Proud & Healthy

An overview of community based needs assessments on sexual health of LGBTIs in Southern Africa.

CREDITS

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PROUD & HEALTHY

An overview of community-based needs assessments on the sexual health of LGBTIs in Southern Africa.

JULY 2014

COC NETHERLANDS

IMPRESSIONS, PERCEPTIONS, REALITIES

'I have seen colleagues treat lesbian women in a bad way… but I can't say anything, since they will think I want to promote homosexuality…'

– Health-care worker, Swaziland

'No, I don't know my casual partner's status, but I think, being lesbian,…it is not easy to get infected...'

– Lesbian, South Africa

'When I went for a consultation, they [the health-care providers] would not help me... My ID says I'm male... The nurse called other nurses into the room to look at me... I decided to leave and did not return.'

– Transgender woman, Botswana

'I have occasionally had unprotected sex with other guys... It just depends... Sometimes I asked them to put a condom on..., but other times we had unprotected sex... I never ask about their status.'

– Gay man, South Africa

'... I never think of going to a local clinic when I'm sick. If the nurses find out that I'm intersex, they will tell the whole township. I know those people, you can't trust them.'

– Intersex man, South Africa

'… I go to the clinic as a private citizen and I do not mention that I am gay...'

– Gay man, Mozambique

'At times the idea of getting tested is intimidating. Just the mere thought of being found to be infected is traumatising.'

– Gay man, Zimbabwe

DIDIRI & BRIDGING THE GAPS – PARTNERS OF COC IN SOUTHERN AFRICA

Malawi

The Centre for the Development of People (CEDEP) is a registered human-rights organisation that addresses the needs of and challenges for minority groups in Malawi in the context of human rights, health and social development. Such minority groups include prisoners, sex workers and people in same-sex relationships as well as any other minority groups whose rights are often neglected.

Botswana

BONELA is a national network of individuals and organisations that promotes a just and inclusive environment that contributes to a better quality of life for people affected by HIV and AIDS through advocacy, capacity building and building a network of individuals and organisations.

Botswana

LeGaBiBo (Lesbians, Gays and Bisexuals of Botswana) is the first LGBTI (lesbian, gay, bisexual, transgender and intersex) organisation in Botswana. It was founded as a project in 1998 and is currently operating in strong collaboration with BONELA. LeGaBiBo aims to build an independent, non-partisan organisation that promotes the recognition, acceptance and equal protection of all human rights for the LGBTI community in Botswana.

Botswana

Rainbow Identity Association (RIA) is a non-profit organisation based in Gaborone, Botswana. It is an organisation of transgender and intersex people (transwomen, transmen, gender-questioning, queer-gender, transsexuals and gender-nonconforming). The organisation aims at exploring ways of challenging transphobic laws and transphobia in Botswana.

Swaziland

SWAPOL (Swaziland Positive Living) is a non-governmental organisation operating countrywide to ensure that people living with HIV can be duly assisted. SWAPOL provides counselling and education and seeks to improve the living conditions of people who are affected by or infected with HIV in the rural areas, many of whom are women.

South Africa

OUT is dedicated to building healthy and empowered lesbian, gay, bisexual and transgender communities in South Africa and internationally. OUT wants to reduce heterosexism and homophobia in society.

South Africa

The Triangle Project aims to contribute towards eradicating discrimination against and within the lesbian, gay, bisexual and transgender (LGBT) community and to provide defined services to the LGBT community until they are no longer required.

South Africa

The Durban Lesbian & Gay Community & Health Centre (a project of the KZN Coalition for Gay & Lesbian Equality) is a drop-in centre, a safe and secure space for the lesbian, transgender, gay, bisexual and intersex communities in Durban and KwaZulu-Natal.

South Africa

Transgender and Intersex Africa strives to support transgender and intersex individuals with safe spaces to debrief and share necessary information with one another. TIA strives to raise awareness through education and training for the transgender and intersex community, their families and society in general about the existence of black South African transgender and intersex people and about the issues they face.

South Africa

Gender DynamiX is a South African organisation devoted solely to the African transgender community. The organisation focuses on advocacy and education and provides resources, support and information to transgendered and other gender-nonconforming individuals, their loved ones, their employers, and the general public.

Zimbabwe

GALZ (Gay and Lesbians Zimbabwe) is a voluntary membership-based organisation established in 1990 to serve the needs of the LGBTI community in Zimbabwe. GALZ's vision is 'a just society that promotes and protects the human rights of LGBTI people as equal citizens in Zimbabwe'.

Zimbabwe

The Sexual Rights Centre aims to build a sexual-rights culture in Zimbabwe by developing programmes focused entirely on upholding international recommendations and standards on sexual rights including the right to sexuality education, the right to live free from violence, the right to express and choose your sexual orientation without fear, the right to bodily integrity and the right to freely express one's sexuality.

Zambia

Friends of Rainka is a non-governmental, not-for-profit organisation that champions the rights of sexual minorities in Zambia through advocacy, information dissemination, legal reform, research and direct service provision.

Zambia

Friends of Rainka Medical Consultancy (Men's Network) is a community-led MSM grouping that works to provide and advocate for the provision of comprehensive health services for men who have sex with men in Zambia. The organisation's mission is to have an equitable and supportive environment for Zambian MSM. The main goals are to provide competent and comprehensive health services for MSM, to create a conducive legal and policy environment for health programming for MSM, to establish and secure recognition, respect, fulfilment and the protection of human rights for MSM.

Zambia

Transbantu Zambia's aim is to end discrimination against and the exclusion of trans people in Zambia by building a strong and educated trans movement through community education, support groups and capacity building. TBZ advocates for policy reforms to protect the human rights of trans people. Through a joint strategic planning and learning process with trans groups across Southern Africa, TBZ encourages regional exchange and movement building.

Swaziland

Rock of Hope is a community-based non-profit organisation focusing on LGBTI issues. Rock of Hope intends to communicate its research findings through various media and advocacy, mobilise the MSM community, and partner with government stakeholders to combat stigma and improve access to health and HIV prevention, treatment and care services.

Swaziland

HOOP (House of Our Pride) is a support group for gay, lesbian, bisexual, transgender and intersex (GLBTI) people. HOOP was established in July 2009 and is currently part of SWAPOL.

Mozambique

LAMBDA (Mozambique Association for Sexual Minority Rights) is a Mozambican organisation that was formed in 2006. The vision of the organisation is a Mozambican society where sexual orientation and diversity are recognised by the state, respected by citizens and protected by law. The target group is all sexual minorities, covering the whole LGBTI spectrum.

LAMBDA promotes the civic, human and legal rights of the LGBTI community through public awareness and education as well as advocacy and social dialogue.

Namibia

Out Right Namibia (ORN) is a Namibian LGBTI, MSM and WSW human-rights-based organisation. As the voice for lesbians, gay men, bisexual men and women, and transgender and intersex people in Namibia, ORN advocates to further address, redress and arrest the amount of homophobia rhetoric in the country.

South Africa

The objective at Matrix Support Group is to promote the protection of human rights and the legal recognition of the LGBTIs in Lesotho, to encourage a healthy life-style, to prevent HIV transmission and to give support to LGBTIs living with HIV/AIDS.

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PREFACE

Factors such as stigma, discrimination, violence, exclusion from national HIV-health surveillance, gaps in the knowledge and attitudes of health-care workers, and the criminalisation of same-sex acts adversely affect the access to and uptake of health-care services by LGBTIs.

LGBTI people in Southern Africa experience danger and insecurity. Legal and social oppression is the order of the day. Across the region, LGBTI issues continue to carry stigma and remain taboo subjects. Indeed, in recent times, governments seem to have demonstrated an increased reluctance to address LGBTI concerns. There is still no health programming on lesbians and women who have sex with women (WSW) in Southern African countries. The existing provisions on transgender people and men who have sex with men (MSM) in the national strategic plans and frameworks of most of the countries in the region have unfortunately often remained unimplemented. The lack of clear guidelines on health-care provision to LGBTI people often results in challenges to health-care workers in their quest to ensure universal access to health services for all citizens, including the LGBTI community.

The LGBTI movement in most of Southern Africa (excluding South Africa) is a relatively new phenomenon. This movement is characterised by many young and ambitious LGBTI organisations, although they are often faced with low levels of capacity, very little experience in public-health interventions and insufficient research skills. To address the need to build and strengthen the capacity of LGBTI organisations in Southern Africa in the domain of public-health research and interventions, partnerships have been formed between COC Netherlands and 19 LGBTI organisations in nine countries in the region. Together with COC Netherlands and other regional and global partners working on HIV prevention and LGBT rights, these partners have embarked on the Dignity, Diversity and Rights (DiDiRi) programme and the Bridging the Gaps programme, which receive funding from the Dutch Embassy in South Africa and the Dutch Ministry of Foreign Affairs, respectively. These partners are the following organisations: LAMBDA (in Mozambique); Friends of Rainka Zambia, Friends of Rainka Medical Consultancy and TransBantu Zambia (in Zambia); Matrix Support Group (in Lesotho); Rock of Hope, SWAPOL–House of Our Pride (in Swaziland); Sexual Rights Centre and GALZ (in Zimbabwe); Rainbow Identity Association, BONELA and LeGaBiBo (in Botswana); Centre for the Development of People (in Malawi); Out Right Namibia (in Namibia); Gender DynamiX, OUT, Triangle Project, the Durban Lesbian & Gay Community & Health Centre and Transgender and Intersex Africa (in South Africa).

One of the main activities that these partners have started carrying out is the conducting of community-based needs assessments focused on the carefully articulated health-care needs of LGBTI people in South Africa, Botswana, Lesotho, Malawi, Mozambique, Namibia, Swaziland, Zambia and Zimbabwe. Prior to performing these community-based needs assessments, many of the partner organisations had never carried out any form of research work.

Unfortunately, the needs assessments carried out by both Friends of Rainka Medical Consultancy and Out Right Namibia were not completed in time for the results to be integrated within this publication.

COC Netherlands works according to a programmatic approach with community-based organisations, which is referred to as 'inside out'. COC believes in supporting, mentoring and capacitating grassroots organisations to stimulate their evolution towards a more sustainable and effective national LGBTI rights movement and in supporting the strengthening of the existing regional LGBTI movement.

In carrying out the needs assessments, the partners focused on identifying those factors that restrict the access and uptake of health services amongst specific target LGBTI groups within each partner organisation's catchment area. Through the needs assessment, the partner organisations also identified factors that influence risky sexual behaviour. This is a key element of COC Netherlands' plan-based and evidence-informed methodology. In a sector confronted with resource constraints, COC Netherlands works with this methodology to help partners manage resources efficiently by using evidence-informed methods to identify actual problems, and in the process, to come up with an effective intervention matrix to address those problems and to support LGBTI people in the region in feeling proud and living healthy lives.

INTRODUCTION

There is a paucity of research dealing with LGBTI issues in Southern Africa. There have been very few publications on the determinants of sexual risk behaviour amongst LGBTI people. Most of the available data pertains to men who have sex with men (MSM), while the risk profiles of lesbians, bisexual men and women, and transgender and intersex people have largely been ignored. Furthermore, most of the data about MSM is confined to South Africa. On the basis of partnerships with a total of 19 LGBTI organisations in nine countries in Southern Africa, COC Netherlands embarked on both the DiDiRi programme and the Bridging the Gaps programme in order to support its partners in assessing the needs of these various target groups as well as the status of their health care in the region. The present publication captures the studies undertaken by 17 of COC's partner organisations in eight countries.

This publication uses various different public-health terms to refer to the different groups targeted by our partners. This is potentially confusing because terms that would appear to describe the same group can have nevertheless different connotations. For example, some partners have chosen to research 'men who have sex with men' (MSM) and 'women who have sex with women' (WSW), which are both largely public-health terms that attempt to define the respective target groups in relation to their behaviour. The word 'MSM' includes all men who from time to time have sex with men but who do not necessarily consider themselves to have a homosexual orientation. The same type of definition applies to women in the case of WSW. On the other hand, lesbians, gay men, and bisexual men and women are labelled as such on the basis of their physical and emotional preference to people of the same sex (in the case of lesbians and gays) or to both sexes (in the case of bisexuals). Transgender people, on the other hand, are identified as such because they challenge gender binaries and identity. They don't identify with their biological sex; a transgender person who is a biological man would identify as a woman, for example. In common terms, transgender people feel a sense of 'being trapped in the wrong body'. 'Intersex' is a general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn't seem to fit with the typical definitions of female or male.

In the community-based needs-assessment process, partners decided on the particular (sub) target groups they wanted to work with. Some partners had done previous research on a particular target group and decided to focus on another group in a bid to see which cross-learning questions and issues could arise. Others, such as Rock of Hope in Swaziland, took into consideration that a lot of resources were already being directed to the MSM target groups and therefore decided to focus on WSW and lesbians. Some other partners, such as TransBantu Zambia, chose to focus on the specific target group they already catered to. On the other hand, Friends of Rainka Medical Consultancy chose to work with MSM and WSW, even though they have positioned their organisation as MSM focused.

Partners also decided on the particular level of prevention measures, the location and the age demographic they wanted to focus on. Most organisations chose to interview their target groups on the use and uptake of primary (barrier methods) and secondary (HIV/STI testing) prevention measures.

The uptake of tertiary prevention measures such as antiretroviral treatment for HIV-positive individuals was not researched in the needs assessments. The locations chosen were mostly based on the catchment areas of the programme interventions of most of the partners. However, some partners went beyond their coverage areas to get more respondents and to scope out new areas for prospects of expanding their services. The demographic data such as those regarding age were heavily dependent on the age groups for which the organisations were already providing programming and in some cases on information received from secondary sources such as prior research pointing to a particular age demographic with heightened vulnerabilities to HIV/STIs.

Disclaimer:

The needs assessments have some limitations and as such do not have the ambition to be – nor should they be regarded as – scientific studies. It should be kept in mind that the LGBTI organisations that conducted the assessments were operating at a certain level of existing capacity. These are LGBTI movements or groups that have only existed for a few years and that are still trying to mobilise their community members to accept and identify themselves. Limited funding is an important issue for these organisations and influences the choices they can make.

The purpose of this report is to give an impression of the health-care challenges some LGBTIs in Southern African countries face and the individual and environmental factors that might contribute to this situation. The sample sizes for most of the community-based needs assessments were too small to arrive at any conclusive research evidence representing the target groups in the respective countries. It was the first time that most of the partners had independently carried out and been in charge of any form of research. Partners developed the questionnaires themselves with mentoring and feedback from COC throughout the process. This served as a capacity-building process for them, since it was important they would come up with the questionnaires themselves. The community-based needs assessment is unique in the sense that each partner decided which target group it wanted to work with, based on carefully articulated needs. Taking these factors into consideration, it is difficult to compare the different results, especially for such a tailor-made process.

In some cases different target groups were lumped together. For example, some transgender women were lumped together with MSM and gay men, and transmen were sometimes grouped together with lesbians and bisexuals. There were clearly also some knowledge gaps – even amongst the researchers – on gender-identity and sexual-orientation issues. Partners also had major difficulties persuading health-care providers to give in-depth interviews or key-informant interviews or to participate in their needs assessments. In most cases, the health-care providers who participated had already been sensitised by the LGBT organisation or were just more liberal, open-minded people.

Methodology

The partners in this process mostly chose to work with a primary and secondary target group.

