kholofelo continues with a harrowing account of being date raped at a party in a Johannesburg suburb. When trying to get tested for HIV and get PEP the day after at a large academic hospital, Kholofelo reports being sent between multiple security guards and nurses before seeing a doctor:

The lady she, she was like 'okay, go to the that ward and tell the person at the door like your story' and then I go here, I tell the person and they're like 'okay, go that side tell that person'. I go that side, I told over five people and then I realized you know what here I am not going to get any help, these people they, I am getting more victimised because they just want to hear my story. Because like when I was telling – 'oh my word, so how did it happen? So, like he raped you in the ass? – because I wouldn't say I look gay, sometimes I can pass as a straight person so they're 'like omg you're a man and you got raped' and they sound very disgusted and like you know when you're going to be a story for the day, so I was getting tired going from ward to ward so at the next one I just pretended to be straight.

In Kholofelo's narration the security guards and nurses acted as gatekeepers for the hospital, and prevented their use by forcing them to account for their physical assault. This connection between discourses of sexuality, victimhood and care are used in Kholofelo's report to discipline them through shame and observation (Foucault, 1977). The staff in this encounter use this physical act of violence as a resource for knowledge about Kholofelo's subjectivity, and indexing their sexuality as opposed to their material concerns for the body. At the intersection of physical, structural and symbolic acts of violence Kholofelo's queerness is marked for transgressing heterosexual norms and so unhinges the biopolitical project of health. Importantly, by symbolically annihilating their own identity and performing heterosexuality through their speech, Kholofelo was able to safeguard their privacy and access care (Byne, 2017).

This strategic concealment is most prominent in Cleo's story of seeking gender-affirming therapy. In seeking HRT, Cleo structured a storyline to the psychologists on her approval panel:

> ***R: So, obviously when you were going to [clinic] it was specifically to find hormones to sort of make your everyday practices of your gender easier for you and be beneficial for your dysphoria. But were you ever asked to speak about your gender or sexual identity in ways that weren't tailored to your health care needs?***
>
> *P: So, you do kind of tailor your narrative to fit the trans narrative that they're expecting from you and if you know that there's an expectation that,'oh, yeah, I eventually I would get augmentation, eventually I would get a new vagina'. You know if you're non-binary person going into like public health care just pretend you're binary like because my friend who went to [a breast clinic in Johannesburg], they're non-binary predominantly and they just were like, 'I'm a transboy' because this is just it's easier.*

Cleo accounts for the structural violence of gatekeeping by positioning her body as a site of assimilation to the heteronormative order (Padilla et al., 2007). By subsuming her language into the gendered medical discourse of creating female sex characteristics, Cleo fits the trajectory of gender transformation thus re-affirming this social order (Hines, 2009). This account of an "expectation" for breast augmentation and a "new vagina" essentialises gender to sexual biology, and constructs the queer body as disorderly but possible for biomedicine to imagine as its subject. Marginalising practices of gender diversity creates the transitioning body as docile, as Cleo accounts for this violence by displacing her gender performance to get treatment. However, this erasure reinforces heterosexual understandings of the "wrong body hypothesis" which sees the body as the fault line between cis and transgender subjectivity (Hines, 2009, p. 49). In this way, Cleo has to construct a world for her clinicians where she can be a clinical subject as her queerness blocks this ordinary use of discipline.

The docility of the queer body in the clinic in order to become an imaginable target of care also works through confession. In Jacob's narrative of getting antibiotics for an STD he was assumed to be heterosexual which acts as a form of microinvalidation by removing homosexuality as a possibility (Sue, 2010). He also stresses that the confidentiality between user and practitioner is important so that other patients do not know about his sexuality:

> *So, you go into a consulting room you are with one health-health worker. So, that's when it's got to be confidential. Then you will be disclosing to the person. So, but when you disclose to them um it becomes, they already say 'Oh, you are a boy' they expect you to be having sex with girls so only to find out it's the other way around, you are a boy you are having sex with boys. So, that's when that um nurse was so surprised like 'How? How do you do it? Who do who?', you know?*

