



# Lesbian, gay, bisexual, trans- gender and intersex human rights in Southern Africa:

A contemporary literature review

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## LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AAI	AIDS Accountability International
ARASA	AIDS Rights Alliance of Southern Africa
ART	Antiretroviral Therapy
CCM	Country Coordinating Mechanism
CSO	Civil Society Organization
DiDiRi	Diversity, Dignity and Rights
GARPR	Global AIDS Response Progress Report
HIV	Human Immunodeficiency Virus
IBBS	Integrated Biological & Behavioral Surveillance Survey
ILGA	International Lesbian, Gay, Bisexual, Trans and Intersex Association
LAMBDA	The Mozambican Association for the Defense of Sexual Minorities
LeGaBiBo	Lesbians, Gays and Bisexuals of Botswana
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
MSM	Men who have sex with men
MSMGF	The Global Forum on MSM & HIV
NAC	National AIDS Commission
NACA	National AIDS Coordinating Agency
NASA	National AIDS Spending Assessment
NGO	Non-Governmental Organization
NSF	National Strategic Framework on HIV/AIDS
NSP	National HIV/AIDS Strategic Plan
OSISA	Open Society Initiative of Southern Africa
PEPFAR	The President's Emergency Plan for AIDS Relief
PR	Principal Recipient
PrEP	Pre-Exposure Prophylaxis
PSP	Provincial HIV/AIDS Strategic Plan
SADC	Southern Africa Development Community
SAfAIDS	Southern Africa HIV and AIDS Information Dissemination Service
SOGI	Sexual Orientation and Gender Identities
TB	Tuberculosis
TG	Transgender
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNHRC	United Nations Human Rights Council
WSW	Women who have sex with women
ZNASP	Zimbabwe National AIDS Strategic Plan

# Executive summary

Individuals engaging in same-sex acts, individuals identifying as lesbian, gay, bisexual, transgender, and/ or intersex (LGBTI), and individuals who do not conform to heteronormative ideals of gender and sexuality experience structural, institutional and individual discrimination and exclusion across the world. This is no different in Southern African countries. While LGBTI individuals are heterogeneous and face very specific challenges based on their sexual orientation, gender identity, race, class, ethnicity and other factors, they share experiences of structural, institutional and individual discrimination and marginalisation based on their sexual orientation and gender identity (SOGI). In most Southern African countries, same-sex activity remains criminalised, which further marginalises LGBTI individuals, and acts as an additional barrier to accessing public services and realising full civil and political rights. This contemporary literature review focuses on the state of LGBTI human rights in 10 Southern African countries: Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. The purpose of this review is to contribute towards a strong evidence base and scientific foundation for informed programming in the region.

The legal and policy framework governing the rights and lived experiences of LGBTI people in Southern Africa varies greatly from country to country. Lesotho and Mozambique de-criminalised same-sex activity in the recent year. South Africa remains the only country in the region to guarantee constitutional protection from discrimination based on sexual orientation and gender identity (SOGI), and to operationalise this constitutional provision through a series of legislation and case law. In all other countries in Southern Africa, same-sex activity remains criminalised, with widely varying degrees of the implementation of these laws, of prosecution and punishment.

Nevertheless, a recent resolution and report from the African Union acknowledge the impact of such criminalising laws on LGBTI individuals' safety, security and well-being, and call for law reform to eliminate SOGI-related criminalisation.

***In most Southern African countries, same-sex activity is criminalised, creating an additional barrier to accessing public services and realising full civil and political rights***

That protection from violence and discrimination is much needed is attested by an increasing amount of evidence detailing a wide range of human rights violations that LGBTI individuals experience in Southern Africa. Access and quality of public services, especially healthcare and education, remain compromised for many LGBTI individuals due to SOGI-related discrimination and social exclusion.

Such discrimination and exclusion are directly linked to non-normative identities, as LGBTI individuals are rendered invisible and unintelligible to healthcare providers, policy makers, and wider communities. LGBTI individuals experience significant barriers in accessing health care, directly linked to a lack of competency among healthcare providers, and serious gaps in health policies. New initiatives have begun to develop context-specific interventions to reduce barriers to and increase quality of care by providing competency training for healthcare providers. While there is a severe lack of knowledge on general health outcomes of LGBTI individuals, data from studies focusing on HIV demonstrate high vulnerability to HIV transmission and high prevalence levels across the region.

At the same time, advocacy and activism for the human rights of LGBTI individuals in Southern Africa has reached unprecedented visibility and resulted in increased funding for local organisations. While this has resulted in some important and strategic achievements at national law and policy level, it has also brought with it an increased backlash, led by conservative arguments that cite 'culture', 'tradition' and religion as key arguments against realising the human rights of LGBTI individuals. This is further exacerbated by the widespread perception that human rights discourse is a not-so-subtle form of Western donor "queer imperialism". Civil society organisations, funders, researcher and activists need to continue their careful, strategic and nuanced approaches to build on the recent successes to challenge the manifold barriers to realising human rights for all LGBTI individuals in Southern Africa.

# Methodology

For the purposes of this contemporary literature review, sources included academic literature, grey literature (research reports, organisational reports, policy briefs and other published material), as well as publications by international organisations at the UN, AU, and SADC level. To cover recent milestone events, newspaper articles and web-based news reports were also considered.

For academic literature, the databases EBSCOHost, PubMed, and Google Scholar were searched. The references of identified publications were then searched to identify further publications. A search on the websites and within the networks of international development funding partners identified recent reports and other related grey literature. Development partners include HIVOS, COC Netherlands, ARASA, Ford Foundation, Action Aid, DfID and others. UN, AU and SADC documentation was identified through searches on the relevant agency websites and databases, as well as media reports on relevant events. Newspaper sources were identified through a detailed internet search related to recent milestone events. These were: LeGaBiBo's court case for NGO registration in Botswana (which the organisation won in 2016), as well as the decriminalisation of homosexuality in Mozambique in 2015. Further, the researchers employed their professional networks to identify other relevant sources.

Publications and sources were considered if they (1) had been published/released in 2014, 2015 or 2016; and (2) pertained to the rights of lesbian, gay, bisexual, transgender and/or intersex (LGBTI) peoples in Angola, Botswana, Lesotho, Malawi, Namibia, South Africa, Swaziland, Zambia or Zimbabwe. Preference was given to sources published in the African continent.

There was significant thematic overlap between material published before 2014, which was covered in the previous literature review, and the publications identified for this 2016 review. In order to maintain the analytical and thematic depth of the previous report, we decided to revise, add to, and expand on the previous report's findings instead of writing a new report. We believe that this approach was favourable to creating a new document because (1) the previous report provided important baseline and background information for the 2016 report; (2) for a number of countries and thematic areas, not a lot of new literature has been published over the past 3 years. Where this was the case, we added new findings to the 2014 findings to avoid information-scarce sections; (3) the previous report laid the foundation for a more analytical/ theoretical understanding of the context of LGBTI rights in Southern Africa. We believed it was beneficial for the comprehensive understanding of the reader(s) to keep those sections.



# Country profiles

In the following section, the ten country profiles in Southern Africa are presented: Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe. The profiles are intended to give a brief overview of each national context in relation to LGBTI human rights. The profiles will outline the legal environment, the civil society landscape, and HIV/AIDS policy and progress for LGBTI populations in each of the ten countries.