The primary target group were the beneficiaries (LGBTI) of the needs assessment. The secondary target group were health-care providers. The choice for the secondary target group was obvious, considering the purpose of the needs assessment, which was to gather information about the primary target groups and their access to and uptake of health services. Transbantu Zambia decided to pick a tertiary target group to go deeper into the legal and policy framework of Zambia and to gain insights into the legality of access to health for transgender people and into how the law and policy provisions affect attitudes of health-care workers who provide health services to them.

The partners used a mix of methods to gather data, including self-administered survey questionnaires, focus-group discussions and key-informant interviews (semi-structured interviews). Individual interviews with key informants using semi-structured questionnaires were held by Rock of Hope, SWAPOL–HOOP, LAMBDA, Friends of Rainka, CEDEP, BONELA, LeGaBiBo, Sexual Rights Centre, GALZ, MATRIX Support Group, the Durban Lesbian & Gay Community & Health Centre, OUT, Triangle Project, Transgender and Intersex Africa and Gender DynamiX. In addition, focus-group discussions were conducted with the target groups by Rock of Hope, CEDEP, Sexual Rights Centre, Transgender and Intersex Africa and Gender DynamiX. SWAPOL–HOOP also collected data from the secondary target group using self-administered survey questionnaires.

LGBTI respondents were assembled using snowball-sampling and convenience-sampling techniques. Snowball sampling is a non-probability sampling technique where existing study objects recruit future subjects from amongst their acquaintances. Snowball sampling was used by all partner organisations with LGBTI respondents except GALZ. Many organisations used convenience sampling or purposive sampling to assemble health-care providers. Convenience sampling is a non-probability sampling technique where subjects are selected because of their convenient accessibility and proximity to the researcher. GALZ used convenience sampling in the needs assessment it conducted among its own members in Zimbabwe.

Some interviews and focus-group discussions were conducted in the mother tongue of the respondents. These answers were later translated to English. All respondents completed written consent forms authorising the use of the answers provided.

The data gathered was processed by the researchers in several ways. In most cases individual interviews were audio-recorded and processed verbatim. In some cases (Rainbow Identity Association, Transbantu Zambia, MATRIX) answers were captured in writing. Data was either given to a database agency to process and create a database or processed in Excel by the partner organisations themselves.

This publication aims to provide information on individual and environmental factors that cause LGBTI people to behave in a particular, risky way. It intends to provide a broad overview not only of the findings of 17 LGBTI organisations in the region on the key behavioural issues, but also of the how all those issues play a part in the actual uptake of and access to services.

The next chapter, which deals with risk behaviour, deals with each subgroup within the broad spectrum of lesbian, gay, bisexual, transgender and intersex people separately because there are clear cut differences in their respective risk profiles.

It is pertinent that this is clearly articulated. In the subsequent chapters, the data on lesbians, gay men and bisexual men and women will be presented jointly, as will the data on transgender and intersex people, due to the fact that there are more commonalities than differences with respect to the sexual-orientation and gender-identity issues, respectively.

Country	Malawi	Botswana	Zimbabwe	Lesotho	South Africa	Zambia	Mozambique	Swaziland
Focus	Lesbians, gay men and bisexual men, WSW and MSM	Lesbians, gay men, bisexual men and women, transgender and intersex people	Lesbians, gay men, bisexual men, transmen and MSM	Transgender and intersex people	Lesbians, gay men, bisexual men and women, transgender and intersex people, MSM and WSW	Lesbians, gay men, bisexual men and women, transgender and intersex people	Lesbians, gay men, bisexual men and MSM	Lesbians, gay men, bisexual men and women, transgender people and WSW
No. of primary target group interviewed	**67 individuals:** 19 gay men 39 bisexual men 9 lesbians	**132 individuals:** 28 lesbians 52 gay men 32 bisexual men and women 6 transmen 12 transwomen 2 intersex people	**97 individuals:** 19 lesbians 69 gay men 9 bisexual men 4 MSM 2 transwomen	**50 individuals:** 49 transgender people 1 intersex person	**378 individuals:** 92 lesbians 27 bisexual men and women 66 gay men 113 transgender people 27 MSM 39 WSW 14 intersex people	**109 individuals:** 26 lesbians 55 gay men 23 bisexual men and women 5 transgender people	**38 individuals:** 24 gay men 10 bisexual men 4 lesbians	**269 individuals:** 106 lesbians 74 gay men 67 bisexual men 4 transmen 2 transwomen 16 WSW
No. of secondary target group interviewed	27 health- care workers from private and public health facilities	91 individuals: 76 health- care workers 15 traditional leaders	No secondary target group	15 health- care workers from private and public health facilities	19 health-care workers	22 health-care workers from private clinics and one government hospital.	No secondary target group	46 health-care workers including six health-care workers from the Ministry of Health in two provinces
Location	Mzuzu, Lilongwe, Blantyre	Gaborone, Francistown, Palapye	Harare, Bulawayo	Leribe, Mafeteng, Maseru	Pretoria (Thswane), KwaZulu-Natal, Limpopo province, Mpumalanga province, North West Province, Gauteng Province, Worcester, Paarl, Wellington	Central, Copperbelt, Eastern, Lusaka and Southern provinces	Maputo, Beira, Quelimane	Hhohho, Lubombo, Manzini, Shiselweni
Average age	25	25	27	23	27	25	25	27

EVIDENCE-INFORMED HEALTH PROMOTION AMONGST THE LGBTI COMMUNITY

All organisations working on sexual-orientation and gender-identity issues will have some visionary ideas about what kind of activities they would like to implement that would cater to the needs of the LGBTI groups they work for. Some of those activities will actually be implemented, while others, due to financial, capacity or contextual circumstances, will merely remain hopes for the future.

Intervention developers, or staff in charge of the programming in LGBTI organisations, should base their decisions on which interventions to prioritise on their experience of what is needed and what is feasible. The programme staff are rational people who aim to accomplish effective, efficient and relevant interventions.

The level of effectiveness, efficiency and relevance of these interventions is influenced by the quality of information on the needs and quality of the understanding of the effect of the intervention. Working on health promotion is all about understanding the problem and understanding the response.

Community-based needs assessments form an important tool for organisations to get full understanding of the underlying factors of the health problems experienced by LGBTI people. In a needs assessment, programmers not only explore the manifestations of the problems but also try to (better) understand the issues that influence the problem and the underlying determinants.

This is important as – being part of the community themselves – programmers could sometimes make assumptions about the needs of the community and risk not clearly presenting the grounds for their assertions. The individual programmer might see different dynamics underlying the problems than other people in the community see. It is crucial to objectify what we know and to be able to explain to others how we know what we know. Data from other research, contextual baselines, anecdotal evidence from practice and the monitoring of current interventions all play an important role in this process as well.

The additional evidence gathered in a needs assessment will be used to improve the quality of health-promotion interventions, but it can also be used for advocacy purposes. Not unimportantly, implementing a needs assessment can also be an avenue to (re)connect with new parts of the LGBTI community in the area where the LGBT organisation is active as well as an ideal 'neutral' reason to engage with service providers.

The community-based character of the needs assessment is an important element, because access to LGBTI groups can be extremely difficult in contexts were people are forced to keep their sexual orientation and/or gender identity hidden. Furthermore it allows community-based LGBTI organisations themselves to build their research capacities so they will be able to keep taking charge of their own programme development and advocacy in the future. The power to change the health and rights situation of LGBTI people lies within those LGBTI people themselves.

Health promotion

Health promotion is the process of enabling people to increase their control over – and improve – their health. It entails actions directed at strengthening the skills and capabilities of individuals. It also entails actions directed towards changing social, environmental and economic conditions, such as advocating policies that are favourable to health, creating environments that will be supportive to health or reorienting existing health services.[1]

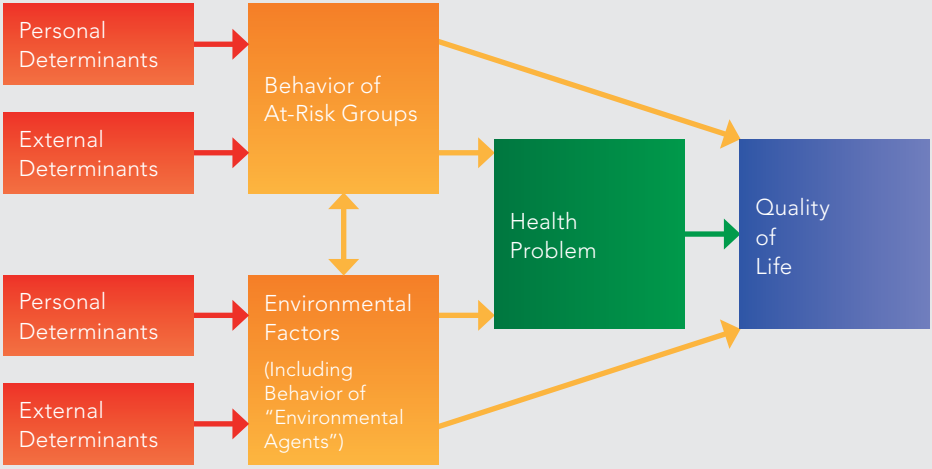
Health promotion requires the reinforcement and maintenance of healthy behaviour or a change in unhealthy behaviour. In the context of LGBTI people in Southern Africa, HIV and other STIs have a major influence on the quality of life. Sexual behaviours that either endanger or promote the health situation of people have therefore often been some of the central issues identified by programmers. However, there are also other key health issues (e.g. alcohol use, psychological stress, medically uncontrolled cross-gender hormone replacement therapy).

Theoretical framework behind COC's needs assessments

In developing community-based needs assessments, COC's partners are supported to keep the PRECEDE model in mind. In principle, the needs-assessment report developed by the LGBTI organisation tries to give information on all components of this model, providing a more rich and less subjective understanding of reality. The model guides data collection and analysis. It provides clues about what to change in the behaviour of the at-risk group or the environmental agents in order to create a health-promoting situation.

The PRECEDE model, developed by Green & Kreuter, gives a description starting with the quality of life and health problems. Lessening these problems should be the intention of a health-promotion intervention. Subsequently, the planner must find evidence of behavioural and environmental causes. A behavioural analysis typically includes specifying what the at-risk individuals do that increases their risk of experiencing the health problem or that makes the health problem more severe. The environmental analysis includes specifying conditions in the social and physical environment that influence the health problem and influence or hinder health-promoting behaviour. The next step of this model is to analyse the personal determinants of behavioural and environmental factors.[2] This gives an in-depth understanding of the underlying determinants, the aspects that the health-promoting programmers might be able to influence. Determinants include elements like behavioural and normative beliefs, beliefs about efficacy, attitudes, norms, self-efficacy,[3] skills, intention and environmental constraints. Whereas the behaviour of at-risk groups and the environmental factors can't be changed directly, it is with these underlying determinants that change could be supported.

Figure 1: The PRECEDE-model



Source: Adapted from Green & Kreuter, 2005

RISK BEHAVIOUR AND HEALTH ISSUES AMONGST LGBTIS, MSM AND WSW

The community-based needs assessments conducted by the LGBTI organisations in Southern Africa have identified two main (sexual) health problems amongst LGBTIs in the region. Both **sexual risk behaviour** and the **failure to seek health-care services** are extremely prevalent amongst LGBTIs in Southern Africa. They expose these communities to health issues and enhance their probability of suffering from ill health.

Behaviour can be defined as the actions or reactions of a person in response to external or internal stimuli. Actions have a certain impact, either on the individual's environment or on the individual him/herself. Sexual risk behaviour and not seeking health-care services are both troublesome behaviours due to the consequences that engaging in this behaviour may bring for the individual and others.

Sexual risk behaviour

Sexual risk behaviour involves sexual actions that can expose an individual to health risks. The most common health issues related to sexual risk behaviour are HIV and other sexually transmitted infections (STIs). There are several ways in which individuals can contract HIV or other STIs.

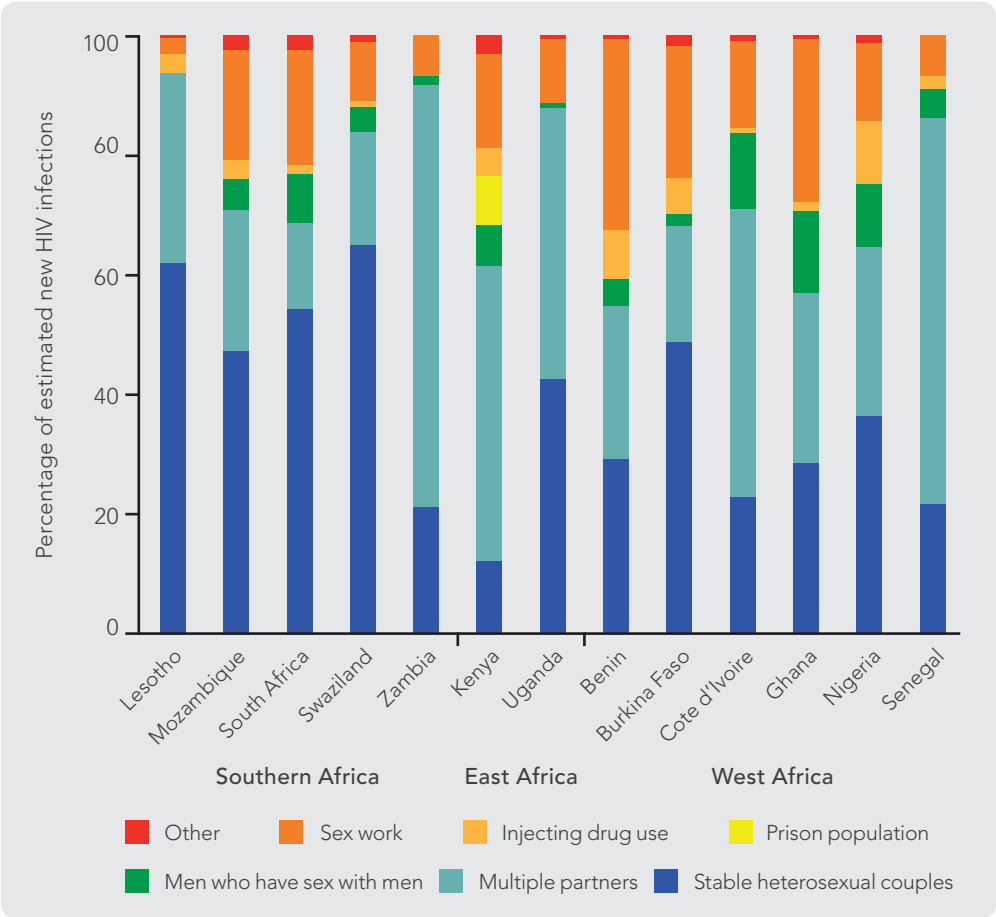
Sexually transmitted infections are a major public-health concern in Southern Africa. The presence of STIs is problematic for the following reasons:

(i) Untreated STIs can be the cause of cervical cancer, pelvic inflammatory disease and infertility.
(ii) The presence of an STI increases one's susceptibility to HIV infection;
(iii) The presence of an STI could be an indication of one's having engaged in unprotected sex with multiple concurrent partners, thus increasing one's risk of coming into contact with STIs and HIV.

Blood, semen, breast milk, vaginal fluids and rectal discharge are some of the bodily fluids known to be capable of containing high levels of HIV.[4] Behaviours that expose an individual to these bodily fluids can therefore be classified as risk behaviours that can lead to HIV infection. The transmission of HIV can occur during unprotected vaginal and anal intercourse, drug use involving injections, blood transfusions, and birth and breastfeeding (mother-to-child transmission), as well as through occupational exposure (individuals working in a health-care setting).