Hiding queer subjectivity within the confides of the clinic sees sexual orientation as a matter of confessing – a sharing of privileged information which cannot be readily spoken in society (Foucault, 1982). Jacob's compulsion to confess links the language of authority to the language of freedom, where because he is in a consult, he is now able to speak about his sexuality. The nurse operates as a confessional listener when asking Jacob about his practices has power to decipher and validate his subjectivity (Green, 2010). Sex as a "privileged theme of confession" is a discourse of the self, drawn out by the medical examination (Foucault, 1978, p. 61). By treating heterosexuality as the assumed default, through the erasure of LGBT subjectivity both structurally and symbolically, the queer user has a keen sense of themselves as "othered" (Jackson, 2006). However, Jacob structures this narrative against the archetypal resistive story of being gay, but rather emphasises his compliance (Zimman, 2009). His account of violence is important to understanding his docility, and how he asserts his queerness only to confess it and become a possible object of care.

All of the participants of this study spoke to the stability within their sexuality which can only be concealed or displaced due to its performative aspects. Importantly, the sociohistorical conditions which try to correct the queer subject can also be used to assert this subjectivity into the clinic. The corrective power of medical discourse can be complex, as in Lucky's narrative where even his asserting of his subjectivity was denied by a nurse:

> *You'll see how when you tell them who you are, how they react, even like really like, they still don't take it. Although, you'd see they have their own doubts and all that like 'How?' and all that and even the-the conversation sometimes they will talk to you in a way that they're trying to convert you.*

As already seen, heterosexuality is viewed as an exclusive mode of being in the medical field as the archetype of the patient (Payne & Davies, 2012) and this nurse uses the consult as a space to re-form queer identity back to the assumed position of heterosexuality and render Lucky's health observable. This process of claiming a LGBT identity which Lucky tries may act as a political moment to increase visibility and, consequently, to minimise discrimination. However, McIntyre and McDonald (2012) follow that resisting the erasure of queerness in the medical setting can reposition structural violence into more expressive forms. In her story of seeking gender-affirming HRT, Cleo similarly pushes back against forms of microaggressive violence from a nurse aimed at questioning the possibility of her body and ordering her within the traditional moulds of gender. By re-directing these innocuous acts from the intended target to their speaker, Cleo is cognizant about how this positioning of power relations can compromise her own safety:

> *So, I get asked about my genitalia, I get asked about my body again, and I generally try to flip them which also then will upset people they'll be like, 'so when did you first know you were a girl?' and I'm like, 'so when did you first know you were a boy?', 'Nice, gender did your mom pick it up for you?'. And I mean that's in the mood, but-that's if I'm feeling spicy and generally I'm not because it's kind of just easier to not confront people. Because also for them it's theoretical and for me, it's my life. You know, it's not theoretical it's personal.*

Prefacing of queer identity by practitioners, however can be used to order these subjects exclusively under gender and sexuality. Again, Zaha works within the discourse of a gender binary to describe how clinics she has used who claim to have undergone LGBT sensitisation re-assert heterosexual authority:

> *I may not have a wig on or may not have makeup on but my identity still remains a transgender woman, so why must I be discriminated against because I don't look a certain way? You know and that is what the health care facilities are doing and some of them tend to want to assist but I don't think they-they going about doing it the right way because some of them feel that okay, 'I'm sensitised. Let me assist this transgender woman'. So what they do is they tend to what I would call overdoing it. You know so that (participant puts on an affected accent) 'Hi sweety, how you doing? Yes, girl. Let me help you' and you know that is also off puttish, you know, because a transgender person now feels okay so what is this all about?*

Zaha reports that the nurses play into her presentation, but by enacting innocuous prejudice through the microinsult by overperforming their 'acceptance' as emphasised in the remark "yes girl, let me help you". Symbolic violence here pushes an understanding of Zaha's body as alternative through this overperformance by the nurses acting as a characteristic of surveillance. In this way, Zaha's concern with appearance and performance of femininity indicates the preoccupation of society on performance to maintain orderly gendered subjects (Butler, 2011b). As an unruly queer subject who does not try pass within the binary, her gender transfers into the clinic through violence.