## ANGOLA

### *Legal environment*

Articles 70 and 71(4°) in the Angolan Penal Code of 16 September 1886, as amended in 1954, is the basis upon which criminal penalties are imposed on people “who habitually practice acts against nature” (Global Legal Research Centre, 2014). The penal code, inherited from the Portuguese colonial era, has no reported cases of this law being enforced (United States Department of State Bureau of Democracy, Human Rights and Labor, 2013). Articles 70 and 71 (4°) do, however, determine that security measures imposed on homosexuality may include: confinement in an insane asylum, confinement in a workhouse or agricultural colony, being put on probation, a pledge of good conduct, and disqualification from the practice of a profession (Global Legal Research Centre, 2014; Carroll & Itaborahy, 2015). Even though this clause has not yet been enforced, it can be employed to target LGBTI people.

The Angolan constitution and law prohibit discrimination based on race, gender, religion, disability, and language (United States Department of State Bureau of Democracy, Human Rights and Labor 2013), but there is no anti-discrimination provision to protect individuals from being discriminated against on the basis of their sexual orientation and/or gender identity (Johnston, 2015). There is therefore no legal protection for lesbian, gay, bisexual, transgender, or intersex people in Angola.

### *Civil society, perception, obstacles, and support*

Multiple aspects relating to the Angolan cultural context impact the degree to which LGBTI rights are being advocated for. Angolan society is inherently patrilineal and influenced by Catholicism, both of which affect the human rights of LGBTI people. Currently, there is limited empirical research on the frequency at which homophobic, transphobic, and intersexphobic attacks occur in Angola. Some reports suggest that LGBTI people face significant discrimination, stigma, and marginalisation in Angola (Johnston, 2015). While there is little literature on this prevalence, a survey has shown that Angola is the second most accepting population of homosexuality in the region, albeit still at a very low acceptance rate of 34% (Dionne, Dulani & Chunga, 2014). Despite a relatively accepting social climate, the government of Angola limits the existence of non-governmental organisations in Angola, particularly ones for LGBTI people (DiDiRi Collective, 2013). It has been reported that Angola has a limited network of LGBTI support groups or civil society organisations working to support LGBTI rights. However, in 2006, the NGO, Acção Humana (Human Action) tried to develop a prevention programme for gay men that intended to educate about condom use as well as combating discrimination against gay men by advocating for LGBTI human rights. In 2007, the NGO presented a project proposal to donors, but they were rejected on the basis that the homosexual population in Angola were too small for the project to be justified (PlusNews, 2008). In the past few years, activists have emerged from small civil society groups, who are raising awareness about men who have sex with men (MSM) in relation to HIV transmission. There are no formal registered LGBTI organizations working in Angola. However, according to the United States Department of State Bureau of Democracy, Human Rights and Labor’s country report on human rights practices for 2013, a small underground LGBT community in Luanda exists. Further, an LGBT group, “The Divas”, held the first gay pride parade in the country in November 2013 (United States Department of State Bureau of Democracy, Human Rights and Labor, 2013). Additionally, the organisation, Iris Angola, is also working to ensure the human rights of LGBTI people in Angola. It should also be mentioned that one of the most popular musicians in Angola is a trans woman, Titica, no small feat in a country where gender and sexual minority face extreme social stigma. The United Nations Programme on HIV/AIDS has approached Titica to become an ambassador for the agency, but there is no confirmation of such a collaboration (Redvers, May 2013).

Without legal recognition or a vibrant civil society, support for LGBTI people in Angola is a challenge. The lack of civil support of LGBTI community have in ways been regulated by the government of Angola. In 2010, The Global Health Charity, PSI, launched a HIV awareness campaign, targeting high risk groups. However, the Angolan Ministry of Health requested them to “hold back” on the initiatives aimed at the homosexual community (Redvers, May 2013). The only LGBTI data found in Angola after 2014 was a study that aimed to find a population size estimation and biological/behavioural surveillance survey among MSM (Kendall et al., 2014). The study estimated a population size of 6236 MSM in the city of Luanda. Further, Kendall et al. (2014) found that MSM who experienced homophobic episodes were significantly more likely to be HIV positive, which is strong rationale for the need for programs which combat discrimination and promote human rights in the country.

## *HIV/AIDS*

According to the 2014 UNAIDS estimates for HIV and AIDS, 300,000 people in Angola are currently living with HIV. The estimated HIV prevalence amongst adults aged 15-49 is 2.3% (Government of Angola, 2014). Data on the HIV prevalence rates among MSM, women who have sex with women (WSW), and transgender people in Angola is limited. This is due to the country’s criminalization of same-sex activity, which makes it difficult to collect data concerning the prevalence of LGBTI people living with HIV in Angola.

The Ministry of Health is mainly responsible for the distribution of condoms in healthcare facilities, while NGOs also distribute condoms amongst their target groups. There are, however, no programmes specifically targeting MSM, WSW, and/or transgender people in terms of prevention measures (Johnston, 2015).

The Angolan government has implemented a National Strategic Plan (NSP) on the Control of STIs, HIV, and AIDS (NSP), which is a nationwide policy on HIV in Angola. The most recent plan was implemented in the period between 2011 and 2014. MSM are included in the list of populations at increased risk of infection (along with sex workers, migrant populations, and prison populations). The NSP notes that there are available seroprevalence studies for MSM in the country, which indicate that MSM account for 2.1% of new HIV infections. The NSP outlines education in schools and universities as a key strategy, committing to conducting further research on at-risk populations – including MSM – and to disseminate the findings to relevant government ministries, civil society organizations, and media outlets. Lastly, the NSP includes priorities around skills development for at-risk populations as well as peer education among prison populations (including MSM). WSW, lesbian women, transgender, and intersex people are not included in the country’s current policy (Government of Angola, 2010).

In May 2014, the government reported data on all four UNGASS indicators for MSM (Government of Angola, 2014). According to the government’s 2014 Global AIDS Response Progress Report (GARPR), the HIV prevalence among MSM in Angola is 8.2%. The proportion of MSM reached with prevention programs is 80.1%. The percentage of MSM who used a condom the last time they had anal sex with a male partner is 33%. Lastly, the government reported that 91.2% of MSM in the country received an HIV test in the past year and know their results. While it is commendable that the government is reporting data for these populations (many countries do not), these numbers should be interpreted with a certain degree of circumspection. The same source is cited for this data in Angola’s 2012 GARPR, yet the numbers are different. For instance, in 2012 Angola reported 29.6% of MSM had received an HIV test in the past year, making the 2014 performance of 91.2% look like a marked improvement. However, given the source of data is the same for both years (a 2011 MSM study conducted in Luanda), the validity of this data should be called into question.

## **BOTSWANA**

### *Legal environment*

Section 164 of the Botswana Penal Code, amendment Act 5, 1998 on “unnatural offences” provides that any person who “(a) has carnal knowledge of any person against the order of nature; (b) has carnal knowledge of any animal; or (c) permits any other person to have carnal knowledge of him or her against the order of nature, is guilty of an offences and is liable to imprisonment for a term not exceeding seven years.” (Government of Botswana, chapter 08:01, penal code). According to Section 165, an attempt to commit “unnatural offences” is also an offence, liable to imprisonment

for a term not exceeding five years. Further, Section 167 has provisions around committing or procuring acts of “gross indecency with him or her whether in public or private” (Government of Botswana, chapter 08:01, penal code). However, according to the Global Legal Resource Center (2014), in order for carnal knowledge to be against the “order of nature” there must be anal penetration by a sex organ. As such, while sodomy is an offense under this provision, homosexual acts that do not involve anal penetration with a sex organ may be legal. It has also been noted that the law does not explicitly criminalise consensual same-sex sexual activity. However, there is a widespread belief that the criminalisation of “unnatural acts” by the law is directed towards LGBT persons (United States Department of State Bureau of Democracy, Human Rights and Labor 2013).