The United Nations Joint Programme on HIV/AIDS (UNAIDS) recommends the use of the modes of transmission (MOT) model to learn more about groups are more at risk of infection.[5] This approach emphasises the importance of understanding, at the local level, which subpopulations are most at risk of HIV infection and which risk behaviours may facilitate transmission, and of using this information to tailor national responses.[6]

Figure 2: Sources of new HIV infections estimated by the modes of transmission model in sub-Saharan Africa, 2008–2010, WHO



This chart gives an impression of the estimated number of new HIV infections in Sub-Saharan Africa between 2008 and 2010 by the modes of transmission model. MSM and individuals engaging in multiple concurrent partnerships are explicitly identified as groups at risk of infection. Even though the multiple concurrent partnerships covered by this chart mainly involve heterosexual partnerships, this practice is also prevalent amongst same-sex partners and thus an important factor to take into account.

UNAIDS has recognised **unprotected sexual contact** as a very important cause of HIV infections.[7] In public health, considerable attention has been placed on establishing a hierarchy of risk associated with STI and HIV transmission. The hierarchy ranges from minimal risk (abstinence) to highest risk (anal intercourse with internal ejaculation).

The estimated risk per exposure is highly dependent on the type of sexual activity undertaken and the HIV status of one's sexual partners.[8]

Figure 3: Estimated risk of HIV transmission per exposure for specific sexual activities

ACTIVITY	RISK-PER-EXPOSURE
Vaginal sex, female-to-male, studies in high-income countries	0.04% (1:2380)
Vaginal sex, male-to-female, studies in high-income countries	0.08% (1:1234)
Vaginal sex, female-to-male, studies in low-income countries	0.38% (1:263)
Vaginal sex, male-to-female, studies in low-income countries	0.30% (1:333)
Receptive anal sex amongst gay men, partner unknown status	0.27% (1:370)
Receptive anal sex amongst gay men, partner HIV positive	0.82% (1:123)
Insertive anal sex, gay men, partner unknown status	0.06% (1:1666)
Insertive anal sex with condom, gay men, partner unknown status	0.04% (1:2500)
Receptive fellatio	Estimates range from 0.00% to 0.04% (1:2500)

Estimated HIV transmission sexual risk per exposure for specific activities and events
Source: http://www.aidsmap.com/Estimated-risk-per-exposure/page/1324038/

It seems that there are differences between the public-health views and the popular conceptions regarding the relative risk of contracting HIV and STIs. Sexual activities such as having unprotected sex in ongoing relationships, being the insertive partner during vaginal or anal intercourse, engaging in anal intercourse without ejaculation, engaging in cunnilingus or anilingus and sharing sex toys all carry considerable risks. However risk perceptions about these activities are generally low.[9]

It appears that gay men and lesbians incorporate 'scientific' knowledge acquired from health promotion leaflets and 'unofficial' knowledge acquired from friends and social circles in order to arrive at a personal solution, which may include either being overly safe or not being safe enough.

Multiple concurrent partnerships and casual encounters

The probability of contracting HIV or other STIs can be enhanced by engaging in unprotected sexual activity with multiple concurrent partners. Multiple concurrent partnerships often include casual encounters where the use of barrier methods might not be negotiated.

Not knowing about the casual partners' HIV status and engaging in unprotected sexual activity therefore puts individuals at a heightened risk of infections with HIV and other STIs. This means it is not the casual nature of the sexual encounter per se, but rather the risk-taking behaviour that occurs during the encounter that increases one's risk.[10]

An alarming aspect of multiple concurrent partnerships and casual encounters is the possibility that individuals will consistently engage in unprotected sex with their primary partner (if in a relationship), while also, in certain cases, engaging in unprotected sex with a casual partner. This means it is important to explore the combination of casual encounters and steady relationships as a potentially significant factor that may facilitate sexual risk-taking behaviour.[11]

Unprotected sexual activity is the main cause of HIV infection amongst members of the LGBTI community in Southern Africa. The needs assessments conducted by partner organisations therefore focus on understanding the individual and environmental determinants that influence this specific behaviour.

Delaying or not seeking health-care services

Another important risk behaviour identified amongst LGBTIs in South Africa is their failure to seek health-care services. Seeking health-care is a particular aspect of help-seeking behaviour. Individuals differ in their willingness to seek help from health-care services. Some people go readily for treatment, while others only seek health care when they are in pain or in advanced stages of ill health.[12]

Not seeking health care when it is needed is a risk behaviour in itself, since it exposes individuals to the possibility of advanced ill health. Furthermore, for those who engage in sexual risk behaviour, the failure to seek health care becomes even more problematic since it could mean that they would remain untreated for a possible infection with HIV and/or other STIs and run an increased risk of infecting a sexual partner.

Sexual risk behaviour and delaying or not seeking health care are thus troublesome when considered together, since the combination expedites the spread of HIV and other STIs. On its own, the failure to seek health care turns out to be an important risk behaviour due to fact that other non-sexual health issues can remain undetected. It exposes individuals to the risk of suffering from illnesses that could have been prevented or treated if they had been discovered on time.

There are several factors that may drive someone in delaying or failing altogether to seek health care, including a lack of knowledge of health issues, one's attitude towards health-care services and one's perceived need for treatment of illnesses. Individuals may also often choose to self-administer medication when confronted with ill health. The community-based needs assessments conducted amongst LGBTIs in Southern Africa found a low willingness amongst the members of this group to seek health-care services. This report presents an overview of the factors influencing this behaviour amongst LGBTIs in the region.

The fact that health-care services are available in a country does not necessary mean that every individual from every community will be able to access those services.

The tension between the availability and the accessibility of health-care services is influenced by several factors. Aside from the perceptions and knowledge of those who seek health care, the social climate in a community as well as practical issues such as (a lack of funds for) transportation and the attitudes and knowledge of health-care providers are also key in bridging the gap between the availability and the actual accessibility of services.

The following chapters outline the individual determinants of both sexual risk behaviour and the failure to seek health care. The needs assessments looked into the level of knowledge, the attitudes, and the awareness and beliefs that the target groups have about sexual risk behaviour and about accessing health-care services. In addition, environmental factors such as the social and legal environment of the target groups and the knowledge, awareness and practices of health-care service providers are discussed. This report concludes with a discussion on how to tackle the challenges in providing health care to the target groups.

DETERMINANTS OF SEXUAL RISK BEHAVIOUR

Several factors can influence whether or not someone will engage in high-risk sexual behaviour. It is crucial to understand what these factors are in order to plan for health promotion. Promoting sustainable and effective protected sex requires that the individuals engaging in the sexual activity understand and underwrite the need to use barrier methods. Looking into the exact determinants of risk behaviour opens up the possibility of getting to the root of factors that are of influence during unprotected sexual activities.

The community-based needs assessments amongst LGBTIs found several determinants that influence whether or not one engages in sexual risk behaviour. These determinants differ between sexual orientations and gender identities. The most frequent drivers of risk behaviour are: **a lack of knowledge regarding the probability of contracting HIV/STIs, substance use prior to engaging in sexual activity and one's attitude towards same-sex relationships and sexual activity.**

An overview of the determinants that surfaced per sexual orientation or gender identity in each specific country is given here.

Lesbians, bisexual women and women who have sex with women (WSW)

Although several studies have shown no evidence of HIV transmission between women who have sex with women (WSW),[13] a few reports have described cases of female-to-female transmission identified on the basis of the absence of a history of alternative risks for HIV infection. In March 2014 a new **case of female-to-female transmission of HIV** was reported by CDC.[14] When engaging in unprotected sexual contact with an infected sexual partner, however, WSW are definitely at risk of contracting STIs.

Malawi:

None of the nine WSW interviewed reported using protection during female-to-female sexual contact. The respondents mentioned **not knowing of any place where preventive materials such as dental dams and finger cots can be obtained.** Furthermore, the respondents mentioned that they trusted their sexual partners.

The WSWs interviewed in Malawi considered female-to-female sexual contact as being a low-risk activity. **The women interviewed thought that HIV could not be transmitted through female-to-female activity unless one of the women had slept with a man.[15]**

Most of the WSW interviewed reported having had an HIV test. The most common reason for doing the test was the suspicion that one's partner had engaged in sexual activity with a man.[16] However, none of the WSW reported having multiple sexual partners at the same time.

The women who indicated perceiving the rate of HIV infections to be relatively high amongst WSW attributed that high rate to their belief that WSW who are sex workers infect their female partners with HIV from male clients.[17]

Botswana:

The needs assessment on determinants of risk behaviour for LGB in Botswana was conducted amongst men and women simultaneously in the cities of Gaborone, Francistown and Palapye. The information provided under this section includes the views of both groups.

Almost half of the 112 LGB respondents interviewed in Botswana indicated engaging in same-sex sexual activity without any protection or barrier methods.[18] The respondents indicated **feeling that the methods were either inappropriate or unavailable or that they did not know where to obtain suitable barrier methods.[19]**

Half of the total respondents reported thinking that the risk level for HIV-infection was the same for same-sex sexual partners as for heterosexual partners. The respondents who reported using barrier methods indicated most commonly using condoms;[20] only two respondents indicated using dental dams. It was not specified whether the women interviewed use alternative protection methods aside from dental dams.

Ten of the respondents indicated **not to be willing to use any protection.** The reasons provided were trusting one's partner and being afraid of being seen as unfaithful if one would suggest using protection.[21]

Half of the LGBs interviewed knew of the existence of HIV tests and reported having had such a test at some point.

Zimbabwe:

When questioned on what they understood HIV and STIs to be, one-third of the 19 lesbians and WSW interviewed described them as 'diseases with no cure'.[22] This belief is interesting in the light of assessing the willingness of lesbians and WSW to seek health care. The belief that HIV and other STIs are incurable could be of great influence in terms of the fear they might feel of being infected and the extent to which they expect that a visit to a health-care provider could be useful. Other prevalent answers given regarding what they considered HIV and other STIs to be were 'diseases obtained via unprotected sex' and 'they exist, therefore be wise'.[23]

Of the 19 lesbians interviewed, more than 50% indicated not practising safe sex. The most prevalent reason for this behaviour **was the belief that these female-to-female sexual activities did not involve much exchange of bodily fluids.[24]** One respondent argued that the lack of available protection methods for women led to her not using any.

Seventy per cent of the respondents had witnessed a close relative or friend succumb to HIV-related illnesses. Half of them therefore had concerns about possibly contracting HIV and indicated being vigilant. However, more than a third of those who had witnessed a close relative succumb to HIV indicated still not having any concerns.[25]

When asked if they would engage in unprotected sexual activity with someone who was HIV positive, two-thirds of the total number of respondents indicated that they would not do so.[26] It is alarming that over a third of the respondents would still consider doing that.

All of the respondents were aware of the existence of voluntary counselling and testing opportunities. Ninety per cent reported having had an HIV test. The most prevalent reason given for having had an HIV test was that the individual had been separated from her partner and went for the test once they were reunited.

South Africa:

Three partner organisations each conducted needs assessments on determinants of risk behaviour for lesbians, bisexual women and WSW in several provinces in South Africa. OUT interviewed 39 Lesbians and WSW in Tshwane. The Durban Centre interviewed 89 lesbians and WSW in KwaZulu-Natal and Triangle Project interviewed 45 lesbians and WSW in Western Cape.

'Drinking alcohol is more fun and you are not being cautious… You just do it… and only think about it in the morning…' – Lesbian, South Africa

Most of the 39 lesbians interviewed in Tshwane indicated consuming alcohol frequently. Increased alcohol use was reported during the time leading up to casual sexual encounters. A respondent reported: **'not worrying about safety when drunk'.**[28]

The needs assessments in Tshwane and Western Cape revealed that lesbians often have an erroneous risk perception and negative attitude towards barrier methods. Respondents **indicated not recognising female-to-female sexual activity as risk behaviour.**[29] Knowing one's sexual partner and the mere fact of that person's being female were seen as sufficient reasons not to need the use of barrier methods. Other respondents expressed the opinion that no 'protective stuff' is needed in lesbian sex and that being the 'active' (top) sexual partner is safer than being the receptive partner (bottom). The needs assessments point to a **general belief amongst the lesbians and WSW that they are not at risk of contracting HIV/STIs.**[30]

The more masculine-identified lesbians interviewed admitted being reluctant to use barrier methods, often stating that using barrier methods would indicate that they thought that their partner had been unfaithful.[31] **The belief was prevalent that if a partner really loved her masculine lover, she would not want to use safer sex methods.**

Respondents in Western Cape reported knowing about the existence of STIs and that lesbians could get infected but **not knowing how transmission takes place.**[32] All of the 45 women interviewed in Western Cape indicated knowing about the existence of HIV/AIDS, but only one-third knew about other STIs.[33] Most respondents reported **having no knowledge of safer sex practices for lesbians and WSW.**[34]

Many of the respondents interviewed in KwaZulu-Natal reported engaging in casual sex. Respondents reported frequenting places such as sports clubs and bars and having circles of friends where **casual sex is very prevalent.**

The general trend appears to be that barrier methods are not always used when engaging in sexual activity with a complete stranger.[35]

Mozambique:

The needs assessment on determinants of risk behaviour for LGBTI, MSM and WSW in Mozambique was conducted by Lambda amongst men and women simultaneously. Only a small number of WSW participated in this assessment. Please refer to the section on gay men, bisexual men and MSM for the relevant findings.

Zambia:

The needs assessment on determinants of risk behaviour for MSM and WSW in Zambia was conducted amongst both groups simultaneously by Friends of Rainka Zambia. A small number of WSW participated in this assessment. Please refer to the section on gay men, bisexual men and MSM for the relevant findings.

Swaziland:

Two organisations conducted needs assessments on determinants of risk behaviour for LGB in Swaziland. Rock of Hope interviewed 91 lesbians, WSW and transgender men[1] in Hhohho, Lubombo, Manzini and Shiselweni. SWAPOL–HOOP interviewed 204 WSW and MSM in the same provinces. A very small percentage (5%) of WSW participated in the assessment conducted by SWAPOL–HOOP. The information provided in this section is derived from the assessment conducted by Rock of Hope.

The majority of the WSW who were interviewed by Rock of Hope indicated engaging in unprotected sexual activity with their primary partner and with their casual partners. The reasons they gave for practising unprotected sex with multiple concurrent partners were the **'feeling of not being at risk of contracting HIV/STIs as a lesbian' and 'sexual freedom'.**[36]

Fifty-two of the respondents indicated having multiple concurrent partners of the same sex. Of this group, 15% reported having both male and female concurrent partners. Hardly any of them reported using protection during these encounters. The respondents indicating experiencing sex as 'a way of escaping from their daily lives'.[37]

Seventy per cent reported never having been treated for an STI. It is not clear whether they had never had an STI or simply had never been to a clinic to get treated. **Only 64% reported ever having had an HIV test; only 45% of this group actually also went to collect the results.**

Only a few of the respondents indicated being aware of the existence of dental dams. Respondents mentioned that their sexual partners are often reluctant to use dental dams and gloves, since they are not familiar with these commodities.[38]

1 - Transgender men are men. Depending on the phase of their transition, they could be exposed to sexual risks similar to those that WSW face. This led to the decision to include them in the needs assessment conducted amongst lesbians and WSW in Swaziland.