4.2.7 Queerlogical Citizenry

In this study, violence was reported as a reductive force against the LGBT community and similarly it was also accounted for as an opportunity to create new possibilities for queer subjects in the clinic. Anderson (2012) indicates that biopolitical power targets the individual through the collective, as a formation of power which takes control of life itself with the body as

one site and population as the other. Although the modern clinic holds a taxonomic function for subjectivity (Green, 2010), biopower provides the subject new discourses to constitute them as placeholders for their sub-populations. The medical interaction is unique in these reports, as queer beneficiaries, even though sanctioned, can claim their right to health which could undermine attempts to openly other them or subject them to more sovereign, spectacular forms of violence. By expecting a certain level of care regardless of the individual practitioner's motives, queer users are empowered to take up their health through the language of the constitution. Akanyang exemplifies this when he counters, "do not question me, do not question my sexuality that has nothing to do with you. So, just give me what I want. Just give me the service that's all I wanted" to a nurse who through a microaggression probed him on how gay male sex is even possible. In spite of sexuality being used as a hallmark for health, queer users can focus on the objective of getting the medical attention they require and empower themselves through their biopolitical goals (Mann, 2013).

Some participants were able to resist physical violence in their narratives by claiming their rights as citizens were being infringed upon. Lucky situates himself as a leading protagonist in his narrative who is empowered by the constitution to force accountability mechanisms in the clinic (Andrews et al., 2013). Structuring his narrative as an individual against the system, Lucky indicates how civil rights discourse can counter violence and provide a sense of autonomy in his reporting. He continues by accounting of an incident where a security guard attacked and verbally abused him when seeking treatment at the clinic where he occasionally convenes LGBT youth support groups:

> *The security guard um they usually search our bags but that they he was, he was more rude and all that. And, he ended up hitting us and saying you know – telling us how gay*

we are and how we have our gay meetings so late and all that which is not allowed and all that. We reported it to the management and all that and the security was, the security company was completely changed. They were because we also told them that if they don't act on the interest of young people who are coming to the clinic then we will definitely have to take a step further you know?

As an agent of physical violence, the security guard in this reporting uses sovereign power to try gatekeep the services of this clinic. This violent act did not remove Lucky's sexuality, but rather he used his knowledge of the system and the ability to speak as a member of a marginalised group to displace it (Neville & Henrickson, 2006). In this instance Lucky was able to pit the discourse of rights against this initial violence providing access to transform the system in his account. Lucky continues his narration of this incident by focusing on how he is an empowered subject under the constitution:

Think everything it's still stuck in who you sleep with and all that and for that fact that our public healthcare centres and you can be able to-to level up with them when they put out their bullshit then you double it up and you stand up to what you believe it's right.

The use of "level up" in this report discursively suggests the queer subject is below the norm and treated as sub-class in health. In Lucky's account, an LGBT patient can become an empowered citizen, if they have details of the correct procedures and monitor tasks they can prevent poor delivery and encounters. This particular application of knowledge relates to a formation of biopower where the system which manages the individual can also be acted against in order to sustain life (McWhorter, 2004). Critically, this emancipated narration by Lucky demanding to be treated like everybody else is an attempt to create a world where the LGBT community is seen as

normal. In doing so, Lucky demands the violence he faces to be moved from punishment to discipline (Foucault, 1977).

Trying to be disciplined was also carried out through biopolitical language, using a discourse of life and biology to subsume the queer subject into traditional discipline of the clinic. After having unprotected sex when they moved to Johannesburg, Kholofelo tried to get PEP from an inner-city clinic. When they recounted their story, a triage nurse inserted a microinvalidation, "she was like 'Um, so who was the man? Who was the woman?' and I was like 'We're both knives there was no spoon'" This symbolic violence tries to understand Kholofelo as a heterosexual subject, however, once they re-affirmed their queer subjectivity the nurse escalated this violence:

> *And then now she was getting very annoyed, she was very loud like screaming 'No, man! What are you telling me?' So, now everyone was looking at me knowing that I was having anal sex and to top things off I was bottoming. So, basically everyone had to look at me and I was like oh my word I wish I didn't come here but I need this PEP it's my right so whatever, I don't know these people, two days from now they aren't even going to remember my face. And I got that PEP.*

The nurse enforces an act of spectacular punishment, scolding Kholofelo in a public manner as if to shame them (Green, 2010). Kholofelo's narrative structures this episode of violence as peripheral to their main concern, as despite being reductively punished, their body remains a site of biomedical need. By focusing on getting medication to sustain their life, Kholofelo's account of violence relates back to the aims of biopower instead of the social consequences in the moment (McWhorter, 2004).