There are no specific laws that criminalise transgender people; however, transgender people are or might be prosecuted with other laws that are used specifically against them, such as provisions against public nuisance or anti-sodomy laws. There is little to no anti-discrimination provision to protect individuals from being discriminated against on the basis of their sexual orientation and/or gender identity (Johnston, 2015). It is worth noting, however, that Botswana’s recent Employment Amendment Act of 2010 protects LGBTI people from wrongful dismissal if based on their sexual orientation or gender identity. Botswana is one of the only countries in the region to defend this right. There is no clear legal stance on transgender people seeking to undergo affirming hormonal therapy in order to transition their gender. It is not unlawful for individuals in transition to access oestrogen or testosterone. However, this legal vacuum exposes transgender individuals to other challenges, such as the lack of protocol on which procedures should be followed when it comes to amending identity cards or birth certificates (Johnston, 2014).

In June 2014, Botswana supported a call by the African Union’s highest human rights body to protect the human rights of LGBTI people – though it did not commit to repealing its own laws criminalizing same-sex relationships (Human Rights Campaign Foundation and Human Rights First, 2014; Potts, 2014, June 17).

### *Civil Society, Perceptions, Obstacles and Support*

Perceptions from the LGBTI community suggest that the people of Botswana are relatively tolerant, it is only the laws and policies that discriminate: “We like to say that Botswana are not homophobic, that the country itself is homophobic” (Oberth, 2012, p. 12). Some Botswana politicians and public officials have expressed animosity

***The High Court in Botswana ruled that “lobbying for legislative reforms is not per se a crime. It is also not a crime to be a homosexual.”***

towards the LGBTI community. The Director of Civil and National Registration and the Ministry of Labour and Home Affairs of Botswana refused to allow the LGBTI organisation Lesbians, Gays and Bisexuals of Botswana (LEGABIBO) to register as an organisation. The reason for the disapproval seems to be based purely on moral disagreement with the objectives of

LEGABIBO (Johnston, 2015). Fortunately, in November 2014, the High Court in Botswana ruled in favour of LEGABIBO, which will permit them to register as an officially recognized organization in the country. The judge ruled that “lobbying for legislative reforms is not per se a crime. It is also not a crime to be a homosexual.” (LEGABIBO, November 2014). In early January 2015, the Government of Botswana appealed the high court stating that “the constitution of Botswana does not recognize homosexuality” (Sapa, January 2015). The government wanted the high court ruling to be set aside. However, the government’s appeal case has not been included in the court roll. The Botswana Court of Appeal found that the government’s refusal to register LEGABIBO was unlawful because it violated the activists’ rights to freely participate in democracy. On April 29, 2016 LEGABIBO was registered as the first organisation to publicly advocate for LGBTI people’s rights in Botswana (Esterhuizen, May 2016).

Along with LEGABIBO, BONELA similarly work to ensure the human rights of LGBTI individuals in Botswana. These two civil-society organisations representing LGBTI people are participating in national-level coordination and policy-making forums in Botswana such as the National AIDS Council (NAC), CCM, UN technical working groups and PEPFAR (Johnston, 2015). Additionally, the Rainbow Identity Association (RIA) is an organisation of transgender and intersex people, which aims to challenge transphobic laws and transphobia in Botswana. The organisation was legally registered as an NGO in December 2010 (Valenza, January 2011). The human rights organisation DITSHWANELO (The Botswana Centre for Human Rights) is working to promote and protect human rights in Botswana. The organisation seeks to affirm the equality of gender, ethnicity, religion and sexual orientation.

## HIV/AIDS

According to the UNAIDS (2014) estimates for HIV and AIDS, over 390,000 people in Botswana are living with HIV. This estimated HIV prevalence amongst adults from 15-49 is 25.2% (Government of Botswana, 2014).

In 2002, Botswana became the first country in sub-Saharan Africa to introduce a national ART programme. The programme, called Masa, provides free and universal therapy according to national guidelines. Currently, 95% of those who are eligible for treatment have access to ART (Johnston, 2015).

The HIV response is currently guided by The Second Botswana National Strategic Framework (NSF) for HIV and AIDS (2010-2016). The NSF was published in 2009, which makes it one of the oldest in the region. This is an important factor to consider when assessing policy considerations for LGBTI communities. According to Botswana's strategy, the current Ministry of Health definition of most-at-risk populations includes: sex workers, truck drivers, seasonal farm workers, and construction workers. MSM, WSW, gay men, lesbian women, transgender, and intersex people are not included in the country's current policy (Government of Botswana, 2009).

While the country's current NSF does not include LGBTI people, the government's 2014 GARPR states that MSM and transgender individuals are included as key populations for HIV programmes in the country (Government of Botswana, 2014). Further, Botswana's 2014 GARPR features data for all four MSM indicators: The prevalence of HIV among MSM in Botswana is reported at 13.1%. The proportion of MSM that reported using a condom the last time they had sex with a male partner was 84.2%. The percentage of MSM who received an HIV test in the last year was 76.9%. Finally, 44.9% of MSM in Botswana were reached with HIV prevention programs. The Botswana National AIDS Coordinating Agency states that the MSM indicators show similar - or in some cases better - results than the general population, but also notes that these UNGASS indicators do not address issues and challenges such as stigma and discrimination, which place MSM populations at increased vulnerability to HIV. The government's 2014 GARPR also highlights that more than 75% of services for MSM and transgender people are provided by civil society. The GARPR does not address WSW or lesbian women, or intersex individuals.

## LESOTHO

### *Legal environment*

There is uncertain and conflicting evidence on Lesotho's legal environment. ILGA's 2013 State-sponsored Homophobia Report places Lesotho on the list of countries where homosexuality is legal, stating that "It seems that homosexual acts in Lesotho are legal, probably since the entry into force of the Penal Code Act on 9 March 2012. The Sexual Offences Act of 2003 did not explicitly repeal the common law offence of sodomy (see its article 37)" (Itaborahy & Zhu, 2013, p. 50). However, in ILGA's 2014 edition of the report, Lesotho is back on the list of countries where homosexuality is illegal (without explanation) and there is no mention of the March 2012 Penal Code Act. ILGA 2014 states: "Sodomy is prohibited as a common-law offence, defined as 'unlawful and intentional sexual relationship through the anus between two human males'" (Itaborahy & Zhu, 2014:37). However, in the ILGA 2015 report, Lesotho appears under the section Same-sex sexual acts legal with the note: "In the Penal Code Act 2010, which had entered into force on 9 March 2012, sodomy does not seem to be criminalised as it used to be in section 185(5) of the 1939 Criminal Procedure and Evidence Act." (Carroll & Itaborahy, 2015). The ILGA 2016 report confirms that "In Article 52 of the Penal Code Act 2010, which entered into force on 9 March 2012, there is no mention of sodomy: this article replaces section 185(5) of the 1939 Criminal Procedure and Evidence Act which had previously enumerated [male] sodomy as a punishable act. As such, same-sex sexual relations amongst consenting adult males in Lesotho was decriminalised by this 2010 Act." (Carroll, 2016: 34).