They reported negative reactions from their sexual partners who consider using protection to be a sign of a lack of trust, the presence of undisclosed diseases, infidelity and a barrier to pleasure. **Having unprotected sex thus becomes a way to prove a degree of trust and fidelity in the sexual relationship.**[39]

The majority of the respondents admitted regular substance use. Respondents reported using alcohol, marijuana and/or hard drugs such as ecstasy and cocaine.[40] Consistent substance use is linked to the feeling that bars and clubs are some of the rare places where everyone is treated equally.[41] **Respondents admitted that they 'only get the confidence to approach girls for sex' when they are intoxicated.**[42]

None of the participants said they used protection during these encounters. They typified the encounters as 'hurried', having 'no time to negotiate using protection'. Some respondents also **admitted fearing rejection from potential sexual partners if they introduced the idea of using protection.**

Gay men, bisexual men and men who have sex with men (MSM)

Sexual risk behaviour accounts for most of the infections with HIV and other STIs amongst MSM. Unprotected anal sex carries the highest risk of passing on HIV during sex. Gay men are at an increased risk for STIs such as syphilis, gonorrhoea, and chlamydia.[43]

Malawi:

'I previously thought HIV could not be contracted from same-sex sexual intercourse. I have learnt this year that it can be transmitted through MSM.'
– MSM in Mzuzu who had been sexually active for 14 years

Of the 58 MSM interviewed, most admitted **thinking that HIV could not be transmitted through male-to-male sexual activity.**[44]

Most of the MSM interviewed reported having had at least one HIV test. One respondent said he took the test because he had had more than ten sexual partners and had never used condoms because he thought HIV could not be contracted through anal intercourse.[45]

All MSM interviewed reported having multiple concurrent sexual partners. The majority of the participants said it was **necessary to have multiple sexual partners (both male and female) in order to cover-up their true sexual orientation.**[46]

Respondents in all districts reported **using alcohol (beer) to get rid of their fears and approach other men in order to engage in sexual contact.**[47] Respondents mentioned that they are usually unprepared for sexual encounters, which is to say they rarely ever have condoms and lubricant with them if they happen to meet an MSM with whom they can have sexual contact when they are out drinking.[48]

Botswana

The needs assessment on determinants of risk behaviour for LGB in Botswana was conducted amongst men and women simultaneously in the cities of Gaborone, Francistown and Palapye. Please refer to the section on lesbians, bisexual women and WSW for the relevant findings.

Zimbabwe:

In Zimbabwe, two partners each conducted a needs assessment amongst a specific segment of the LGBT community. The assessment conducted by GALZ focused on 34 MSM in Harare, while the one conducted by the Sexual Rights Centre focused on gay men, bisexual men, other MSM and transgender women[2] (GBT) in Bulawayo.

'Alcohol is an issue… Many of us lose control and make silly decisions when we are drunk, which is why people end up sleeping with many people.'
– Gay man, Zimbabwe

A total of 50 GBT in Bulawayo were interviewed about how they estimated their likelihood of contracting HIV/STIs. Ninety per cent was under the impression that GBT are at risk of contracting HIV.[49] When asked whether they perceived this risk to be greater than the risk run by other groups, 22% indicated that they did not.[50]

Almost all respondents felt that it was important for GBT to get tested for HIV/STIs. Over 90% reported actually having had an HIV test.[51]

The respondents had a good perception of what risk-bearing behaviour is. All of them ranked unprotected anal sex and oral sex with HIV-positive men or with men of an unknown HIV status as the behaviour carrying the highest risk.[52]

Incorrect and inconsistent condom use with HIV positive partners or partners with an unknown status, substance use while engaging in sexual activity and engaging in sexual activity with multiple concurrent partners were also ranked high as potentially risky behaviour by the respondents.

Most of the men interviewed by GALZ correctly identified HIV as a 'disease obtained via unprotected sex'.[53] However, close to two-thirds of the respondents indicated not using barrier methods during every sexual encounter.[54]

The respondents in Harare were also questioned about their familiarity with the consequences of an HIV infection. Over 40% of the respondents had cared for a close relative or friend who was infected with HIV.[55] This experience was of influence on the individual's knowledge of HIV infections. Close to 90% of this group reported having done an HIV test themselves.[56]

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2 - Transgender women are women. Depending on the phase of their transition they could be exposed to sexual risks that are similar to those that MSM face. This led to the decision to include them in the needs assessment conducted amongst gay men and MSM in Zimbabwe.

South Africa:

The needs assessment on determinants of risk behaviour for gay men, bisexual men and MSM in South Africa was conducted by two partners in two provinces. OUT interviewed 36 (white) gay men and MSM in Tshwane, Gauteng province and the Durban Centre interviewed 57 gay and bisexual men in KwaZulu-Natal.

'I usually look down there to see if there is anything suspicious… If there is nothing, then we can have sex… In general I don't think I am at risk of anything.'
– Gay man, South Africa

A quarter of the 57 men interviewed in KwaZulu-Natal reported **never using protection when engaging in sexual activity.**[57] The remaining group indicated irregular condom use with casual partners and no condom use with their primary partner when in a monogamous relationship. A quarter of these respondents reported thinking that they were HIV positive.[58] Only 27% of the total respondents reported ever having been tested for HIV.[59]

The majority of the 36 men interviewed in Tshwane seemed to be **aware of the risks of unprotected sexual activity** and casual encounters and tended to moderate their sexual practices accordingly. However, there are situations in which most of the respondents indicated not practising safe sex. An additional alarming factor is that they **are not likely to disclose casual encounters to their primary partner, with whom they consistently have unprotected sex.[60]**

One respondent explained risk-taking behaviour as a result of *'… gay HIV infections… [being] stabilised… People are feeling more comfortable and so they revert back to their old ways, thinking "it does not affect me, it is not part of my life, it is not my problem" and then they take risks.'*[61]

This conscious risk-taking, combined with maintaining secrecy about engaging in sexual activity with others beside one's own primary partner, enhances one's chances of getting infected and infecting one's other sexual partner(s).

The needs assessment held amongst men in Tshwane revealed that many respondents, whether involved in a (monogamous) relationship or not, engage in regular casual sexual encounters. Inconsistent condom use is prevalent during these casual encounters. The high number of casual encounters could be explained as a result of **internalised homophobia,**[62] which is understood to be accompanied by negative self-images and self-destructive tendencies.[63] In order to manage a 'spoiled identity', many gay men may try to compensate by pursuing the masculine ideal. Notions of masculinity are associated with strength, power, control, rationality and virility.[64] This compensation is possibly intensified by an increased sexual drive. A 30-year-old gay men formulates the high sexual drive as being *'… a manly thing… Men have something in them… It is all about lust… As men we need to have sex to get rid of that lust.'*[65]

All respondents indicated **not being consistent in their condom use and not always negotiating safer sex practices.[66]**

The needs assessment revealed that the more 'known' or familiar the sexual partner is (e.g. friends), the less likely it is that condoms will be used. Social theory explains that most people have the belief that certain 'risk' groups outside one's own group are more at risk of HIV, such as prostitutes, drug addicts, the poor or people of certain races.[67] This belief leads to people maintaining a sense of invulnerability to risks, by attributing threat and blame to people identified as 'the other'.[68]

Substance use is prevalent in many clubs and bars in the gay scene. Respondents interviewed in Tshwane reported using alcohol and various drugs recreationally.[69] The most common recreational drugs mentioned were ecstasy, cocaine and khat. One respondent indicated experiencing using drugs as a way to *'increase his stamina and go further'.*[70] **Substances are used to decrease inhibitions.** It seems that substances play a major role in increasing the likelihood that risk-taking behaviour will occur.

Zambia:

The needs assessment on determinants of risk behaviour for MSM and WSW in Zambia was conducted amongst both groups simultaneously by Friends of Rainka Zambia. As only a small percentage of WSW participated in the study, their answers were grouped together with those of the MSM. Therefore the information provided here reflects the beliefs, knowledge and attitudes of both groups.

Sixty-five per cent of the 84 respondents interviewed **recognised engaging in unprotected sexual activity as an important mode of transmission for HIV.[71]** Other modes of transmission they recognised were having sexual contact with multiple partners (78%), engaging in oral sex without barrier methods (22%) and sharing needles (52%).[72] Despite this knowledge **53% of the respondents reported having had unprotected sex with casual partners at some point.[73]**

Most of the respondents reported regularly engaging in unprotected sexual activity.[74] It was not specified to what extent this sexual activity was with their steady partner or with a casual partner.

One-third of the respondents indicated using lubricant every time during penetrative sexual activity.[75] The lubricants most commonly used include water-based lubricants, Vaseline, saliva and baby oil.[76]

Seventy-nine per cent of the respondents indicated having **engaged in sexual activity while being drunk.[77]** Only a third reported having used protection while engaging in sexual activity when drunk.[78] Some respondents also reported using recreational drugs such as marijuana and cocaine, and of those who reported doing so occasionally, 17% reported having had sex while under the influence of drugs, and of these, a third indicated **not using protective measures while having sex when intoxicated.[79]**

Only a third of the respondents reported being willing to use barrier methods when engaging in insertive or receptive anal intercourse.[80]

Reasons mentioned for not using a condom were: trusting one's partner (32%), being otherwise refused by the sexual partner (16%), knowing the sexual partner's HIV status (23%) and thinking that the sexual act was safe (21%).

Thirty-two per cent of the men interviewed in Zambia reported still never having been tested for HIV.[81]

Mozambique:

The needs assessment on determinants of risk behaviour for LGBTI, MSM and WSW in Mozambique was conducted by Lambda amongst men and women simultaneously. Therefore the information provided here reflects the beliefs, knowledge and attitudes of both groups.

Two-thirds of the 38 men and women interviewed in Maputo identified the possibility of contracting HIV or other STIs as their most important health concern.[82] The respondents were found to have a general idea of what STIs were, but did not have specific knowledge of transmission modes and ways to prevent infection.[83]

Swaziland:

In their needs assessment on determinants of risk behaviour for WSW and MSM in Swaziland, SWAPOL–HOOP interviewed 204 respondents in the same provinces, 5% of whom were WSW.

Ninety-five per cent of the respondents indicated knowing that HIV/STIs can be transmitted through same-sex sexual activity.[84] The majority of these respondents also recognised male-to-male sexual activity as more risk-bearing than heterosexual sexual activity. Twenty-two per cent were under the impression that same-sex sexual activity bears a lower risk of getting infected.[85]

Over half of the respondents reported always using a condom. More than a quarter admitted never using a condom and 10% reported using condoms sometimes.

Condoms appear to be the only barrier methods used by the respondents. The respondents who reported irregular or no condom use attributed this to 'condom breakage during use', 'a lack of suitable condoms for WSW' and **'my partner would suspect a lack of trust if I suggest using a condom.'**[86]

Transgender people

Transgender communities are amongst the groups at highest risk for HIV infection. **Behaviours and factors that contribute to high risk of infection with HIV/STIs** amongst transgender people include higher rates of drug and alcohol use, sex work, incarceration, homelessness, unemployment, lack of familial support, violence, stigma and discrimination, limited health-care access, and negative health-care encounters.[87]

Botswana:

The needs assessment on determinants of risk behaviour for transgender and intersex people in Botswana was conducted amongst both groups simultaneously. The information provided in this section includes the views of both groups.

Ninety per cent of all transgender and intersex people interviewed indicated perceiving anal intercourse as the most risk-bearing type of activity in terms of contracting HIV/STIs.[88] Most respondents believed that promoting the use of sex toys would be an effective measure to reduce HIV transmission. Other 'safer' practices mentioned were oral and manual sexual activities. Even though sharing sex toys and engaging in manual and oral practices can be qualified as 'safer' sexual practices, the sexual practices can still bear risks of contracting STIs.

Almost all respondents indicated having engaged in sexual interactions while under the influence of alcohol. A small percentage (18%) indicated having engaged in sexual contact under the influence of marijuana at some point.[89] Of the total number of respondents who had ever engaged in sexual contact while intoxicated, 80% indicated having used barrier methods.[90] Four respondents reported not knowing whether a barrier method was used at the time or not. The needs assessment does not specify exactly which type of barrier methods were used.

Most of the respondents **indicated not being aware of their sexual partners' HIV status prior to engaging in sexual activity with them.** Close to half of the respondents reported not discussing the use of barrier methods with casual partners.[91] Reasons for not negotiating the use of protection are 'feeling ashamed or embarrassed' at having to discuss their gender identity and/or sexual orientation.

Zimbabwe:

The needs assessment on determinants of risk behaviour for transgender people in Zimbabwe was conducted simultaneously with that for gay men, bisexual men and other MSM in Harare. Please refer to the section on lesbians, gay men, bisexual men and women, MSM and WSW for the relevant findings for Zimbabwe.

Lesotho:

The needs assessment on determinants of risk behaviour for transgender and intersex people in Lesotho was conducted amongst 50 respondents: 49 transgender people and one person with an intersex condition.

Twenty respondents indicated being **in a monogamous relationship, and 75% of them admitted never using condoms or other protective barriers when having sex with their partner.[92]** The respondents who indicated being in a non-monogamous relationship indicated irregular condom use with their partner.[93] The **choice not to use or to stop using protection is usually made by the sexual partners together.** However, in many cases, one partner initiates the discussion.

Eighty-seven per cent of all respondents reported having knowledge of HIV prevention and access to education materials.[94] **Seventy-five per cent of the respondents who had had an HIV test at some point reported having had unprotected sex since their last test.**

South Africa:

The needs assessment on determinants of risk behaviour for transgender and intersex people in South Africa was conducted by two partners in several provinces. Gender DynamiX (GDX) interviewed 33 black transgender and gender-nonconforming individuals in KwaZulu-Natal. Transgender and Intersex Africa (TIA) held focus-group discussions with 52 transgender and intersex individuals in the provinces Gauteng, Mpumalanga, Limpopo and North-West. Sixteen respondents were interviewed in Kwazulu-Natal by TIA in face-to-face meetings.

'… I don't use any protection during sex. I can't use male condoms; I'm a transgender man and I have never had any surgery. There are no safe-sex materials available to me, and even if I wanted them I wouldn't know where to get them…' – Transgender man, South Africa

Fifty-six per cent of the 16 respondents interviewed by TIA in KwaZulu-Natal indicated not knowing their HIV status,[95] while 13% reported being HIV positive. Of the 33 respondents interviewed by GDX in Kwazulu-Natal, 27% indicated being HIV positive.[96]

As transgender people become sexually active adults, issues of gender identity and gender-identity confusion can result in sexual experimentation and high rates of risky sexual behaviours.[97] All participants in the needs assessment conducted by TIA indicated that local clinics provide only male condoms and that they did not know of other public facilities where other forms of safer sex materials could be obtained.[98]

The assessments did not reveal to what extent these groups had knowledge and awareness of HIV transmission modes and their probability of contracting HIV/STIs. Both groups of transgender, intersex and gender-nonconforming people interviewed in the two needs assessments showed relatively low levels of education and high levels of unemployment compared to the other groups surveyed in the community-based needs assessments carried out by other organisations.[99] The lack of resources due to unemployment and the lack of education could be important factors influencing the level of knowledge these groups have of both the modes of transmission and the methods for preventing it.

Intersex people

No formal research has been done on the exact HIV/STI prevalence amongst people with an intersex condition. However, unprotected sexual intercourse with female and/or male partners expose people with an intersex condition to the same risks as the other key populations.