The sanctity of life itself functions in Kholofelo's account to resist violence to punish by trying to subsume their subjectivity into the medical gaze of discipline. As these forms of violence have different logics – sovereign acts restrict life and discipline creates it in specific ways – biopower provides possibilities for the subject to move between them (Wilcox, 2015). By demanding their "right" to "PEP" as a medicine to protect the body Kholofelo's account is a demand to be disciplined in the same way in the clinic, using life to dispense the power to control, instead of sanction, their subjectivity which is not as an escape from power itself. This nexus where the subject is positioned as queer, biological and a citizen is foundational in the accounts of violence in public hospitals for the LGBT community in South Africa.

Chapter 5: Conclusion, Limitations and Recommendations.

The people making up the four letters 'LGBT' have been studied to show how sex and gender stigmatise, sanction and socially regulate subjects in the modern state (Edley, 2001a; Foucault, 1978; Green, 2007). Queer subjectivity has a resonance to violence, marginalised through historical and modern formations of hate, prejudice and social deviance (Yep, 2003). Central to this project of making the queer subject abnormal has been the clinic, where sexual and gender variance are pathologised under professional control (Feldman, 2008). Literature focusing on barriers to accessing care and health risk in the LGBT community are limited by theorising about the queer subject without violence. Much of the work on healthcare in South Africa focuses on equitable health and risk without a critical engagement on how this neglect speaks to an absence of traditional discipline (Fredriksen-Goldsen et al., 2014; Rispel et al., 2011). These queer subjects are produced into docile bodies through the historical pathologising of sexuality, authority of medical confession and regimented surveillance in the clinic (Foucault, 1978). The critical study of health must understand queer subjectivity as a nexus between multiple power relations informed by and uncovered through violent ends. This study aimed to explore the accounts of violence in self-identified LGBT users of public health in South Africa and has shown how violence in spectacular, structural and symbolic forms is a technology for the self in these interactions.

Ten narrative interviews were conducted with queer health users and a discourse analysis performed on their episodic stories of violence in the clinic. Despite having unique life histories which contextualised these accounts, the queer subject appears to be constituted by the discursive medicalisation of sex and gender, the moral imposition of religion, the very infrastructure of clinics, collective identities, unruly bodies, and biological rights which is superimposed onto the

structure of their narrations. As a ‘perverted’ other, queerness was constantly contrasted against heterosexuality which acted as norm to surface or silence this subjectivity in the clinic. Sex was constructed in relation to physical violence with pathological language defining how, where and when assaults were used to ‘correct’ queerness. Comparatively, structural violence through the professional consultation and in medical interventions promoted the hegemonic authority of hospitals and their workers to classify queer subjects as opposition to the biopolitical project of heterosexuality.

Adding to this surveillance, symbolic violence levelled at the very stability participants saw in their subjectivities created new opportunities to incentivise discipline in micro interactions in health. In these ways, violence added to the knowledge of LGBT/queer subjectivity and guided how participants reported participating in their community inside the clinic. The subjectivity studied in this report was constrained by forms of violence, but these moments also presented as opportunities to resist the heterosexual order through collective and health subjectivities. This theoretical component of this report can potentially contribute to policy in the health sector. From the hostile separation of ‘inclusive’ clinics to the lack of targeted services and issues of social cohesion, this study provides partial insights into how staff/patient interactions are linked to violence in participant accounts. By helping to contour the very nature of violence in the clinic for LGBT people, transformation in the sector may be informed through staff sensitivity training, large-scale awareness campaigns or specialised care through gender-therapy units in hospitals as both the participants in this study and other works have argued for (Byne, 2017; Meer & Müller, 2017). With this knowledge, the accounts of these participants provide a sliver of living data for the need to adapt South African hospitals and clinic procedures to make them accessible for the LGBT/queer population.

5.1 Limitations

A unique issue in the study of violence is the target of analysis and how to study to the act itself. By using recollected narratives, this study makes use of accounts of violence to underscore queer health but this bypasses the actual accomplishment of a violent act in the clinic. Innovative work which is able to draw a closer proximity to the action of violent outcomes, without risking the unit of study, such as through an interactional lens of conversation or digital ethnography may further contribute to understanding the production of violence itself (Whitehead, Bowman, & Raymond, 2018). Similarly, quantitative analysis of health trends around population groups, geographies or socio-economics may help track historical links to the power relations found in discourses of queer health. This report is methodologically limited by its use of recollected reports of violence and consequent works could expand knowledge about how violent situations are accomplished in the clinic.