There is no anti-discrimination provision to protect individuals from being discriminated against on the basis of their sexual orientation and/or gender identity in Lesotho (Johnston, 2015). This also means that transgender and intersex people are not recognised in any health policies.

There seem to be health facilities that treat transgender people (most of which are private), but there is a major lack on information about which procedures to follow (Johnston, 2014). No information could be found on the accessibility of hormonal therapy for individuals in transition, or on the accessibility of gender-reassignment surgeries.

## *Civil Society, Perceptions, Obstacles and Support*

Matrix Support Group is a leading group advocating for LGBTI rights in Lesotho. In May 2016, The People's Matrix Support Association held their fourth annual public LGBTI march in Maseru, Lesotho in celebration of the International Day Against Homophobia, Transphobia, and Biphobia (Stewart, May 2016). Miller (2014) notes that these events "seem to be having an impact on the MSM community and how it deals with stigma and discrimination" (Miller, 2014: 45).

***The majority of LGBTI people in Lesotho express that they have experienced human rights abuses related to their sexuality, and more than half say they have been verbally or physically harassed.***

Despite some progress, led by Matrix, LGBTI people in Lesotho do suffer from negative perceptions from the general community. The majority (76.2%) of LGBTI people in Lesotho express that they have experienced human rights abuses related to their sexuality, and more than half (59.8%) say they have been verbally or physically harassed (DiDiRi Collective, 2013). LGBTI people in Lesotho can access HIV-prevention programmes offered by Matrix Support Group.

### *HIV/AIDS*

According to the 2014 UNAIDS estimates for HIV and AIDS, 310,000 people in Lesotho are currently living with HIV. The estimated HIV prevalence amongst adults aged 15-49 is 23.4% (Government of Lesotho, 2015). The HIV/AIDS response in Lesotho is currently guided by the country's National Strategy Plan (NSP). The National HIV Prevention Strategy for a Multi-Sectoral Response to the HIV Epidemic in Lesotho (2011/12-2015-16) identifies MSM as an underserved, at-risk population, indicating that this group likely contributes roughly 3-4% of new HIV infections in the country (Government of Lesotho, 2010). A cross-sectional study from Lesotho in 2011 found an HIV prevalence of over 11% amongst MSM (Baral et al., 2011).

The NSP strategy sets out to increase the percentage of districts providing prevention services for MSM. The strategy also sets targets for increasing the percentage of MSM accessing HIV prevention services. Under key strategies and activities, the government commits to conducting formative research, doing population size estimates, developing and implementing comprehensive HIV prevention programmes, and training facilities to deliver proper services to MSM. The NSP hereby identifies MSM as being part of the MARPs (At Most Risk Population) and vulnerable groups in Lesotho. However, the NSP makes no explicit mention of WSW, lesbian, intersex, or transgender people (Johnston, 2015).

Lesotho is the only country in the region that has reported HIV prevalence data for WSW (Government of Lesotho, 2012). According to the GARPR (2012), the prevalence of HIV among WSW in Lesotho is 7.1%, as compared to 11.6% for MSM and 22.9% for the general population.

It should be noted that these prevalence data were generated from a study with a relatively small sample size of 190 MSM and 208 WSW. The most recent published GARPR (2015) does not, however, mention the HIV prevalence for WSW (Government of Lesotho, 2015). GARPR (2015) further reports that the HIV prevalence among MSM is estimated to be 1.4 times higher than the adult population (33% compared to 23%). Lesotho does not address transgender or intersex individuals in its reporting.

## **MALAWI**

### *Legal environment*

Section 153 of Malawi's Penal Code on "unnatural offenses" criminalises having carnal knowledge – or permitting a man to have carnal knowledge - of any person against the order of nature. This is punishable by a fourteen-year prison term. Section 154 criminalizes attempting to commit an "unnatural offence," which is punishable by up to seven years in prison. Further, Section 156 criminalizes "indecent practices", which warrants five years in prison for acts of

gross indecency (Global Legal Research Center, 2014). In December 2010, Malawi's Parliament passed a bill which amended the Penal Code of Malawi to include Section 137A on "Indecent practices between females". The bill was signed into law in January 2011, making it illegal for any female person to commit acts of "gross indecency" with another female, punishable by a prison term of five years (Carroll & Itaborahy, 2015). There is no anti-discrimination provision to protect individuals from being discriminated against on the basis of their sexual orientation and/or gender identity (Johnston, 2015). Even though the Malawian penal code only criminalises same-sex sexual activity, individuals can be arrested if they are suspected of homosexuality. According to a recent study in Lilongwe (Johnston, 2014), two girls were arrested and imprisoned for a year based on suspicions regarding their sexual orientation. After being released, the couple made a complaint, received little monetary compensation, and subsequently dropped the case.

## *Civil Society, Perceptions, Obstacles and Support*

Same-sex relationships are deemed immoral by cultural norms and religious ideologies in Malawi. Afrobarometer-Malawi data shows that 94% of Malawians disagreed that people practicing same-sex relationships should have the right to do so (Dionne, Dulani & Chunga, 2014). Widely made homophobic statements by the media, religious groups, NGOs, and the government contribute to high levels of fear within the LGBTI community. There is a lack of sensitivity about sexual orientation and gender identity, which exposes LGBTI people to stigma, discrimination, violence, rape, and blackmail from members of the police, the judiciary, and other government officials in Malawi (Johnston, 2015). The political homophobia in Malawi escalated in 2010 when the government prosecuted Tiwonge Chimbalanga, a transgender woman, and Steven Monjeza, a cisgender man, for violating antisodomy statutes. Since then, homophobia has saturated national politics. In this environment, HIV/AIDS, human rights, and feminist activists have limited their public expressed support for LGBT rights (Currier, 2014). A qualitative study from Malawi finds that most Malawian HIV/AIDS, human rights, and feminist organisations expressed a concern of acting in solidarity with organisations defending LGBT rights because it could compel "a toll on individual activists and on organisations" (Currier, 2014). Another study from Malawi (McNamara, 2014) presents qualitative data featuring Malawians who feel that homosexuality should be legal. One participant mentioned that legalizing homosexuality would improve business. Another participant noted that criminalizing an identity was futile. A third participant said that it should be legal because same-sex sex work is the way he is able to feed his family.

***Afrobarometer-Malawi data shows that 94% of Malawians disagreed that people practicing same-sex relationships should have the right to do so***

One of the leading organisations for LGBTI human rights in Malawi is the Centre for the Development of People (CEDEP). The organisation aims to provide support to minority groups. MSM and WSW can access HIV/STI prevention services from CEDEP. CEDEP is also implementing a sexual-health programme for MSM and WSW communities with the aim of providing them with knowledge.

## *HIV/AIDS*

According to the 2014 UNAIDS estimates for HIV and AIDS, 1.1 million people in Malawi are currently living with HIV. The estimated HIV prevalence amongst adults aged 15-49 is 10% (Government of Malawi, 2015). Malawi's current HIV strategy – the Malawi National HIV and AIDS Strategic Plan (2011-2016) and the National HIV Prevention Strategy 2015-2020 - indicates that there is a gap for MSM, noting that comprehensive combination prevention interventions to date do not focus on this group (Government of Malawi, 2011; Government of Malawi, 2014a). The policy therefore commits to the following strategic actions for MSM: develop procedures, guidelines, and minimum packages for interventions to reach MSM; identify the locations and numbers of MSM to reach and identify their health needs; scale up a comprehensive risk reduction package of combination prevention interventions in high prevalence geographic areas; strengthen linkages to HIV prevention and treatment, and HTC services; create an enabling environment for the implementation of an effective strategy. The government also prioritizes conducting population size estimation and biological and behavioural surveillance among MSM. However, while the strategy sets 2015/2016 targets for bringing down the HIV prevalence of other key populations, such as sex workers, fishermen, and police, there are no targets set for MSM (stated "TBD"). The current strategy does not address WSW, lesbian women, transgender or intersex individuals.