For information on determinants of sexual risk behaviour for people with an intersex condition in Botswana, Lesotho and South Africa, please refer to the section on transgender people.

READINESS OF LGBTIS, MSM AND WSW TO ACCESS HEALTH-CARE SERVICES

The second risk behaviour identified by the community-based needs assessments conducted amongst LGBTI communities in Southern Africa is delaying or not seeking health-care services.

Whether or not someone accesses health care is influenced by the ideas and beliefs an individual has regarding his/her probability of being treated in a satisfactory way. Attitudes, knowledge, the society one lives in, the anticipated attitude of health-care providers and the actual availability of adequate health service are important drivers in terms of the readiness of a person to access health-care services. Cultural norms governing how acceptable it is for young people to talk with older adults about sexual activities can also become important barriers for the openness of health seekers towards health-care providers.

Access to health care is important for every individual. The constitution of the World Health Organisation enshrines the highest attainable standard of health as a fundamental right of every human being.[100] The right to health means that states must generate conditions in which everyone can be as healthy as possible. It does not mean the right to be healthy. However, vulnerable and marginalised groups in societies often tend to bear an undue proportion of health problems and therefore may require special attention and health programming.[101]

Negative experiences and/or presumptions about the way in which one will be treated can influence the extent to which individuals are willing to seek health care when needed.

The community-based needs assessments exposed the **fear of being harassed by health-care providers, a lack of trust in the health-care system, the perceived low quality of the services and a lack of funds as the main drivers when it comes to LGBTIs** not accessing or delaying their accessing of health-care services.

This chapter presents an outline of the main determinants for not seeking health-care services by LGBTIs. Since the determinants seem relatively similar for gay, lesbian, bisexual, WSW and MSM, the findings for all these groups will be presented together. The determinants for transgender and intersex people will also be presented together, as the needs assessments amongst those groups were carried out simultaneously by COC's partner organisations. In the following chapters, the data gathered from the community-based needs assessments will be presented in these same groupings.

Lesbians, gay men, bisexual men and women, MSM and WSW

Malawi:

The needs assessment on the accessibility of health care for LGBTI, MSM and WSW in Malawi was conducted amongst men and women simultaneously.

Therefore the information provided here reflects the beliefs, knowledge and attitudes of all groups.

'It is difficult to really say we are discriminated against in the health-care settings because we try our best to hide our orientation.'
– MSM in Lilongwe, Malawi

A quarter of the 67 MSM and WSW interviewed in Malawi admitted to having **felt afraid of seeking health-care services because of their sexual orientation.**[102] All of the participants feared being harassed by the health-care providers or arrested by the police.

Twelve respondents indicated having heard health-care providers gossiping about them because of their sexual orientation when they went to a clinic for treatment.[103]

A tenth of the respondents reported having been **denied or given low-quality health care because of their sexual orientation.**[104] Of this group, four respondents felt that the low-quality treatment was a direct result of the negative attitude the specific health-care provider had had towards LGBTI people.

One-tenth of the respondents reported having **withheld information from a health-care provider due to their fear of revealing their sexual orientation.**[105] Eleven per cent of the respondents indicated having sought treatment for an STI and having revealed their sexual orientation to the health-care providers. Two of these respondents mentioned that the health-care provider had reacted negatively to this information. One respondent indicated having received treatment, but that the health-care provider was very disinterested. The other respondent indicated having been verbally mistreated by the health-care provider after having revealed his sexual orientation.[106]

Botswana:

Over half of the LGB respondents in the needs assessments carried out by BONELA and LEGABIBO indicated that the quality of health-care services was average.[107] Some respondents indicated experiencing the services provided as **discriminatory due to the focus on heterosexual sexual activity only and the reluctance of health-care providers to diligently help LGB clients.**[108]

One-third of the respondents indicated having **experienced hurtful comments made by health-care providers.**[109]

Zimbabwe:

'To me the issue is professionalism or rather the lack of professionalism that you experience from the health-care provider. Nurses can easily downgrade you; they can discriminate you just because you are gay.' – Gay man, Zimbabwe

Over half of the GBTs[3] interviewed reported having used health-care services in the past three years.

The most common positive experience they reported having had with health-care providers was the fact that no inappropriate questions had been asked.[110] Twelve of the GBT who accessed health services reported that the health-care worker had provided them with an opportunity to discuss their gender identity.

The 27 GBT who had accessed health-care facilities reported having several negative experiences such as an **unfriendly environment at the health facility, receiving advice that took no account of the individual's sexual orientation or gender identity and being asked inappropriate and intrusive questions by the health-care provider.[111]**

As the major barriers to their accessing health care, the respondents mentioned the **anticipated negative attitudes** of health-care providers and the perception that health-care providers presume every health seeker to be heterosexual. Health-care providers are most often described by the respondents as discriminatory and stigmatising.[112]

Many respondents mentioned the **fear of being 'outed' by the health-care provider** when seeking medical care. They were of the opinion that health-care workers often fail to maintain confidentiality.

The respondents indicated that, to their opinion, most of the LGBTI people facing challenges with accessing health-care services were socio-economically impoverished and unable to access private clinics. **The provision of services at government clinics and hospitals was reported to be less sensitive to the needs of LGBT people and the professional demeanour of public-service health professionals was perceived to be poor.[113]**

South Africa:

The needs assessments held amongst lesbians and WSW in Tshwane and Western Cape revealed that there is **no regular testing for HIV and STIs within this group.** Even though no specific research was done on the perception of lesbians and WSW regarding health-care services, the societal context gives reason to assume that lesbians and WSW are less likely to seek health-care service for health issues related to their sexual identity and orientation due to **internalised homophobia and the presumption of homophobic attitudes amongst health-care workers.**

It can be inferred from the respondents' decision-making around safer sex practices that they continuously undermine their own self-worth.[114] Lesbians and WSW in South Africa in general are pathologised and seen as unnatural, immoral, deviant, and inferior. Given these prevailing attitudes, many WSW have experienced some form of rejection or another by society, family and friends because of who they are. Furthermore, many WSW have internalised and generalised this rejection to some degree, often at an unconscious level. It has been argued that **internalised homophobia plays a central role as a predisposing and perpetuating factor in various aspects of ill health and may affect health-related decision-making processes that could have a significant effect on the prevention of illnesses such as STIs / HIV.[115]**

3 - In this case: gay men, bisexual men, other MSM and transgender women.

Stigma and discrimination against the LGBTI community in South Africa are still prevalent. Nearly half of the women interviewed in Western Cape indicated having **experienced harassment in a public place other than their neighbourhood.**[116] Even though the legal environment is welcoming and positive towards LGBTIs, the reality is poignant. Many of the lesbians and WSW who took part in the needs assessments conducted by OUT, the Durban Centre and Triangle Project reported experiencing discrimination and stigma in everyday life. Their presumptions about the attitudes of health-care workers – based on the experiences with other individuals in the public sphere – may heavily influence the readiness of lesbians and WSWs to seek health-care services when needed.

Of the total number of women interviewed by OUT in Tshwane, over a third indicated having a low income.[117] It can be concluded from their answers that most of these women have no health-care insurance and thus cannot make use of private health facilities, which are sometimes known to be more LGBT friendly.

'I am nervous about being tested… I don't feel comfortable going for the test.'
– Gay man, South Africa

The needs assessments carried out amongst gay men, bisexual men and MSM in Tshwane and KwaZulu-Natal, respectively, revealed that there is **no regular testing for HIV and STIs within this group.** The assessments did not focus specifically on how these men perceive health-care services or on their reasons for not accessing those services.

The researchers who conducted the needs assessment in Tshwane reported getting the impression that the men they interviewed appeared to be **apathetic and disinterested in taking responsibility for their own sexual health and well-being.**[118]

Given these circumstances, it could be assumed that accessing health services and undergoing HIV/STI testing could be confrontational for the men since the information they might receive could reveal their secret sexual activities to their steady partner. This could be an important reason why these gay men fail to access health-care services.

Zambia:

Thirty-five of the 109 LGBT respondents indicated that their **sexual orientation played a big role in their hesitance to seek health care.**[119] However, 71% reported never having been denied health-care services or access to barrier methods due to their sexual orientation. However, it is not clear whether those respondents had disclosed their sexual orientation while seeking these services.

Forty-three per cent of the respondents reported having experienced that health-care providers gossiped about them when they tried to access health-care services.[120] Many respondents also indicated fearing being reported to the authorities when they try to access health-care services.[121]

Although health-care services are available to many respondents and the majority of the respondents reported not having been denied access to health-care services, **the perceived fear of being stigmatised, discriminated against and talked about by health-care providers** has formed an obstacle to the meaningful use of these services by many LGBTIs.

The respondents gave several reasons for not accessing services, such as the fear of being stigmatised, denied treatment or outed to the community, but also practical barriers such as the cost of travelling to the clinic.[122]

Mozambique:

All respondents indicated that health care should be sought whenever needed and reported having visited public-health facilities for their health needs. However, when asked whether the **health facilities respond to their needs as LGB people, 95% indicated that they did not.**[123] Respondents showed a preference not to disclose their sexual orientation to health-care providers. They indicated not presenting themselves as LGB when seeking health care.[124]

Thirty-one per cent of the respondents reported having experienced poor treatment and discrimination from health-care providers and **having felt that the health-care providers were not prepared to deal with LGB clients.**[125]

Swaziland:

Seventy-four of the 91 women interviewed by Rock of Hope in 2013 reported using public-sector clinics for their health needs.[126] Fifty-four respondents indicated that they had needed health care at some point in the previous six months, yet 36% of these had refrained from actually seeking health care due to their **fear of being stigmatised and to the discrimination they had experienced in the past.**[127] The prevalent feeling was that the **care they would receive would not be adequate anyway.**

Many respondents identified the negative attitude they usually face or expect to face from health-care providers as the main reason for not going in for HIV testing and counselling.[128] They indicated **having lost their trust in the health-care institution.**[129] A small percentage (12%) indicated not having sought health care due to a **lack of money to pay for the treatment.**

Of those who did receive health care, a third **reported not being satisfied with the service** they got – mainly in public-health centres – because of the discriminatory attitudes of the health-care providers.[130] Three-quarters reported not having disclosed their sexual orientation or sexual practices to the health-care providers for fear of being discriminated against. Some respondents reported having experienced hearing the health-care providers gossiping about them.

Other respondents admitted not having disclosed their sexual orientation because they felt ashamed of who they are and because they were under the impression that homosexuality[4] is criminalised and they feared being arrested or outed to their families.[131]

Close to 15% of all respondents reported having been denied health-care services due to their sexual orientation and practices.

Transgender and intersex people

Botswana:

The needs assessment on determinants of risk behaviour for transgender and intersex people in Botswana was conducted amongst both groups simultaneously. The information provided under this section includes the views of both groups.

'The last time I attempted to visit a clinic in order to have a Pap smear, I was sent away because of my manly appearance. The nurse said that since I look male I could not have a Pap smear. I never went in again for another consultation.'
– Transgender man, Gaborone

Over half of the transgender and intersex people interviewed admitted not accessing health-care services, such as voluntary HIV testing, due **to their fear of stigma, discrimination and humiliation by service providers** based on their gender identity.[132]

A tenth of the respondents indicated **that services had been denied to them after they disclosed their gender identity and sexual orientation.**[133] The assessment found that most transgender and intersex people interviewed were **discouraged from seeking health care due to the unsatisfactory service they had received from service providers in the past.**[134]

Most respondents reported preferring to ask a friend for advice than to approach a service provider when confronted with a medical issue.

Zimbabwe:

The needs assessment on the accessibility of health-care services for transgender people in Zimbabwe was conducted simultaneously with that for gay men, bisexual men and other MSM in Harare. Please refer to the section on lesbians, gay men, bisexual men and women, MSM and WSW for the relevant findings for Zimbabwe.

Lesotho:

Thirty-four of the 50 respondents reported having had an HIV test at some point.[135] Forty per cent of the respondents did not feel the need to have (or repeat) a test since they felt healthy. Some respondents admitted fearing doing a new test because they were **afraid the test results would be positive.**

Most of the respondents reported having accessed health services in the past year. The respondents who did not access health-care services attributed this to their transgender identity and their **fear of how health-care providers would react.**

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4 - Homosexuality is not criminalised in Swaziland. According to common law, sodomy is criminalised, which is defined as sexual intercourse between two men. The mere fact of being homosexual does not constitute a criminal offence.

As most employees in rural health centres are local residents, transgender people are **afraid that such employees might break their confidentiality oath** and discuss their issues with other residents.

Additional reasons that respondents gave for not accessing health-care services were a **lack of trust in the health-care providers and a lack of money for travelling to the health-care facilities.**[136]

As some of the health centres are owned by the Christian Health Association of Lesotho (CHAL), many transgender people choose not to visit these health facilities out of **fear of being judged on religious grounds.**[137]

South Africa:

Almost all of the 33 respondents interviewed by GDX in KwaZulu-Natal reporting **having no medical insurance.**[138] Eighty-eight per cent nevertheless indicated having a health-care provider and being out to that person.[139] Of those who had a health-care provider, only 19 respondents reported feeling that that person was knowledgeable about transgender and gender-nonconforming issues.

The respondents in KwaZulu-Natal reported having **difficulty talking openly to health-care providers about their sexual health due to age differences and cultural norms that prohibit young people from talking about sex with people of an older generation.**[140]

In the focus-group discussions carried out by TIA, the respondents elaborated on the reasons that make them hesitant to visit health-care facilities. Twelve participants from Mpumalanga province admitted **not trusting their local clinic's nurses with confidential information,** because the nurses reside in the same village and could tell others in the community about their private health matters.[141]

Thirty-five respondents in the focus discussion groups in Gauteng province mentioned being **uncomfortable at local clinics because the nurses and doctors did not have any knowledge of transgender issues.**[142]

AWARENESS OF THE AVAILABILITY OF ADEQUATE HEALTH-PROMOTION SERVICES FOR LGBTIS, MSM AND WSW

Health promotion includes health-related activities such as health education and health-care services. Health-care services and education can be considered to be adequate when they are competent, non-discriminatory and sensitised. One of the key factors behind the actual uptake of health-care services is an individual's **knowledge** about where and how to access these services. In other words, access to health-care services also involves knowing where adequate health care can be obtained.

Lesbians, gay men, bisexual men and women, MSM and WSW

Malawi:

Most of the 67 MSM and WSW interviewed were **aware of the existence of STI-treatment clinics at government hospitals.**[143] Three respondents mentioned not knowing about such clinics. Ninety per cent of all respondents indicated **not knowing of any clinics that are specifically MSM/WSW friendly.**[144] Only in the city of Blantyre did some respondents express a willingness to visit the Johns Hopkins clinic there if they had an STI because they knew that clinic was MSM/WSW friendly. However, an interview with the health-care providers at the Johns Hopkins STI clinic revealed that the uptake of services at the clinic has not improved over the past two years.[145] They reported seeing no more than one LGBTI client a month and that those clients almost never bring along their sexual partners.[146]

With regard to general health-related information, participants get their information primarily from the media (i.e. radio, newspapers and TV), the Internet, CEDEP, schools and government health facilities.[147] Thirty respondents (45%) reported getting information about health-related issues concerning their sexual orientation or practice from CEDEP.