At the practical end of limitations, participants were sourced through organisations which offer supplementary health services and support groups for queer people, and although a helpful inlet it must be acknowledged that this excluded members of the community who do not use their specific services. This study is also limited by the number of participants and invisibility of certain gendered and sexual formations of queerness as not every categorisation of subjectivity under the LGBT umbrella volunteered. This lack of representation can unwittingly contribute to exclusive understandings of queerness and violence and erase potentially new insights (Driskill, 2010). Targeting these subjectivities in future works could add to the violence-health-queerness nexus.

5.2 Strengths

An important contribution of this study is locating how violence in the clinic is situationally accounted for by queer users. How these discourses appeared was attached to the individual clinician, the politics of the institution and how their own bodies were understood. As the authors Meer and Müller (2017) explain, “healthcare spaces are overwhelmingly heteronormative, although queer service-users' subversive practices suggest alternative spatial configurations. However, such resistance relies on individual empowered action and risks disciplining responses.” (p. 92). Simply, then, violence has the capacity to constitute sexuality and gender but cannot determine how these identities are lived through and invented by queer people. This theoretical contribution was partly informed by the use of a narrative-discursive design which allowed for the accounts of violence to be produced within participant’s own speech and in relation to their own cases.

In these episodes of health, Foucauldian (1982, 2007) theorising around sovereign, disciplinary and biopolitical power is useful to index the power relations between the queer subject, the healthy body and the clinic. The primary logic of power’s operation through modern medicine has been to categorise bodies so subjects consume their own surveillance and self-discipline (Green, 2010). Queer populations present disorder to this system and violence presents as a means to order these lives. In spite of collapsing sexuality onto disease such as HIV being used to construct the queer subject as unhealthy, queer users can focus on the objective of getting the medical attention they require to report themselves as empowered subjects of health (Mann, 2013). Where the constitutional protection granted to the LGBT community has not removed discrimination, it has inserted a new rights discourse which these subjects can assert to reform power relations. However, in the accounts of biopower offering resistance to sovereign acts, the

queer subject petitions for their right to be punished ordinarily. A significant addition from this study is the analysis of how violence co-opts traditional logics of power which poses bigger questions about the democratisation of violence in South Africa for sub-altern groups. These four letter lives demonstrate what the clinic never overlooks: the nexus of subjectification, violence and power - disciplinary or sovereign.

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List of Tables

Table 1. Demographic information and list of participant pseudonyms for the sample.

Appendices

Appendix A. Research Instrument

Building Question:

1. How do you self-identify in terms of sexuality and gender?

Narrative Interview Schedule

All the questions posed during the interviews were participant, and as such what appears below serve only as topics which were freely associated with by the narrator and used to guide the storytelling if neccessary.

Initial Prompt: Take your time in answering the few questions I have, try and answer with as much detail as possible but only if you feel comfortable sharing your story.

1. Do you have any stories of struggling with being queer?
2. Have you ever faced discrimination or violence for being queer?
    a. If yes, can you tell me about the most memorable experience you ever faced?
3. Can you tell me about the most recent act of violence/discrimination you faced if at all?
4. Can you tell me about the first time you made use of public health facilities?
    a. Potential Prompts: What do you remember most about the experience?
    b. Where you out during this visit?
5. Can you tell me what the admissions process was like?
6. Where you misgendered during this process or throughout your stay?
7. Can you tell me what led up to your going to this facility?
8. What was your stay/visit at this facility like?
9. How would you categorise the treatment you received from the staff at the hospital?
10. Did you experience any moments of hate speech or dismissal during your treatment?

11. Did it ever seem as if you were treated differently/poorly/unfairly during your stay at Hospital? Can you tell me more about this?
12. If so, was it ever stated that you by anyone that you were being overly sensitive for thinking this?
13. Where you ever asked, or did you ever speak about your gender/sexual identity during your stay?
14. Did you feel safe disclosing your sexual orientation to those in your ward/hospital staff?
15. Do you have any specific stories about the staff or patients you were around at the time?
16. How would you categorise how fellow users of the hospital treated you?
17. Where there any specific messages or comments made about your identity?
18. Can you remember any particular moment about your visit that is stuck in your mind?
19. Would you use the facility again?