Malawi's 2014 GARPR highlighted that 21% of MSM are living with HIV (stated in the narrative - no data was included in the matrix) (Government of Malawi, 2014a). Despite this high number – more than double the prevalence of the general population (10.3%) – the report notes that infections among MSM contribute less than 1% of the total number of new HIV cases in the country. The Government of Malawi did not report data on any of the other MSM indicators (prevention programs, condom use, and HIV testing). Malawi does not address WSW, lesbian women, transgender or intersex populations in their GARPR.

## MOZAMBIQUE

### *Legal environment*

Homosexuality has been decriminalised in Mozambique since 2014. In December 2014, the president signed a new penal code, which decriminalised same-sex sexual acts (Carroll & Itaborahy, 2015; Redação, December 2014).

### ***Homosexuality has been decriminalised in Mozambique since 2014.***

Mozambique now appears on the ILGA 2015 list of countries where same-sex sexual acts are legal (Carroll & Itaborahy, 2015).

### *Civil Society, Perceptions, Obstacles and Support*

Mozambique is reported to be one of Africa's most tolerant countries towards LGBTI people. While the government has reported fairly little on LGBTI rights, all of what has been said has been positive (Johnston, 2015). Grossman (2013) similarly finds that Mozambique is one of the more tolerant countries in the region when it comes to public perceptions of homosexuality. The study finds that Mozambicans are a more tolerant society than Botswana, South Africa, and Zambia, as they are less likely to indicate that they view homosexuality to be morally wrong (Grossman, 2013).

Mozambique is one of only three countries in Africa to offer protection from any form of discrimination against gay, lesbians, and bisexuals. However, the leading organisation supporting LGBTI human rights in Mozambique, LAMBDA, has not been able to register officially as an organisation (Johnston, 2015). A spokesperson from LAMDA welcomes the decriminalisation of homosexuality in 2014, but also reveals that they still face a long struggle for full equality in Mozambique (Smith, June 2015). No official events or celebrations were scheduled to mark the occasion. A blogger and activist says that there has been an absence of public discussion over homosexual rights in Mozambique (AFP, June 2015). A human rights activist in Mozambique indicates that one of his biggest challenges has been to explain to people that they need to fight for their rights (DiDiRi Collective, 2013). Further, even in the least homophobic countries, LGBTI people are persecuted, if not by law, then by public opinion (DiDiRi Collective, 2013).

### *HIV/AIDS*

According to the 2014 UNAIDS estimates for HIV and AIDS, 1.5 million people are currently living with HIV. The estimated HIV prevalence amongst adults aged 15-49 is 10.6% (Government of Mozambique, 2014). There is no data available on the prevalence of HIV among LGBTI individuals in Mozambique.

Mozambique's current NSP - National Strategic HIV and AIDS Response Plan (2010 – 2014) - indicates that MSM have been identified as a group that is at high risk of HIV exposure (along with sex workers, refugees, migrants, military, prisoners, injecting drug users, and women in communities where there is pronounced gender inequality) (Government of Mozambique, 2009).

MSM are also mentioned as a priority for the government insofar as the next behavioural surveillance survey will provide data on the prevalence of HIV and behaviour of MSM (along with female sex workers, truck drivers, and miners working in South African mines). The current policy acknowledges MSM, indicating that 5% of new HIV infections in the country are occurring among MSM. Aside from MSM, the current policy does not address other groups within the LGBTI spectrum. Mozambique's most recent GARPR does not report any data for MSM, WSW, or transgender individuals. However, it does highlight the need for greater involvement and role played by high risk groups like MSM (Government of Mozambique, 2014).

# NAMIBIA

## *Legal environment*

The criminal procedure act in Namibia that criminalises sodomy is inherited from the South African Roman-Dutch common-law (Carroll & Itaborahy, 2015). The law defines sodomy as “sexual relations per anum between two human males”. It does not take into account whether the sexual intercourse is consensual or non-consensual. There is no information on penalties imposed for the commission of this crime (Johnston, 2015; Global Legal Research Center, 2014).

There is no anti-discrimination provision to protect individuals from being discriminated against on the basis of their sexual orientation and/or gender identity (Johnston, 2015). Rather, same-sex relationships are explicitly excluded from protection by the 2003 Combating of Domestic Violence Act. There is therefore no legal protection for lesbian, gay, bisexual, transgender or intersex people in Namibia.

## *Civil Society, Perceptions, Obstacles and Support*

One of the most comprehensive resources on LGBTI civil society in Namibia is Ashley Currier’s recent book *Out in Africa: LGBT Organizing in Namibia and South Africa* (2012a). Currier explores issues of strategic visibility of LGBT organizations in Namibia, discussing how, when, and why different groups choose, or are forced to, increase their public visibility or withdraw. In his review of the book, Paternotte (2014) highlights how Currier points out the shared histories of South Africa and Namibia, but draws attention to the sharp differences in their stances on LGBTI rights; Namibian leaders were quick to adopt a more hostile stance.

Currier (2012a) also argues that the support of LGBT activists from South Africa and Zimbabwe likely influenced the strategic choices of Namibian LGBTI civil society more than Northern funding has. Namibian LGBTI organizations have long histories of consulting with South African and Zimbabwean organizations for advice on law-reform campaigns as well as support in establishing regional and continental networks of African LGBTI activists (Currier, 2012b). There is a small but relatively strong LGBTI civil society in Namibia, with an organization sitting on the Country Coordinating Mechanism (OutRight Namibia). Out Right Namibia (ORN) advocates for the human rights of LGBTI people at national, regional and international level and engages with national, SADC and AU mechanisms to further address homophobia in the country. Further, the country receives a large proportion of external funding for MSM programs, compared to many of its neighbours (Ryan et al., 2013).

Despite the relatively absent legislation against LGBTI people, and the relative strength of LGBTI civil society in Namibia, recent trends at the United Nations Human Rights Council (UNHRC) bring the country under a negative spotlight. In September 2014, at the 27th Session of the UNHRC, Namibia joined Egypt, South Sudan, Uganda, Sierra Leone, Congo, United Arab Emirates, Malaysia, Djibouti, and Bahrain in signing a suggested amendment to remove Sexual Orientation and Gender Identity (SOGI) from the proposed resolution. The amendments were not accepted and the SOGI resolution was passed by the UNHRC.

## *HIV/AIDS*

According to the 2014 UNAIDS estimates for HIV and AIDS, 260,000 people are currently living with HIV. The estimated HIV prevalence amongst adults aged 15-49 is 16% (Government of Namibia, 2015).

MSM are included in the current definition of most-at-risk populations in the National Strategic Framework for HIV and AIDS Response in Namibia (2010/11 – 2015/16) (Government of Namibia, 2010). Targets are set specifically to increase condom use among MSM (increases by 20% between FY2010/11 and FY2012/13 and by 50% between FY2010/11 and FY2015/16). The government says that proper size estimates for MSM have not yet been determined, but they cite a World Bank estimate of 2,600 MSM in Namibia. The strategy indicates that there has previously been a lack of focus and targeting on key epidemic drivers among MSM, since the focus has been affected by available funding. The strategy highlights bisexual men, too, within its discussion of MSM vulnerabilities. The current strategy does not address WSW, lesbian women, transgender or intersex individuals.