The rest of the respondents reported having no specific resources other than discussing things with fellow MSM/WSW, who are also not very knowledgeable about these issues. Fourteen participants (21%) said they knew where to access general counselling services.[148] All the participants said they would want to receive health information specifically related to their sexual orientation and practices. This information included knowledge about the transmission and prevention of STIs, about safe sexual practices and about how to deal with relationships.

Zimbabwe:

The LGB respondents, all of them members of GALZ, appear to be quite well informed about HIV prevention and care.[149] Most of those interviewed mentioned obtaining their information about HIV/AIDS prevention from NGOs.[150]

While it was not specified which NGOs those are, they can be assumed to be NGOs that focus on HIV prevention. The rest of the respondents reported receiving relevant information either from GALZ or from the media.

Seventy-three per cent of the GBTs interviewed by the Sexual Rights Centre reported having **knowledge of community-based organisations that offered services specifically for their group.**[151]

These respondents reported that they **access health information from community-based organisations that work specifically with the LGBTI community.**[152] These organisations are the Sexual Rights Centre and GALZ. The commodities and information that the respondents in both assessments considered to be most important were condoms, lubricants and information on STI/HIV prevention and care.

South Africa:

The needs assessments conducted amongst lesbians and WSW in South Africa did not focus on the availability of health care for this specific group. The lesbians and WSW interviewed in KwaZulu-Natal reported receiving information about HIV/STI prevention from a gay and lesbian organisation but that this information is not specifically targeted towards WSW.[153] The women in Tshwane indicated receiving their information from reading general information on HIV/STI prevention and from communication provided by OUT.[154]

In KwaZulu-Natal only 18% of the men interviewed reported having had access to information about HIV/STI prevention specifically targeted towards MSM.[155]

OUT has scaled up its outreach activities and its dissemination of HIV/STI prevention materials and commodities. OUT and the Durban Centre have an in-house clinic that gay men can visit for counselling and testing. The uptake of these services indicates that a growing segment of the gay community in Tshwane and KwaZulu-Natal is becoming increasingly aware of the availability of health-care services.

Zambia:

Most respondents who reported being aware of voluntary counselling and testing centre services and 24% were aware of the existence of HIV support groups. A low percentage (24%) was aware of where they could access STI-related services in their communities.[156]

Sixty-three per cent of the respondents indicated having accessed health services in their community at some point.[157]

Swaziland:

The majority of the 143 men interviewed said they knew their HIV status.[158]

Only a quarter of the respondents said they knew where to access health-care services that catered specifically to their needs as LGB people.[159] Seventy-five per cent of all respondents reported having accessed health-care services in public hospitals.

Most respondents (87%) reported accessing HIV-related services; only 3.5% reported having accessed STI-related services.[160] The difference between the number of respondents who indicated knowing where to access special services and the higher number of respondents who said indicated accessing such services, could mean that many LGBs choose to access health services despite not recognising these services as being MSM/WSW friendly.

Transgender and intersex people

Botswana:

The respondents interviewed indicated not knowing of any transgender friendly public clinics in Botswana.[161]

Lesotho:

The needs assessment in Lesotho focused mainly on the accessibility of HIV education and prevention materials for transgender and intersex people in that country. The research shows that the target group is able to access information on HIV/STIs widely, but that the information does not include any reference to their gender identity.[162]

There is no information on the accessibility of hormonal therapy for individuals in transition, nor is there any on the accessibility of gender-reassignment surgery.

South Africa:

'I am a transgender person and I have never seen any information about HIV that is specifically written for transgender people. Most of the information is about gays, and some of it is about lesbians, but there's nothing on transgender people.'
– Transgender woman, Limpopo, South Africa

In South Africa, only 16 of the 381 public hospitals are capable of performing sex (re) assignment surgery.[163] In **two-thirds[164] of the provinces** there are no facilities **for transgender people and people with an intersex condition.**

Respondents mentioned that there are several challenges impeding a consistent uptake of hormonal therapy. As one respondent explained: '*you are lucky if you get your hormones… Sometimes you get there and they say there are no hormones… [as they] are saving those for cancer patients.'*[165] Considering that hormonal therapy is not available in many provinces, transgender patients are forced to travel to Gauteng or Cape Town to receive this medical service.[166]

LEGAL AND SOCIAL ISSUES INFLUENCING THE UPTAKE AND PROVISION OF HEALTH-CARE SERVICES TO LGBTIS, MSM AND WSW

The uptake of health-care services by LGBTIs is influenced by individual and environmental determinants. Individual factors that influence behaviour include things like not knowing about the existence of health services or where to access them but also someone's personal beliefs about how he/she will be treated there. Environmental factors such as the social climate in which one lives and the actual attitudes and practices of others in relation to him/her are of equal influence on the individual's behaviour.

The social and legal climate in a country influences the attitudes and practices of both LGBTIs and health-care providers, since both groups live in the same society. This chapter gives an impression of the social reality for LGBTIs in each country.

The legally stipulated availability of health-care services in a country is not the only thing that determines whether those services will actually be accessible for every individual. Aside from personal beliefs and knowledge, which can influence an individual's likelihood to access health care, there are also societal challenges that can form significant obstacles. A country's legal climate in relation to LGBTIs can make those people afraid to access health-care services. In the same way, it can make health-care providers afraid to provide such services. Social factors such as the stigma and discrimination that LGBTIs face within the communities in which they live but also the social pressure from their peers may likewise be drivers that influence the behaviour of individuals.

The community-based needs assessments conducted by COC's partner organisations gathered information and provided a context scan of the social and legal realities for LGBTIs in Southern Africa. The LGBTI organisations chose to highlight the most important issues for those communities on which they focused in these needs assessments. This is therefore not a complete[167] overview of all issues that may confront LGBTIs within the specific countries.

Lesbians, gay men, bisexual men and women, MSM and WSW

Malawi:

'If you are gay, you cannot seek legal aid against anyone who has violated your human rights because the government does not believe you exist.'
– MSM, Lilongwe, Malawi

According to the Malawian penal code, anyone who *'has carnal knowledge of any person against the order of nature […] or permits a male person to have carnal knowledge of him or her against the order of nature*' commits an 'unnatural offence', a felony, which, on conviction, is punishable by a 14-year prison term.[168]

All 67 respondents felt that their **rights to health care, and therefore to life, are not protected by the laws of their country.**[169] The participants felt that they would be open towards health-care providers if the laws were not discriminatory against them.

The fear of accessing health-care services is also driven by homophobia in the broader community. Even though the Malawian penal code only criminalises same-sex sexual activity,[170] **individuals suspected of homosexuality can be arrested without proof of having committed any actual criminalised act.** In Lilongwe, two girls were arrested and incarcerated for one full year based on suspicions regarding their sexual orientation. After being released they lodged a complaint and received a very low monetary compensation. They dropped the case because no one seemed to be interested in it.[171]

Almost all of the respondents reported instances of **verbal abuse from strangers and acquaintances.**[172] The needs assessment found that there are no legal facilities available to protect sexual minorities in Malawi.

Botswana:

Same-sex sexual activity is criminalised in Botswana by the country's penal code.[173] Having *'carnal knowledge of any person against the order of nature'* makes an individual guilty of a criminal offence and liable to imprisonment for up to seven years. In 2003, the Botswana Court of Appeal ruled that the **conviction of a man for sodomy and unnatural sex under the penal code was constitutional, non-discriminatory and not in violation of the rights of homosexual people.**[174]

This ruling fuelled fears within the LGBTI community in Botswana since it proved that people who engage in same-sex sexual activity can actually be prosecuted. The case essentially endorsed homophobia in Botswana.

Most of the respondents interviewed indicated experiencing discrimination by strangers and family members in daily life. Respondents indicated having been **insulted by strangers and being made fun of due to the way they dress.**[175]

Zimbabwe:

'Considering the law in Zimbabwe I will not disclose my sexual orientation to a health-care worker, because I am afraid they will call the police and I will be charged for practising homosexuality.'
– Gay man, Zimbabwe

The Zimbabwean common law criminalises *'Any male person who, with the consent of another male person, knowingly performs with that other person anal sexual intercourse, or any act involving physical contact other than anal sexual intercourse that would be regarded by a reasonable person to be an indecent act.'*[176] *Individuals engaging in this activity 'shall be guilty of sodomy and liable to a fine up to or exceeding level fourteen or imprisonment for a period not exceeding one year or both'.*[177]

The criminalisation of same-sex sexual acts drives the homophobia in the country. Even though the penal provision only speaks to male-to-male sexual activity, there is also ample discrimination against lesbians.

Three-quarters of the 50 GBTs interviewed reported having experienced stigma and discrimination based on their sexual orientation.[178] Thirty-eight of the respondents admitted **feeling that they had to conceal their sexual orientation or lead a double life as a consequence of the stigma they experience.[179]**

Strangers, neighbours and church members were identified as the most common perpetrators of discrimination. Only 4% of the respondents indicated experiencing health-care workers as a common perpetrator of discrimination. This can possibly be explained by the low numbers of respondents that reported having visited a health-care facility in the past three years.[180]

Thirty-nine per cent of the respondents indicated having experienced violence due to their sexual orientation. Only a few reported having sought help from the police following these attacks. **All the respondents who reported having been attacked also reported having experienced mental distress as a result of this.** Only six of these victims reported having sought medical help for their mental distress.

South Africa

'They hate us. I don't understand why they hate us… Why can't they just let us be ourselves?' – Lesbian, South Africa

South Africa has the most welcoming and liberal constitution in Southern Africa when it comes to the place of LGBTI people in the society. The 'equality' clause in the constitution protects everyone and specifically includes sexual minorities. The constitution further instructs that legislation should be enacted that will prohibit discrimination. This has resulted in an enabling legislative framework. However, the social reality of many LGBTI communities is daunting.

Half of the 89 respondents in KwaZulu-Natal reported having experienced some kind of discrimination towards them, usually in a public place. The women reported mainly having experienced **verbal violence (59%) and in some cases physical attacks.[181]** Eighty per cent of the women who indicated having experienced violence did not report that to the authorities. The most prevalent reason they mentioned for not reporting it was because they did not see any point in doing that.[182]

Especially black lesbians in South Africa seem to experience high levels of discrimination due to their sexual orientation. 'Even without physical violence, black lesbians generally are marginalised by their families and communities for their sexual identity. They are told they are being un-African if they do not live a heterosexual lifestyle. But beyond this prejudice, they are often singled out and targeted by men who use rape as a twisted form of "therapy". The term "corrective rape" has been coined to describe this particular type of hate crime, because the rapists claim that they are acting in the lesbian's best interest, by "teaching her to behave like a woman".[183]

Some of the respondents in the needs assessment for Western Cape identified the **fear of death due to violence as an issue of major concern.**[184] They also expressed the fear of being harassed, verbally abused and raped. The powerful effect of this threat can determine how lesbians live their lives.

Even though rape is common in South Africa and unfortunately affects many women, it is interesting that most of the respondents specifically indicated knowing that their perpetrators are 'homophobic'.[185]

Stigmatisation leads to women not being open with their health-care providers about their sexual orientation.

Half of the 57 men interviewed in KwaZulu-Natal indicated having experienced discrimination due to their sexual orientation.[186] Only 7% of those men indicated having reported such incidences to the authorities. The men reported being confronted most often with **verbal discrimination.**[187]

Social stigma and discrimination against LGBTIs is common in South Africa. LGBTI identities are often seen as un-African and frivolous. Unofficial statistics show that gay men in South Africa experience a lesser degree of physical violence than lesbians in the country. Recently, however, more violent attacks on and rape incidents of gay men have been reported.[188] The University of South Africa in Johannesburg has reported that according to studies carried out in three of the nine provinces of South Africa, gay men are victims of homophobic sexual assault as frequently as lesbians are; the studies suggest that under-reporting by male victims and in the media has created the perception that they are at less of a risk of falling victim to the crime.[189] As with female victims, gender-nonconforming gay men are thought to be at the highest risk of violence.[190]

Zambia:

The Zambian penal code deems it illegal to engage in same-sex sexual activities. These activities are defined as *'acts against the order of nature'* and *'unnatural offences'*.[191]

According to the Zambian penal code *'Any person who (a) has carnal knowledge of any person against the order of nature; or [...] (c) permits a male person to have carnal knowledge of him [...] against the order of nature; commits a felony and liable [sic], upon conviction, to imprisonment for term not less than fifteen years and may be liable to imprisonment for life.'*[192]

A quarter of the total respondents indicated having experienced discrimination by members of the general public or by the police.[193] Recently, there have been increasing reports of violence towards LGBT individuals in Zambia. In January 2014 a self-identified gay men was beaten up by a mob in the street, which allegedly included three police officers who threatened to 'un-gay' him.[194]

Several men have been arrested in Zambia on counts of engaging in same-sex sexual activity.[195] When the human-rights defender Paul Kasokomona appeared on *Muvi TV* in 2013 to discuss LGBT and HIV issues, he was arrested as he left the television station. He was charged with 'soliciting in a public place for immoral purposes'.[196]

Mozambique:

The legal status of same-sex sexual activity is ambiguous in Mozambique. There are no explicit laws against homosexual sex, and on March 2011, the Minister of Justice declared during the UN Human Rights Council's Universal Periodic Review that homosexuality is not an offence in Mozambique.[197] Nevertheless, the current penal code still contains an offence of 'practices against nature'. In the new draft of the Mozambican penal code, all reference to 'practices against nature' have been removed.[198]

The commission in charge of the review of the penal code did not make discrimination against LGBT people a crime. The article on discrimination makes offences against people based on race, sex, religion, age, ethnicity, disability or nationality punishable with up to a year's imprisonment. Rights groups want to add 'sexual orientation' to this list, but have so far been unsuccessful.[199]

Swaziland:

Sodomy remains a crime in Swaziland according to the Roman-Dutch common-law instated there by South Africa in 1907. These laws have yet to be repealed, which means they are technically still in effect and could possibly be used to prosecute individuals under their provisions.[200] As common law is a legal tradition based mainly on precedent court verdicts, there is no codified anti-sodomy provision in Swaziland as yet.

Sodomy was a crime under the 1907 common law, punishable either by death or a lesser punishment, at the discretion of the court. By the mid 20th century, 'sodomy' in South Africa had been defined by its courts as 'unlawful and intentional sexual relations *per anum* between two human males.'[201] This effectively criminalises male-to-male sexual activity. While there is no specific provision on female-to-female sexual activity, societal homophobia against lesbians is nevertheless widespread.[202]

The needs assessment carried out by Rock of Hope involved interviews with the target group on the factors that they experience as barriers to living openly as themselves in the community. The barriers they mentioned were social norms such as the expectancy that a girl will get married and procreate, Christian beliefs and the fear of not being able to come out to anybody.[203]

Some respondents admitted feeling that homosexuality is not normal and that something was wrong with them.[204] They indicated sometimes wishing they were heterosexual or faking heterosexual relationships in order to please their families.[205]

The respondents' perceptions indicate that there is a lot of discrimination and stigma in the health-care sector. While there has been no research on the level of stigma and discrimination experienced in public areas, based on the answers provided, it could be concluded that LGBs often feel unaccepted in the community.

Transgender and intersex people

Botswana:

The national laws and regulations of Botswana are silent or at most ambiguous regarding transgender and intersex people.[206] However, several laws are used to criminalise the gender-nonconforming behaviour of transgender and intersex people. They can be prosecuted on the basis of provisions against public disturbances and cross-dressing.[207]

Transgender individuals are often perceived to be LGB people, due to their gender-nonconforming appearance. They often are victims of stigma and discrimination due to their perceived sexual orientation.[208]

Many of the transgender respondents indicated not knowing how to seek redress or assistance when discriminated against, because the law is silent as to the existence of transgender people.