Debriefing Procedure

1. How do you feel having spoken about your experiences?
2. Are you currently feeling any form of distress?

Prompt: Please check the information sheet with relevant contact information should you require further assistance.

Appendix B. Consent Form

School of Human and Community Development
Private Bag 3, Wits
2050
Johannesburg, South Africa
Tel: 27 (0)11 717 4524/5 Fax: 27 (0)11 717 4556

I_____ have read and understood the participant information sheet and I hereby agree to being interviewed on experiences of public health care by self-identified members of the LGBT community. I understand that:

- I am participating freely and without being forced in any way to do so.
- I can withdraw at any point should I not want to continue and that this decision will not in any way affect me negatively.
- I can refuse to answer any questions at any time.
- I understand that this is a research project whose purpose is not necessarily to benefit me personally in the immediate or short term.
- I understand that no information which identifies me will be included in the research report and my responses will remain confidential

Signature of consent: Date:

_____ _____

Appendix C. Participant Information Sheet

School of Human and Community Development
Private Bag 3, Wits
2050
Johannesburg, South Africa
Tel: 27 (0)11 717 4524/5 Fax: 27 (0)11 717 4556

Hello,

My name is Dylan Kukard, and I am conducting research for the purposes of obtaining a Masters Degree in Social and Psychological Research at the University of the Witwatersrand. The aim of my research is to try and understand how violence is understood by the LGBT community when using the public health care system. I am concentrating on the individual experiences of self-identified LGBT people with public health. Much of the existing research which I have read focuses on HIV, stigma and discrimination as preventing LGBT health. This has lead to the LGBT community being considered in these terms and not in terms of access to their basic human rights. Understanding the dynamics of violence involved in accessing healthcare would help to expose the public, academics and medical personnel to more accurate information. This in turn will provide better information available to both them and the policy makers who design interventions and programmes, to improve access to healthcare for the LGBT community.

This project is being run under the supervision of Professor Brett Bowman. We would like to invite you to participate in this study. Participation in this project will involve being interviewed by myself at a time convenient to you. The interviews will be conducted either at the same location of the support group you regularly attend, or the University of the Witwatersrand at your choice. The interview will last approximately 1 hour. With your permission I will record the interview as everything that you say is important and to ensure that whatever you tell me can be analysed accurately. Everything that you say will be kept confidential and no identifying information will be included in the report.

Please understand that your participation is completely voluntary and you are not being forced to takepart in this study. The choice of whether to participate or not, is yours alone. If you choose not to take part, you will not be affected in any way whatsoever. If you agree to participate, you may decline to answer any questions which you do not want to answer. You may also withdraw from the research at any time by telling me that you don't want to continue. If you do this there will also be no penalties and you will not be prejudiced in any way. **The costs for travelling will be covered by the researcher.**

As you may have been contacted by either ANOVA, OUT, WITS SAFE ZONES or a fellow member of the LGBT community to participate in this research, it is possible that your identity will be known to them. However, I will conceal your identity in the final report. Within the report or any other publication, I will refer to you by a unique code number or pseudonym (another name).

The risks associated with participation in this study are no greater than those encountered in daily life. However, should you feel after speaking with me that you are requiring support both OUT (Face-to-Face counselling and a safe-space group contact - 012 430 3272) and the SADAG Hotline (0800 12 13 14) will be able to help you in a non judgemental manner. If you feel that you would like to seek counselling services for some of the issues which you have spoken about, a free or nominally charged service from the Emthonjeni Centre on Jan Smut Avenue, Braamfontein is available. It is just inside the Wits university campus. You can contact them on (011) 717 4513 to make an appointment.

The tape recordings and transcripts thereof will not be seen nor heard by any persons other than my supervisor and myself. They constitute the data for this project and as such are an important element within the study. Both the recordings and subsequent transcriptions will be safe kept on a password protected computer.

You may refuse to answer any questions you prefer not to, and you can at any point withdraw from the study. Should you choose to participate in the study, please complete the form which follows. Should you have any further questions or concerns please feel free to contact me or my supervisor on the details which appear below.

This research will contribute both to a larger body of knowledge on violence and the accessing health services for the LGBT community, as well as to your own understanding of the factors which impact your circumstances. A one page summary of the research results will be made available on request.