The prevalence of HIV among MSM in Namibia was reported to be 12.6% in their 2014 GARPR (Government of Namibia, 2014). This is compared to a prevalence of 14.3% in the general population. No data was reported for the indicators of condom use or testing for MSM, but targets for the 2015/2016 NSF are stated (increase by 50% of baseline and 80%, respectively) which does indicate a certain level of political will and commitment to HIV prevention among this group. The report also states that there is an Integrated Bio-Behavioural Survey (IBBS) ongoing in the country (results were expected for 2015, but could not be accessed at the writing of this review) which will provide more information on population size estimates and behavioural characteristics of MSM in Namibia. Further, the 2014 GARPR states that Parliamentarians are seeking proposals for law reform on MSM.

## **SOUTH AFRICA**

### *Legal environment*

Same sex relationships, as well as same sex marriages are legal in South Africa. The country abrogated laws that criminalized homosexual conduct and legalized same-sex sexual activity in 1998 (Global Legal Research Center, 2014). Same-sex marriages have been legal since November 2006 as per the Civil Union Act. As of 2002, adoption is also legal for same sex couples. The backbone of South Africa's non-discrimination laws is Section 9 of the Constitution, which states that the state may not unfairly discriminate against someone on the basis of their sexual orientation. The Promotion of Equality and Prevention of Unfair Discrimination Act has set up Equality Courts which individuals can approach for redress in line with rights described in Section 9. These courts are not sufficiently used. According to the AJPCR Baseline Survey (2015), respondents showed extremely low awareness of human rights related legislation in which only 10% of the respondents were able to identify any of the relevant Acts (Kimmie, 2015). However, South Africa does not have legislation against hate crimes, but the Department of Justice and Constitutional Development, in collaboration with the 'LGBTI Task Team', is in the process of drafting a Policy Framework on Combating Hate Crimes, Hate Speech and Unfair Discrimination, which is intended to provide the foundation for a law to eradicate hate crimes (Johnston, 2015). Such legislation will include any hate speech directed towards the LGBTI community.

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 and intersex people (Johnston, 2014). However, the constitutional clause does refer to gender, which has been interpreted in the past as including protection based on gender identity. In a 1998 Constitutional Court judgment, Judge Ackermann, in Section 21 of the ruling, established that non-discrimination and equal rights in regards to 'sexual orientation' ought to be broadly interpreted to include 'transsexual' people.<sup>1</sup>Therefore, transgender people in South Africa are entitled to equal protection and non-discrimination under the law.

The Alteration of Sex Description and Sex Status Act, No. 49 of 2003 (Act 49) seeks to legally enable transgender and intersex people to amend their identification documentation from the gender assigned at birth to reflect their gender identity. A report by the Legal Resources Centre & Gender Dynamix (2015) provides an in-depth analysis of the current challenges with Act 49. The report argues that while Act 49 is an important piece of legislation because it seeks to legally enable transgender and intersex people to amend their identification documentation from the gender recorded at their birth to reflect their true gender identity, the implementation of the Act through the Department of Home Affairs has been problematic. The main concerns that the report discusses focus on (1) the unlawful rejection of applications for revised identity documents with the justification that the applicant did not provide proof of gender re-assignment surgery; (2) the waiting period for applications to be processed, reported to take between 1 year and 7 years; and (3) the fact that successful sex description alteration forces married applicants to divorce, as there exist different marriage acts for same-sex and opposite-sex marriages.

In 2014, transgender woman Nadia Swanepoel went on a hunger strike in protest of not being able to get an ID that reflects her name and gender. She approached the Department of Home Affairs three years ago, where she applied for a name and gender change on her identity document. But her application document was lost several times, forcing

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<sup>1</sup>Quote from the original judgment: "The concept "sexual orientation" as used in section 9(3) of the 1996 Constitution must be given a generous interpretation of which it is linguistically and textually fully capable of bearing. It applies equally to the orientation of persons who are bi-sexual, or transsexual and it also applies to the orientation of persons who might on a single occasion only be erotically attracted to a member of their own sex" (<http://www.saflii.org/za/cases/ZACC/1998/15.pdf>)

her to re-apply four times. On submitting her latest application, she was told she would have to have genital surgery to meet the requirements of the Act 49. After the media and lawyers got involved in Swanepoel's case, the department updated her identity documents quickly (Kings, October 2014).

## *Civil Society, Perceptions, Obstacles and Support*

Despite South Africa's progressive legal constitution that upholds the rights of LGBTI people, conservative and discriminatory social attitudes are pervasive (Johnston, 2015). While polls indicate that South Africans hold the most accepting views towards homosexuality in the region, the majority (69%) are not accepting of homosexuality (Dionne, Dulani & Chunga, 2014). Just under half (45.9%) of South Africans say that homosexuality is never justifiable (compared with 56.6% in Zambia and 94.7% in Zimbabwe; *ibid*). Recent studies reveal that many LGBTI people still face high levels of social stigma, discrimination, and violence due to conservative attitudes that have persisted from the Apartheid era (Samudzi & Mannell 2016; Sanger 2015; Legal Resources Centre, Iranti-org & Gender Dynamix 2016; Msibi & Jagessar 2015; van Rooyen 2015; Mavhandu-Mudzusi & Sandy 2015).

South Africa's GARPR (Global AIDS Response Progress Report) (Government of South Africa, 2012a) highlights a handful of LGBTI service organizations which are involved in HIV prevention and service delivery, research and advocacy, including: OUT LGBT (Pretoria), The Triangle Project (Cape Town), Health4Men (Cape Town), The Desmond Tutu HIV Foundation (Cape Town), and The Durban Gay and Lesbian Centre (Durban). The report highlights how these five civil society organizations do mainstreaming of LGBT/MSM/WSW issues in an attempt to sensitize service providers to the needs of these marginalized communities.

***While polls indicate that South Africans hold the most accepting views towards homosexuality in the region, the majority (69%) are not accepting of homosexuality***

## *HIV/AIDS*

According to the 2014 UNAIDS estimates for HIV and AIDS, 6.8 million people are currently living with HIV. The estimated HIV prevalence amongst adults aged 15-49 is 18.9% (Government of South Africa, 2012a). South Africa has the largest and most high-profile HIV epidemic in the world.

South Africa's current National Strategic Plan on HIV, STIs, and TB (2012 – 2016) includes MSM and transgender individuals in its definition of key populations. The strategy sets the objective to support health care workers to understand the difference between transgender people and gay men, which should not be collectively considered to be MSM. Notably, South Africa's is the only NSP in the region to identify the provision of pre-exposure prophylaxis (PrEP) for MSM as an intervention. While WSW are not included in the list of key populations in the NSP, a number of the country's Provincial Strategic Plans (PSPs) do include this group. Further, in the PSPs from the Eastern Cape, Mpumalanga and Kwazulu-Natal, intersex people are explicitly mentioned as a priority population.