Due to the lack of recognition of transgender and intersex people in national health policies, there is a shortage of information regarding sexual-health matters, HIV/STI prevention and modes of transmission for these specific groups.

Hormonal therapy for transgender individuals is available at some private clinics. The treatment is costly, however, and the private clinics providing this therapy are situated mainly in the capital.

Often only gender-affirming therapy is available in the form of hormonal therapy. There are no clinics that offer gender-reassignment surgery.

There is no clear legal stance on transgender people seeking to undergo affirming hormonal therapy in order to transition into the gender they most affiliate with. It is not unlawful for individuals in transition to access oestrogen or testosterone in order to develop secondary sexual characteristics. However, this legal vacuum exposes transgender individuals to other challenges, such as the lack of a procedure to be followed when it comes to amending identity cards or birth certificates.[209]

Transgender people face an impossible task of having their national registration documents amended to reflect the gender they live in. Identity cards that conflict with the perceived gender of these individuals often lead to discrimination and harassment of transgender individuals.

There are also no guidelines in place governing how health-care workers must operate when faced with a new-born intersex babies.[210] This results in little or no documentation of intersex people, nor any follow-up of their medical health.

Cases of individuals who were operated on at birth to be assigned a particular gender have been reported to Rainbow Identity Association. However, there are no procedures or legal recourse for individuals who might want to reverse the effects of incorrect surgeries at birth.

Lesotho:

Transgender people in Lesotho are often perceived to be LGB people, which exposes them to harassment and prosecution based on the country's anti-sodomy laws. The criminalisation of sodomy gives rise to stigma and to discrimination against LGBTI individuals.

Sodomy remains a crime in Lesotho according to the Roman-Dutch common law instated there by South Africa. These laws are yet to be repealed, which means they are technically still in effect and could possibly be used to prosecute individuals under their provisions.[211] Sodomy was a crime under the common law, punishable with either death or a lesser punishment at the discretion of the court. By the mid 20th century, 'sodomy' in South Africa had been defined by its courts as 'unlawful and intentional sexual relations *per anum* between two human males.'[212]

Transgender people are not recognised in any health policies in Lesotho.[213] Even though there are health facilities that treat transgender people (most of which are private), there is a major lack of clarity about which procedures to follow.

Health-care providers have no guidelines for prescribing medications for hormone therapy. Many of the health-care providers interviewed expressed the need for clear regulations and legislation to control the medications that are needed for transgender people wishing to transition.

South Africa:

'We do not understand ourselves. When I'm with my friends, I can't tell them I am a transman. They label me as butch…, but I feel like a transman. So I define myself as butch, society labels me as butch. So we are also confused about our sexuality.'
– Transgender man, KwaZulu-Natal

Hospitals within the five South African provinces that were the focus of the needs assessment that TIA carried out have no guidelines or protocols for transgender and intersex patients.[215] The absence of such specific protocols **creates an environment where transgender and intersex patients can be mistreated and medical service providers can abuse their power.** Most public-health facilities use the requirement of 'long-term experience living in the preferred gender' as a criterion for approving of hormone therapy and gender reassignment surgery.[216] However, due to the lack of guidelines, it is often unclear what counts as 'long-term experience' and the 'preferred gender' can be influenced by the psychologist's gender stereotypes.[217] There is also a lack of doctors with knowledge of adult intersex cases.

Some transgender respondents admitted feeling afraid of being 'found out'.[218] They expressed a need for **help in understanding who they are and what their sexual identity is.** During the interviews in KwaZulu-Natal it became clear that there is a lot of transphobia within the LGB community itself. It was reported that transgender people are perceived by the LGB community as being 'over the top' and attracting unnecessary and negative attention to the LGB community.[219]

South Africa's constitutional clause attributes importance to sexual orientation but does not specifically refer to gender expression and identity. The focus therefore lies on the LGB communities only, excluding transgender people.[220]

The unemployment rate amongst the transgender and intersex respondents in both needs assessments was high.[221] Many respondents had had little education and mentioned the discrimination and prejudice in schools that prevented them from completing their schooling careers.[222] The lack of a higher level of education often translates into enhanced difficulties when it comes to securing jobs.

Sixty-five per cent of the respondents in the needs assessment done by TIA admitted **not feeling safe as transgender and intersex people in townships or rural areas because of the discrimination they experienced.**[223] The intersex respondents reported being afraid to disclose their intersex condition to others out of fear of how they would react.

None of the 52 participants in any of the focus-group discussions led by TIA indicated being willing to report a case of violence against them. **They said they would fear being mocked by the police or being subjected to wrongful arrests and placed in the wrong holding cells.**[224]

Zambia:

The criminalisation of same-sex sexual activity by the Zambian penal code and the homophobic attitudes prevalent in Zambian society expose transgender and intersex individuals to legal risks, stigma and a pressure to conform to normative behaviour.[225] The criminalisation of same-sex sexual activity is a liability for many transgender and intersex individuals who – while not personally identifying as gay or lesbian – often are perceived to be homosexual.[226]

KNOWLEDGE, ATTITUDES AND PRACTICE OF HEALTH-CARE PROVIDERS TOWARDS TO LGBTIS, MSM AND WSW

The previous chapter provided a concise overview of the legal and social context in which both LGBTIs and the health-care providers employed at health-care clinics in their country live.

Many of the LGBTI, MSM and WSW respondents interviewed voiced a fear of accessing health-care services due to experienced or anticipated negativity from health-care providers regarding their sexual orientation and/or gender identity.

The (negative) attitude of health-care providers or other service providers towards LGBTIs, MSM and WSW may be driven by several factors. A person's unfamiliarity with the issue, his/her (mis)perceptions about the legal constraints and/or his/her personal beliefs can become obstacles for an adequate provision of health care.

The community-based needs assessment conducted amongst health-care providers aimed to get to the root of the main factors that influence how health-care providers behave towards LGBTI clients. The health-care providers interviewed mentioned experiencing their **lack of knowledge about LGBTI-specific health needs and LGBTI identities, their personal beliefs about LGBTI identities, the lack of resources and the legal situation in their countries** as important barriers to an effective provision of health care to LGBTI clients.

Malawi:

The 27 health-care providers interviewed in Malawi were employed at government hospitals, a prison hospital and at the Johns Hopkins STI clinic in the cities of Mzuzu, Blantyre and Lilongwe.

'You do not give a child bread without expecting him to eat it; so do you expect us to be advocating 'sodomy' by supplying the prisoners with condoms?'
– Health-care provider, Chichiri Prison

The health-care providers interviewed at Chichiri Prison also considered themselves to be law enforcers. These respondents indicated that the law requires them to arrest anyone who practises same-sex sexual activities, while **as health-care providers they are required to help everyone, regardless of their sexual orientation.** This leads to a conflict in their duties as service providers.

The health-care providers reported that there is a high prevalence of HIV among male prisoners at Chichiri Prison. The facility has a system that allows for all prisoners to be tested for STIs upon being admitted. This system has revealed that prisoners have become infected in the prison facility and suggests that same-sex sexual intercourse is prevalent in the prison.

Even though there are a significant number of prisoners who go to an ART clinic in the prison and even though there have been cases of rape, the prisoners are not supplied with condoms and lubricants.

The health-care providers said they consider it **unlawful to supply these commodities to the prisoners since all prisoners who are found engaging in same-sex sexual activity will be sentenced to another 14 years for practising sodomy.**[227]

The health-care providers admitted that they report all cases of prisoners showing signs of STIs that were most probably contracted from sexual contact with another man.[228] The health-care providers indicated that they would **continue to treat the MSM/WSW as criminals until the laws of the country change.**[229]

Twenty-three health-care providers interviewed in Mzuzu and Blantyre were aware of the existence of the National HIV Policy (NHP),[230] while the four health-care providers interviewed in Lilongwe were unaware of the existence of this policy. None of the respondents were aware of the fact that the NHP contains information about HIV prevention and HIV/AIDS treatment to people engaging in same-sex sexual activity.

The three health-care providers working at the Johns Hopkins research facility had a good knowledge of the HIV prevalence amongst MSM and the specific risks they face.

These health-care providers indicated that it is **difficult to control STIs amongst MSM because they engage in sex with a network of sexual partners, such that it is possible for one person with an STI to infect the whole network.**[231]

The health providers in Lilongwe and Mzuzu did not think MSM/WSW had any more-specific health needs than what can be covered by general health-care services and HIV/STI prevention. However, they did think that the fact that MSM/WSW cannot reveal their sexual orientation to their clinician hinders the latter from providing them with the best available care.

Botswana:

The 53 health-care providers who were interviewed about their knowledge of and attitude towards LGB health issues were employed at public and private health facilities as well as at NGOs in the cities of Francistown, Gaborone, Lobatse, Maun and Mochudi. The 30 health-care providers interviewed about their knowledge of and attitude towards transgender and intersex issues were employed at private clinics in Gaborone that were focused on HIV/AIDS-prevention and HIV/AIDS-care services.

Sixty-six per cent of the health-care providers interviewed about LGB health issues felt that their **health-care services catered to everyone because they were free and non-discriminatory.**[232]

Most respondents indicated **not having had any experience with clients who were in same-sex relationships.**[233]

A majority of the respondents indicated feeling that LGB people choose to engage in same-sex sexual activities and relationships. On a positive note, 64% felt that society must be accommodating to these groups.

Nineteen per cent of the respondents indicated not knowing of any barrier methods that LGB individuals could use. **Forty-one per cent was under the impression that LGBs do not practise safe sex.**[234] The main reason given for the perceived lack of protection was that barrier methods were not widely available to LGBs. Twenty-nine per cent thought that LGBs did not feel that protection was necessary.

Eighty-six per cent of the health-care providers who were interviewed on transgender and intersex issues expressed feeling that the **lack of literature and background information** on transgender people and those with an intersex condition prevents them from being able to provide the best possible service to these groups.[235]

All of the health-care providers interviewed by Rainbow Identity Association expressed that their work ethic and service-delivery guidelines are non-discriminatory towards all people and that transgender and intersex individuals should feel comfortable in accessing whatever services they need.[236]

Half of the respondents interviewed on transgender and intersex health needs acknowledged perceiving these groups as being extra vulnerable in terms of contracting HIV/STIs due to the fact that the specific barrier methods needed by these groups are not readily available.

Lesotho:

In Lesotho, the 15 health-care providers who were interviewed on their attitude towards and knowledge of transgender and intersex health needs were employed at private health facilities in Leribe, Mafeteng and Maseru.

'When I am on leave, transgender clients cannot access services; many health-care providers are still embarrassed when they encounter a transgender client who has special needs. Some health-care providers get openly shocked and that makes transgender clients uncomfortable.'
– Health-care provider, Lesotho

The health-care providers interviewed indicated noticing that many of their colleagues lack any knowledge of transgender issues.[237] Their unfamiliarity with this group also leads to judgmental attitudes.

Six of the 15 health-care providers interviewed indicated having transgender or gender-nonconforming clients. Five of these indicated treating their transgender clients like any other clients, while one admitted initially having felt inadequate about transgender people, but said that after receiving a sensitisation training from Matrix Support Group, he now felt more comfortable.[238]

All health-care providers who had transgender clients indicated **having a friendly professional relationship with their clients and not experiencing it as a challenge to offer services to them, as long as the transgender clients were open about their needs.**[239]

Four health-care providers admitted not being convinced of the necessity to improve or change anything around their services. They indicated feeling that **every resource and service is available and that it is the transgender people who are not accessing them.**[240]

Some health-care providers reported that due to the lack of resources and qualified staff, village health-care workers are often asked to assist the professional health-care workers. These village health-care workers are not professionally qualified. They notice that patients often shut down and become uncomfortable when confronted with unqualified staff because they fear that there will be no confidentiality.

The lack of resources also means a **lack of appropriate equipment to be used in order to cater for the needs of transgender people.**[241] The respondents indicated that they often find that the hormones necessary for hormone therapy are out of stock.

South Africa:

The needs-assessments conducted by OUT, Triangle Project and the Durban Centre, respectively, among lesbians, gay men, bisexual men and women, WSW and MSM did not target health-care providers. This means they provide no direct information about the health-care providers in terms of their attitude towards these target groups or their knowledge about their respective health-care needs.

The needs-assessment carried out amongst transgender and intersex people did focus on the perception of health-care providers, however. The 15 health-care providers that TIA interviewed about their attitude towards and knowledge of transgender and intersex health needs were all employed at health facilities in Johannesburg and Pretoria (Gauteng Province). GDX interviewed health-care providers employed at health facilities in KwaZulu-Natal.

The health-care providers interviewed in KwaZulu-Natal were found to have some knowledge of gay and lesbian identities but little to no knowledge of transgender people. Transgender lives and experiences were often conflated with gay and lesbian practices.[242] The health-care providers who took part in this needs assessment also indicated feeling uncomfortable about discussing sexual health with their transgender clients, due to a lack of knowledge about the services their LGBTI clients needed.[243] The lack of skills, referral networks and transgender health-specific information was reported to be a great concern. The respondents stated that the lack of guidelines regarding health care for transgender and gender-nonconforming people forms a significant barrier in terms of providing optimal, efficient and quality services.[244] The lack of trained staff was mentioned as another important impediment by a health-care provider in KwaZulu-Natal, who said, *'… the hospital does not have enough experienced plastic surgeons. There is very little that you can get from the public-health system as a transgender patient…'*[245]

The service providers also commented on how transphobia and homophobia from the community and the church impacted their ability to provide adequate and quality care for transgender and gender-nonconforming individuals in their communities. One health-care provider expressed the fear of being *'perceived as someone fuelling bad behaviour, if I work with them [transgender clients]. The church might also perceive me as promoting unacceptable behaviour.'*[246]

Zambia:

The needs assessment conducted by Friends of Rainka Zambia targeted five health-care providers employed at health facilities in Lusaka and Eastern Province. The needs assessment conducted by Transbantu Zambia targeted 17 health-care providers employed at private and public clinics in Zambia.

All five respondents interviewed by Friends of Rainka indicated feeling that the current penal code prohibits them from providing health services to LGBTI clients.[247] They mentioned that the current law impeded the distribution of lube, condoms and sexual-health information among LGBTIs.[248] However, all respondents also indicated that they would be willing to give medical attention to an openly gay/lesbian person.[249]

The respondents were also asked whether they felt that it was their responsibility to report an LGB client to the police, considering the legal environment. One respondent answered this question and was convinced that reporting the case to the police would be necessary.[250]

Almost all of the health-care providers interviewed by Transbantu Zambia indicated being aware of the existence of transgender and intersex people. Two respondents reported having heard of the terms but said they had little knowledge of the exact meanings.[251] Eight Zambian health-care providers interviewed reported having sufficient knowledge and skills to cater to the specific needs of transgender people. They did not specify where and how they had acquired that knowledge and those skills.[252]

The majority of the respondents indicated being willing to receive training on the specific needs of the transgender community. However, the other respondents did not see the need for receiving training because they felt that 'transgender and intersex people should be treated the same as any other patient' and that 'they have the same needs as heterosexuals'.[253]

Nine respondents indicated that the general attitude towards transgender and intersex patients who had sought services at their institutions was positive and that they were treated as any other patient.[254]

The health-care providers interviewed by Transbantu Zambia all indicated being under the impression that transgender and intersex identities were against the law.[255] Some reported being unsure of the legal situation for these groups.