Warm regards,
Dylan Kukard

Dylan Bryce Kukard
Dylan.kukard@gmail.com
072 726 5128

Supervisor:
Professor Brett Bowman
Brett.Bowman@wits.ac.za
011 717 8335

I have read and understood the Information Sheet

Signed _____
Date_____

Appendix D. Recording and Quotation Consent Form

School of Human and Community Development
Private Bag 3, Wits
2050
Johannesburg, South Africa
Tel: 27 (0)11 717 4524/5 Fax: 27 (0)11 717 4556

I _____have read and understood the participant information sheet and I hereby consent to being tape-recorded during the interview with Dylan Kukard.

I understand that:

- The tapes and transcripts will only be read/heard by Dylan and his supervisor.
- No other persons from any organisation or in their personal capacity will be privy to these.
- Both recordings and transcripts will be safe kept on a password protected computer
- I agree to being quoted verbatim in reports written in relation to this project.
- I understand that all identifying features will be changed, this includes my name.

Signature of consent: Date:

_____ _____

Appendix E. Ethics Approval Certificate

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

HUMAN RESEARCH ETHICS COMMITTEE (SCHOOL OF HUMAN & COMMUNITY DEVELOPMENT

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: MASPR/18/002 IH**
PROJECT TITLE:	A life in four letters: violence in the accounts of LGBT users of public health services in South Africa
INVESTIGATORS	Kukard Dylan
DEPARTMENT	Psychology
DATE CONSIDERED	19/07/18
DECISION OF COMMITTEE*	Approved

This ethical clearance is valid for 2 years and may be renewed upon application

DATE: 19 July 2018

CHAIRPERSON _____
(Prof. Gillian Finchilescu)

cc Supervisor: Prof. Brett Bowman
Psychology

DECLARATION OF INVESTIGATOR (S)

To be completed in duplicate and **one copy** returned to the Secretary, Room 100015, 10th floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure be contemplated from the research procedure, as approved, I/we undertake to submit a revised protocol to the Committee.

This ethical clearance will expire on 31 December 2020

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Appendix F. Ethics Amendment Approval

School of Human and Community Development

Private Bag 3, Wits

2050

Johannesburg, South Africa

Tel: 27 (0)11 717 4524/5 Fax: 27 (0)11 717 4556

Ethics Amendment

At the request of the student, the School Ethics Committee grants an amendment to the clearance certificate for Dylan Kukard (MASPR/18/002/IH) to include a provision to reimburse participants transport costs should it be necessary to secure voluntary participation.

The Participant Information Sheet has been amended to include the statement "The costs for travelling will be covered by the researcher" and this compensation will occur upon request.

Investigator:

Dylan Kukard

Supervisor:

Prof. Brett Bowman

Chairperson:

Prof. Gillian Finchilescu

Date: 28 August 2018

Appendix G. Supervisor Contract

A STATEMENT OF PRINCIPLES FOR POSTGRADUATE SUPERVISION

IN A CONTEXT OF ACADEMIC FREEDOM AND WITHIN A FRAMEWORK OF INDIVIDUAL AUTONOMY AND THE PURSUIT OF KNOWLEDGE THIS AGREEMENT IS WRITTEN IN THE BELIEF THAT THERE IS A RECIPROCAL RELATIONSHIP AND MUTUAL ACCOUNTABILITY BETWEEN SUPERVISOR AND STUDENT.

THE SUPERVISOR AND THE STUDENT:

1. Will establish agreed roles and clear processes to be maintained by both parties. In the case of joint supervision everyone's role needs to be clarified.
2. Will meet regularly and as frequently as is reasonable to ensure steady progress towards the completion of the proposal, research report, or dissertation or thesis. This time varies but the normal minimum requirement for face-to- face contact, spread across each year of registration is: 10 contact hours for an Honours project, 15 contact hours for a Masters by research report and 24 contact hours for a Masters by dissertation and a PhD.
3. Will keep appointments, be punctual and respond timeously to messages.
4. Will keep one another informed of any planned vacations or absences as well as changes in his or her personal circumstances that might impact on the work schedule. Unplanned absences or delays should be discussed as soon as possible and arrangements should be made to catch up lost time.
5. Will ensure that research on animal or human subjects is conducted according to the procedures and the requirements of the relevant University Ethics committee.
6. Will together complete progress reports on the research project, as requested by each Faculty Graduate Studies Committee.