While South Africa's most recently available GARPR states that the percentage of MSM in the country who are living in HIV is 9.9%, the country also reported disaggregated data from certain "hot spots" and urban locations which paint a different picture: Among MSM aged 18-58 years, in Soweto, Gauteng HIV prevalence is 47%; among MSM from Johannesburg and Durban it is 43.6%; in Cape Town, Durban, and Pretoria, HIV prevalence among MSM is 35% (Government of South Africa, 2012a). More recent research shows that these rates may be even higher; Cloete et al. (2014) find that HIV prevalence among MSM 25 years and older to be 27.8% in Cape Town, 36.7% in Johannesburg, and 71.1% in Durban. These rates are extremely high when compared to the HIV prevalence in the general population, which is estimated at 19.1%. Among all new infections, 9.2% are related to MSM. The percentage of MSM that have received an HIV test in the past 12 months and who know their results is 27.2%. Along with Botswana, South Africa is the only other country in the region to include transgender individuals in the list of key populations in their GARPR.

# SWAZILAND

## *Legal environment*

There are no primary documents detailing the legal status of homosexuality in Swaziland, and no information on the penalties imposed (Global Legal Research Center, 2014). Sodomy, defined as “sexual intercourse per anum between two human males”, is criminalised by common law (Carroll & Itaborahy, 2015). In 2005, the Government planned to include prohibitions of all male and female homosexual acts in a revised version of its Sexual Offences laws. The proposed penalties for same-sex sexual behaviour include a two-year prison sentence or a fine (approx. \$500). However, to this date the proposal has not been adopted (Itaborahy & Zhu, 2014). There is no anti-discrimination provision to protect individuals from being discriminated against on the basis of their sexual orientation and/or gender identity. There is therefore no legal protection for lesbian, gay, bisexual, transgender or intersex people in Swaziland.

## *Civil Society, Perceptions, Obstacles and Support*

Swaziland, sub-Saharan Africa's last absolute monarchy, is a conservative country and societal discrimination against the LGBT community is prevalent. Organizations supporting the LGBTI community have trouble registering and members of the LGBTI community are routinely victimized, and their opinions are ignored and excluded at community meetings (DiDiRi Collective, 2013). However, evidence of government support for LGBTI people and organizations is promising. In May 2013, Swaziland's highest traditional authorities gave their blessings to gays and lesbians who wished to stand as candidates for positions in Parliament later in the year (DiDiRi Collective, 2013).

Swaziland has a small but galvanizing LGBTI civil society movement. Rock of Hope, their largest LGBTI organization, currently sits on the country's Global Fund Country Coordination Mechanism (CCM) as a representative of key populations. HOOP also work as a support group for LGBTI people in Swaziland. Additionally, the organisation SWAPOL works to ensure that people living with HIV can be assisted by providing counselling and education.

## *HIV/AIDS*

According to the 2014 UNAIDS estimates for HIV and AIDS, 210,000 people are currently living with HIV. The estimated HIV prevalence amongst adults aged 15-49 is 27.7% (Government of Swaziland, 2014a). Swaziland has the highest HIV prevalence in the world.

Swaziland's Extended National Multisectoral HIV and AIDS Framework (eNSF) (2014-2018) includes MSM in the list of key populations (along with sex workers and people who inject drugs) (Government of Swaziland, 2014b). By 2018, the country has set targets to increase condom use among MSM to 80%, increase treatment coverage for MSM to 60%, and increase comprehensive HIV knowledge among MSM to 75%. The government also aims to raise coverage of prevention programmes and testing to 70% for MSM. The eNSF does not address bisexuality among MSM, instead noting that MSM are likely to also be involved in heterosexual relationships because of fear of being stigmatized when disclosing their sexual orientation. The current strategy does not address WSW, lesbian women, transgender, or intersex individuals.

Swaziland's most recent GARPR states that the HIV prevalence among MSM aged 16-44 years is at 17.7%, with the percentage increasing with age (Government of Swaziland, 2014a). The report emphasizes that the HIV prevalence

***In Swaziland, the HIV prevalence of MSM is lower than that of men in the general population aged 15-49 and lower than the total general population.***

of MSM is lower than that of men in the general population aged 15-49 (20%) and lower than the total general population (27.4%). Condom use among MSM is estimated at 66% (with non-regular partners) and only 27.1% have been reached with targeted HIV prevention programmes. Swaziland's 2014 GARPR does not report HIV testing data for MSM. The report

also states that among MSM in Swaziland, female partnerships are common, but self and external stigma prevents MSM with female partners (as well as bisexual men) from disclosing their sexual orientation or their HIV status to their female partners. WSW, lesbian women, transgender and intersex people are not discussed in Swaziland's 2014

GARPR. Lesbians and transgender individuals are visibly excluded in all initiatives that raise awareness and education about HIV transmission (Magagula, 2013). The Swazi National AIDS Programme, located in the Ministry of Health, recently published the first population size estimate for MSM in the Mbabane-Manzini corridor (Ministry of Health, 2015). According to this report, MSM make up about 2% of the adult male population aged 18-49 in the urban areas Mbabane/Manzini corridor and Piggs Peak, and 2.5% of the adult male population aged 18-49 in the Nhlanguano area.

## ZAMBIA

### *Legal environment*

Section 158 of Zambia's Penal Code criminalises sodomy, stating that 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, is liable to serve up to 14 years to life in prison. Attempting to engage in sodomy is also a crime, punishable by 7-14 years in prison. The Zambian Penal Code also prohibits "indecent practices between persons of the same Sex" for which adults could serve 7-14 years in prison. If "indecent practices" are committed by a minor under the age of 16, they could instead be sentenced to community service or ordered to undergo counselling (Global Legal Research Center, 2014). Section 158(1) addresses any male who commits "gross indecency", and Section 158(2) is repeated to address any female who does (Carroll & Itaborahy, 2015).

There is no anti-discrimination provision to protect individuals from being discriminated against on the basis of their sexual orientation and/or gender identity. According to a study undergone by the organisation Friends of Rainka, 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 (Johnston, 2014).

### *Civil Society, Perceptions, Obstacles and Support*

In the World Values Survey, 73.3% of Zambians cited homosexuals as a group they would not want as their neighbours (Dionne, Dulani & Chunga, 2014). Further, 56.6% said homosexuality was never justifiable (compared with 45.9% in South Africa and 94.7% in Zimbabwe). Despite these high levels of homophobia, the Human Rights Commission in Zambia has spoken out against discrimination against LGBTI people, though there was a negative response to this from within the country (DiDiRi Collective, 2013).

***The influence of homophobic American-style evangelical churches is a major contributor to discriminatory social attitudes, and legal and policy environments.***

The influence of homophobic American-style evangelical churches in Zambia, which has increasingly dominated Christian religious practice in the country, is an especially relevant obstacle in terms of public attitudes as well as cultures, which inform legal and policy environments. In 1980, there were 515,000 (9%) evangelical Christians in Zambia, which rose to 800,000 (12.6%) in 1990 and leapt to 2.2 million (25%) in 2000 (Grossman, 2013). There is also evidence that religious leaders in Zambia are urging the public to take the law into their own hands, calling for mob retaliation against LGBTI people (DiDiRi Collective, 2013). Green (2014) discusses how the age of social media may be fuelling surges in hate speech in Zambia.

There is a nascent LGBTI civil society in the country, with organisations like Friend of Rainka and Transbantu gaining visibility. However, Oberth (2014) notes that Zambia's LGBTI organisations are often timid and "co-optable" in debate spaces, which feature wider (and often homophobic) civil society, particularly compared to other countries in the region. In 2013, a human-rights activist was arrested after he appeared on a TV programme, where he spoke about the need to recognise the rights of LGBTI individuals. He was charged with the offence of soliciting in a public space for immoral purposes (Lusakatimes, February 2014). The arrest indicates the opposition against the LGBTI community in Zambia.