One doctor reported being fearful of administering hormone treatment to transgender patients.[256]

Swaziland:

The needs assessment conducted by SWAPOL–HOOP targeted 40 health-care providers employed at health facilities in the provinces Hhohho, Lumbombo, Manzini and Shiselweni. Rock of Hope interviewed six health-care providers from the same regions.

Only two of the six health-care providers interviewed by Rock of Hope acknowledged the existence of LGBTI identities.[257] All other health-care providers denied the existence of such identities and indicated never having been confronted with an LGBTI client.

One of the two health-care providers who acknowledged the existence of LGBTIs admitted being **reluctant to administer health care to such individuals.**[258] Two of the respondents blatantly admitted to being homophobic and indicated believing that it was unnatural to be homosexual.[259]

Some respondents expressed interest in knowing more about LGBTI identities and health needs. They seemed more open to discuss lesbian issues and **expressed confusion about transgender individuals, admitting feeling unknowledgeable about their health needs.**[260]

In the needs assessment that SWAPOL–HOOP conducted amongst 40 health-care providers, only 5% of the respondents reported having specific guidelines that address the delivery of service to LGBTI people.[261]

Twenty-two per cent of the total respondents reported having actually provided services to LGBTI clients in 2013.[262] Only 10% of the respondents indicated feeling equipped or sufficiently trained to deal with the specific health needs of LGBTI clients.

All respondents felt that LGBTIs were at high risk of contracting HIV/STIs. The majority of the respondents (90%) felt that LGBTIs do not practise safe sex.[263]

Most of the respondents felt that LGBTIs had knowledge of safer sex practices but a very small number felt that LGBTIs were actually using the available safer sex methods.[264]

DEVELOPING HEALTH-PROMOTION INTERVENTIONS

The in-depth community-based needs assessments provide a wealth of information for programme developers at LGBTI organisations. Based on an increased understanding of the determinants, behaviour and health problems, programmers can make informed decisions about what kind of problems, which behaviours and, ultimately, which determinants to focus on and what kind of interventions would likely be most effective.

Not all determinants that influence behaviour which leads to a health problem are equally relevant. One needs assessment might have found that knowledge was not the major determinant of a certain risky behaviour, for instance, but that the behaviour of the specific groups in that needs assessment was more influenced by group norms or by self-efficacy instead. For example most MSM in a needs assessment knew that the correct use of condoms and lube during anal intercourse was important, yet the group's norm (what was considered to be 'cool') was very much focused on barebacking. Similarly, another needs assessment might have revealed that MSM also did not think they would be able to negotiate condom use with their casual partners (self-efficacy); they might be convinced that in the heat of the moment they would not be able to start a conversation about safer sex. For programmers it is important to know the role of these determinants, as one might otherwise invest unwisely. In these examples, putting all focus on strengthening knowledge might not be the most relevant.

Similarly, not all determinants are as easy to change as others. Programmers need to be aware of this aspect as well when making their decisions on what kind of interventions to develop. For example, the socio-economic situation of transgender women might be a very important determinant for certain risky behaviour. Ideally that socio-economic situation should be improved of course. However influencing this determinant might go beyond the sphere of influence of the programmer or the LGBTI organisation.

Every situation is different and one cannot prescribe in advance which determinant will be more or less relevant or easy to change. The programmer in a specific situation will need to choose which determinants to focus on, considering the limited resources available.

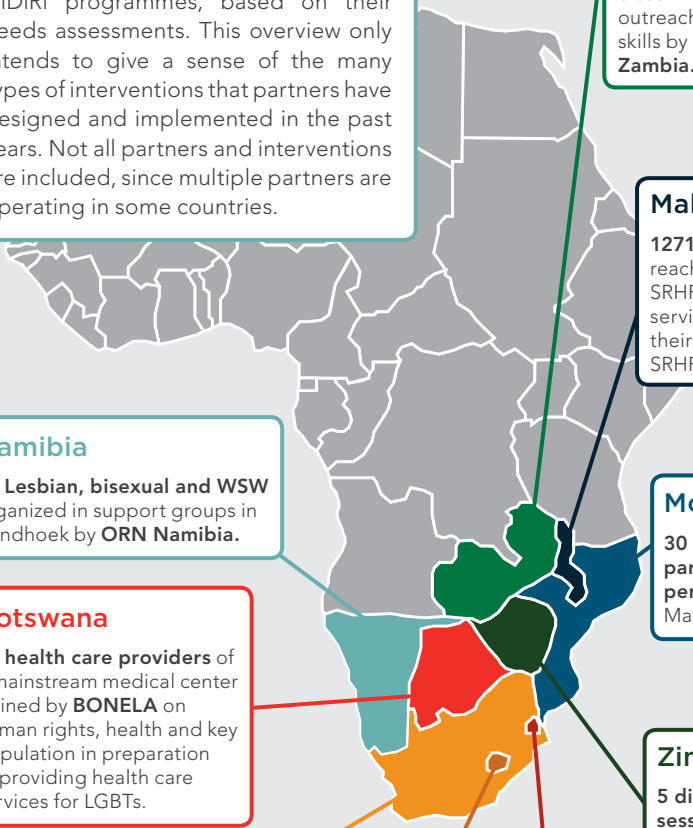
Determinants can be influenced in many different ways: organisations can use leaflets, support groups, peer education, outreach, workshops, etc. Which activity in which form will be most effective will depend largely on the local situation. Some implementation theory is also available in terms of what works and what doesn't. For example, the tactic of scaring people into changing their behaviour has a poor track record. People tend not to respond with structural behaviour change if you present them with images of death and doom. Programmers should reflect on earlier interventions, learn from what has worked and hasn't worked elsewhere and consult theories on behaviour change. Based on the evidence gathered from earlier interventions, programmers need to decide on the ideal intervention mix in their particular context.

Continuous mentoring and reflection on implementation are both important as practice might also call for adaptations midway through the implementation phase.

All partners that have carried out a needs assessment within DiDiRi and/or Bridging the Gap have also received follow-up funding and support from COC Netherlands to implement interventions. In planning those interventions, partners used the above-mentioned weighing of the relevance and changeability of determinants and the evidence about the efficacy of certain interventions to arrive at their particular intervention mix. For most partners, the funding from COC Netherlands is only part of their total funding. In planning their wider intervention mix, partner organisations have shown an increased capacity to act more evidence-informed and plan-based.

COC'S PARTNER ORGANISATIONS AT WORK

This map gives an impression of the interventions implemented by some partners in the Bridging the Gaps and DiDiRi programmes, based on their needs assessments. This overview only intends to give a sense of the many types of interventions that partners have designed and implemented in the past years. Not all partners and interventions are included, since multiple partners are operating in some countries.



Zambia

61 Outreach officers trained in SRHR information dissemination, community outreach and advocacy skills by **Friends of Rainka Zambia.**

Malawi

1271 MSM were reached by **CEDEP** with SRHR information and services to enhance their knowledge on SRHR issues.

Namibia

75 Lesbian, bisexual and WSW organized in support groups in Windhoek by **ORN Namibia.**

Mozambique

30 sessions with parents of LGBTI persons organized in Maputo by **LAMBDA.**

Botswana

26 health care providers of a mainstream medical center trained by **BONELA** on human rights, health and key population in preparation to providing health care services for LGBTs.

Zimbabwe

5 dissemination sessions held by **the Sexual Rights Centre** with **150 stakeholders** on key issues around challenges in accessing health care by LGBTI.

South Africa

OUT's MSM and WSW information websites accessed by more than **55.000 visitors.**

Lesotho

MATRIX support group completed the first ever Lesotho **needs assessment** in 2013

Swaziland

20 peer educators trained on providing support to MSM and Lesbians by **SWAPOL-HOOP**

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APPENDIX:
DEFINITIONS, TERMS AND ABBREVIATIONS

DEFINITIONS

Discrimination is legally defined as unjustifiably unequal treatment:

- **Direct discrimination** occurs where one person or a group of people is treated less favourably than another person or group of people has been, is, or would be treated in a comparable situation on the basis of one or more grounds that are prohibited (including sexual orientation or gender identity).

- **Indirect discrimination** occurs when a provision, criterion or practice would put a person or group of people having a status or characteristic associated with one or more prohibited grounds for discrimination (including sexual orientation or gender identity) at a particular disadvantage compared with other people, unless that provision, criterion or practice is objectively justified by a legitimate aim, and the means of achieving that aim are both appropriate and necessary.

Besides these forms of discrimination there is also what is known as **'experienced discrimination'** (also called 'subjective discrimination'), which is when one person or a group of people experiences being discriminated against. Experienced discrimination does not necessarily entail discrimination in the legal sense of the word.

TERMS

Sex: The biological and physiological characteristics that define and differentiate males/male bodies from females/female bodies.

Sexual orientation: This term refers to an individual's **sexual identity.** Sexual orientation is often used to refer to how one expresses his/her sexual and romantic self.

Homophobia: An irrational fear of homosexuals – that is, lesbians and gay men – sometimes leading to expressions of hostility and acts of violence against them.

Gender: This term refers to the socially constructed roles, behaviour, activities and attributes that a particular society considers appropriate for men or women and normally uses to differentiate men from women.

Gender identity: This term refers to one's innate and private sense of feeling male or female, manly or womanly, as an individual. Generally, one's gender identity coincides with one's biologically assigned physical sexual makeup such as genitalia, whereas differential gender identity refers to a situation in which one's feeling of being male or female does not coincide with one's biologically assigned sexual makeup. This is the case for many transgender, transsexual, gender-nonconforming and intersex people.

Gender queer/Gender-nonconforming: This term refers to individuals who do not behave or act in accordance with or have attitudes characteristic of the sex they were biologically assigned at birth and perhaps even the gender roles they were socially assigned. This includes transgender, intersex and other non-labelled people who simply do not live within the social roles they were raised in.

Transgender: This term refers to people who have a **gender identity** – and often a gender expression ¬– that is different from the sex they were assigned at birth by the default of visible primary sexual characteristics and who may choose to live their lives in the gender of their identity and not in accordance with the social roles of the sex of their biology.

Transsexual: In contrast to transgender individuals, transsexual individuals choose to undergo various procedures aimed at reassigning their sex and bringing their biological makeup into congruence with their gender identity, for example by means of sexual reassignment surgery and/or gender-affirming hormonal replacement therapy through a process commonly referred to as transitioning.

Transphobia: An irrational fear of, and/or hostility towards, people who are transgender, transsexual, gender-nonconforming and intersex and any others who transgress traditional gender binaries and norms.

Transman (FTM/F2M): This term refers to an individual who was born biologically female but has a differential gender identity of a male, identifies with males, lives life as a male and may perhaps transition into being male. Though born female bodied, a transgender man is more comfortable with being referred to with male or masculine pronouns such as he, Mr, Sir, man, etc.

Transwoman (MTF/M2F): This term refers to an individual who was born biologically male but has a differential gender identity of a female, identifies with females, lives life as a female and may perhaps transition into being female. Though born male bodied, a transgender woman is more comfortable with being referred to with female or feminine pronouns such as she, Miss, Mam, woman, girl, etc.

Intersex: This term refers to individuals who were born with ambiguous or unclear sexual characteristics. In this **condition,** which is often categorised by unclear genital makeup of the individual, the individual cannot be categorised as being 100% male or 100% female.

Intersex conditions are multifold and are evident in more than just the ambiguity in genital makeup. It may involve an individual who has medically normal genitalia for one sex but the inner reproductive system of the opposite sex. It may also involve what is known as hormonal intersexuality, where an individual has medically normal genitalia and a medically normal reproductive system for one sex but the endocrine system (or hormones) of the opposite sex.

Hormonal replacement therapy/Gender-affirming hormonal therapy: One part of sexual reassignment involves the intake of hormones in order to generate changes in the sexual characteristics of an individual, causing them to match those of the sex or gender they identify with and wish to transition into. In the case of transgender women, these hormones would be oestrogen and progesterone, which would stem some hair growth and initiate breast growth; in the case of transgender men, the therapy would involve testosterone, which breaks and deepens the voice and promotes the growth of facial and body hair. All this is done to reconstruct one's body to generate the sexual characteristics of the gender and sex that one identifies as.

Gender reassignment: This term is often mistaken to mean sexual reassignment but concerns the re-orientation and re-socialisation of an individual who is in an early stage of the process of transitioning from his/her original biological gender into the gender he or she wishes to live. This process often occurs at the stage of psychotherapy in which one is preparing to transition, so as to prepare one to permanently live in the gender of his/her identity. For the most part, transgender and intersex people are brought up and socialised into the gender roles of their biological make-up, hence the need to undergo gender reassignment so as to know, understand and live in the gender of their identity as preparation for the transition to follow.

Transitioning / Sexual reassignment: These terms refer to a number processes and procedures that an individual with a differential gender identity and/or sexual makeup may embark on in order to have his/her biological make-up match his/her gender identity and to be able to live in a body that will resemble if not be identical with those of the sex and gender he/she identifies with. These procedures may involve sexual reassignment surgery in order to surgically reassign and reconstruct one's biological sex.

Hate crime: This term refers to criminal acts with a bias motive (in this context) towards LGBT people. Hate crimes include intimidation, threats, property damage, assault, murder or any other criminal offence where the victim, premises or other target of the offence is selected because of its real or perceived connection or attachment to, affiliation with, support for or membership of an LGBT group.

ABBREVIATIONS

HIV: Human immunodeficiency virus

AIDS: Acquired immunodeficiency syndrome

STI: Sexually transmitted infection

WSW: Women who have sex with women

MSM: Men who have sex with men

LGB: Lesbian, gay and bisexual

LGBTI: Lesbian, gay, bisexual, transgender and intersex

PRISM: Prevention and Research Initiative for Sexual Minorities

DiDiRi: Dignity, Diversity and Rights

BTG: Bridging the Gap

CDC: United States Centers for Disease Control and Prevention

WHO: World Health Organization

NOTES

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Factors such as stigma, discrimination, violence, gaps in the knowledge and attitudes of health-care workers, and the criminalisation of same-sex acts have adversely affected the access to and uptake of health-care services by LGBTIs in Southern Africa. To address the need to build and strengthen the capacity of LGBTI organisations in Southern Africa in the domain of public-health research and interventions, partnerships have been formed between COC Netherlands and 19 LGBTI organisations in nine countries in the region. Together with COC Netherlands and other regional and global partners working on HIV prevention and LGBT rights, these partners have embarked on the Dignity, Diversity and Rights (DiDiRi) and Bridging the Gaps programmes.

Partners carried out community-based needs assessments regarding carefully articulated health-care needs of LGBTIs in South Africa, Botswana, Lesotho, Malawi, Mozambique, Namibia, Swaziland, Zambia and Zimbabwe. The needs assessments focused on identifying factors that restrict the access to and uptake of health services amongst specific target LGBTI groups as well as factors that influence risky sexual behaviour within those groups. The data gathered from these needs assessments has been instrumental in designing effective interventions aimed at health promotion amongst LGBTIs in Southern Africa.

In its work with community-based organisations, COC Netherlands uses an 'inside out' programmatic approach. Besides supporting the strengthening of existing regional LGBTI movements, COC believes in supporting, mentoring and capacitating grassroots organisations to stimulate their evolution towards more sustainable and effective national LGBTI-rights movements.

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