THE SUPERVISOR:

1. Undertakes to provide guidance for the student's research project in relation to the design and scope of the project, the relevant literature and information sources, research methods and techniques and methods of data analysis.
2. Has a responsibility to be accessible to the student.
3. Will be prepared for meetings with the student. This includes being up-to-date on the latest work in his/her area of expertise.
4. Will expect written work as jointly agreed, and will return that work with constructive criticism within a timeframe (a suggestion of 2-4 weeks) jointly agreed at the outset of the research.
5. Will provide advice that can help the student to improve his/her writing. This may include referrals for language training and academic writing. The supervisor will provide guidance on technical aspects of writing such as referencing as well as on discipline specific requirements. Detailed correction of drafts and instruction in aspects of language and style are not the responsibility of the supervisor.
6. Will support the student in the production of a research report, dissertation or thesis. Provision should be allowed for adequate, mutually respectful, discussion around recommendations made.
7. Will assist with the construction of a written time schedule which outlines the expected completion dates of successive stages of the work.
8. Will ensure the student has the opportunity to present work at postgraduate/ staff seminars/national/international conferences as appropriate.
9. Will assist with the publication of research articles as appropriate.
10. Will discuss the ownership of research conducted by the student in accordance with the University guidelines and rules on intellectual property, co-authorship and copyright.
11. Will ensure that the research is conducted in accordance with the University's policy on plagiarism.
12. Will ensure that the student is made aware in writing of the inadequacy of progress and/or of any work where the standard is below par. Acceptability will be according to criteria previously supplied to the student.
13. Has a duty to refuse to allow the submission of sub-standard work for examination, regardless of the circumstances. If the student chooses to submit without the consent of the supervisor, then this should be clearly recorded and the appropriate procedures followed.

THE STUDENT:

1. Undertakes to work independently under the guidance of the supervisor. This includes reading widely to ensure that the literature pertinent to his/her chosen topic has been identified and consulted.
2. Is obliged to make appointments to see the supervisor and will arrange meeting times well in advance.
3. Will think carefully about how to derive maximum benefit from these contact sessions by planning what he/she wants in these sessions.
4. Should submit written work for discussion with the supervisor well in advance of a scheduled meeting. The kind and frequency of written work should be agreed with the supervisor as the outset of the research.
5. Undertakes to submit written work that is relatively free of basic spelling mistakes, incorrect punctuation and grammatical errors. Responsibility for the accuracy of language, the overall structure and coherence of the final research report, dissertation or thesis rests with the student.
6. Undertakes to heed the advice given by the supervisor and to engage in discussion around suggestions made. Ultimately the student has to take responsibility for the quality and presentation of the work.
7. Should strive, within reasonable bounds, to maintain a focus on his/her research area and to work within the agreed time schedule.
8. Will prepare material for presentations at seminars and conferences.
9. Undertakes to submit papers for publication.
10. Agrees to honour agreements about ownership of the research and in accordance with the University's guidelines and rules in relation to co-authorship, copyright and intellectual property.
11. Will ensure that the work contains no instances of plagiarism and that all citations are properly referenced and that the list of references is accurate, complete and consistent.
12. Agrees to work in accordance with the criteria of acceptability as supplied by the supervisor.
13. Undertakes not to place the supervisor under undue pressure to submit work for examination until the supervisor is satisfied that it has reached an acceptable level of quality.

I confirm that I have read and understood this statement and agree to be guided by its principles

Name of student : PB KUKARD

Student's signature :

Name of Supervisor : PROF. BRETT BOWMAN

Supervisor's signature :

Name of Co-Supervisor : —

Co-Supervisor's signature : —

The broad area of study is: VIOLENCE, HEALTH & QUEER EXPERIENCE

Provisional submission date is: _____

Degree : MASPR

School : SHCD

Faculty : HUMANITIES

Date : 06/18/18

Specific agreements pertaining to: ownership and joint publication, funding, etc. may be attached and signed.

GRIEVANCE PROCEDURES. It should be acknowledged that during the course of the research, both students and supervisors can feel aggrieved. In this event, matters should be dealt with as swiftly as possible by the parties involved and, if necessary, the appropriate Postgraduate Coordinators and Committees. There is, in addition, a University Grievance Policy to help guide deliberations. It is available on www.wits.ac.za/prospective/postgraduate.