A recent article (Van Klinken, 2015) explores the heated public and political debate over LGBTI rights with reference to the stance and role of the human rights commission (HRC). The HRC is stating that LGBTI people should not be discriminated against, while at the same time ensuring that sexual orientation is not recognized as a possible ground of

discrimination protected by the constitution. The article argues that this can be understood as an attempt to negotiate the tensions between the commitment to human rights, on the one hand, and the politicized Christian character of the country, on the other (Van Klinken, 2015).

## *HIV/AIDS*

According to the 2014 UNAIDS estimates for HIV and AIDS, 1,2 million people are currently living with HIV. The estimated HIV prevalence amongst adults aged 15-49 is 12.4% (Government of Zambia, 2014). The Zambia National AIDS Strategic Framework (2011 – 2015) includes data on MSM, indicating that they are estimated to contribute 1% of new infections in the country (Government of Zambia, 2010). The report also includes the female partners of MSM, recognizing bisexuality and/or social pressure, which necessitate heterosexual relationships among gay men. The government expresses that more empirical evidence on size estimation of MSM and their partners is needed to adequately inform policy and programming. This is the extent to which MSM are included in the national strategy, and WSW, lesbian women, transgender or intersex individuals are omitted altogether. According to the National AIDS Strategic Framework 2014-2016, Zambia has allowed groups to lobby support for populations such as MSM (Government of Zambia, 2014-2016).

Zambia did not report any data for LGBTI individuals in its most recent GARPR (Government of Zambia, 2014). However, it does note that small studies exist in the country. For 2008, an incidence model estimated about 732 new infections occurred among MSM (1% of all new infections), and about 40 new infections in the female partners of MSM (0.05% of all new infections). The report also mentions that a study by The Panos Institute of Southern Africa was approved in 2011 to look at MSM and WSW. The GARPR provides a definition of MSM and says that transgender men are included within this definition.

## **ZIMBABWE**

### *Legal environment*

Section 73 of the Zimbabwean Penal Code prohibits homosexual conduct between men, expressly stating that this extends beyond sodomy to also include anything that would be regarded by a reasonable person to be an indecent act. If convicted, this is punishable by up to one-year imprisonment and/or a fine (Global Legal Research Center, 2014). Homosexual acts between females is not explicitly mentioned in the Zimbabwean penal code, but according to ILGA

***In Zimbabwe the lack of anti-discrimination law means that there is no legal protection for LGBTI people.***

2015 “female/female sexual acts” is marked as legal (Carroll & Itaborahy, 2015). Despite the criminalisation provision only addressing male-to-male sexual activity, it does not mean lesbians are not exposed to discrimination (Johnston, 2014). The constitution of Zimbabwe does promote equality for all people, yet it

nonetheless also includes a “claw back clause” which undercuts these fundamental rights by recognizing the primacy of customary law over the Bill of Rights (DiDiRi Collective, 2013). There is no anti-discrimination provision to protect individuals from being discriminated against on the basis of their sexual orientation and/or gender identity. There is therefore no legal protection for lesbian, gay, bisexual, transgender or intersex people in Zimbabwe. A thesis focusing on the Zimbabwean criminal law (Madzikatire 2015) argues that there is an urgent need to address the consequences that emanate from the prohibition of same sex marriages and the criminalisation of same sex sexual relations by focusing on the inclusion of sexual orientation as a protected ground of discrimination. It suggests to repeal Section 78 (3) of the criminal codification, as it is discriminatory against LGBTI persons, as well as to amend Section 73 (1) of the Code which punishes consensual sodomy between consenting adults as it discriminates, belittles and devalues gay men for expressing their sexual desires. It suggests that embracing sexual minority rights could be achieved by the inclusion of sexual orientation as a protected ground of discrimination, juxtaposed with the introduction of a Civil Partnerships Act, which could extend the legal consequences of marriage to LGBTI persons; and by bolstering these legal provisions with a National Policy on the promotion and protection of LGBTI persons.

## *Civil Society, Perceptions, Obstacles and Support*

In the World Values Survey, 67.8% of Zimbabweans cited homosexuals as a group they would not want as their neighbours and 94.7% said homosexuality was never justifiable (compared with 45.9% in South Africa and 56.6% in Zambia) (Dionne, Dulani & Chunga, 2014). Though they are few, there are also voices of support. Scholars from the University of Zimbabwe argue that “despite disapproval that homosexuality in un- African, it is as African as the baobab tree and as Zimbabwean as the Great Zimbabwe Ruins” (Mabvurira et al., 2012, p. 218). Mabvurira et al. (2012) argue that it is the responsibility of social workers in Zimbabwe to assume advocacy roles around the absence of adequate services for LGBTI communities.

President of Zimbabwe, Robert Mugabe has repeatedly said that gay rights are not human rights. Mugabe publicly spoke in support of the Ugandan Anti-Homosexuality Act, signed by the Ugandan President Museveni in February, saying Museveni was “fighting a just fight”. In a statement, Mugabe said he was keen to know who is a member of GALZ (Gays and Lesbians of Zimbabwe), who has been advocating recognition of gay rights in Zimbabwe, and that he would “deal with the organisation”. As a result, on 12 March 2015, a youth volunteer for GALZ was arrested and charged with illegally holding a public meeting. The police have indicated that they will proceed by way of summons. The volunteer was released without charge (Government of the UK, 2015).

The organization Gays and Lesbians of Zimbabwe (GALZ) has been a long-time defender of LGBTI rights in the country, and indeed the region. Epprecht (2012; 2013b) writes extensively on the history of civil society resistance to LGBTI human rights violations in Zimbabwe, focusing on the history of GALZ as an organization. He notes how memoirs by founding members of GALZ show that the organization was formed as a result of strong lesbian leadership, though today much of their work is framed within the public health umbrella against risks MSM face with respect to HIV (Epprecht, 2012). In January and February 2014, GALZ won a landmark legal victory as the courts ruled that the state returns GALZ property, which had been seized, and that GALZ was permitted to continue as an organization despite not being registered (Littauer, 2014, February 28).

## *HIV/AIDS*

According to the 2014 UNAIDS estimates for HIV and AIDS, 1,6 million people are currently living with HIV. The estimated HIV prevalence amongst adults aged 15-49 is 16,7% (Government of Zimbabwe, 2015).

Zimbabwe’s current NSP – the Zimbabwe National HIV and AIDS Strategic Plan [ZNASP II] 2011-2015 - acknowledges the gap that there is no size estimation or bio-behavioural surveillance on MSM (even though it was proposed in ZNASP I) which is severely hampering the government’s ability to develop appropriate behaviour change and communication interventions for MSM (Government of Zimbabwe, 2011). The strategy also recognizes that MSM are hard to reach as they often go underground for fear of social and legal reprisals (due to what the strategy terms “illicit sex”). The only priority strategy aimed at MSM in the National Strategic Plan is to increase condom use among this group. Other populations within the LGBTI community are not mentioned in ZNASP II. Zimbabwe’s latest GARPPR (Government of Zimbabwe, 2014) is completely silent on LGBTI people. In fact, the indicators are not even listed.

# Law and policy framework

***The legal environment for LGBTI people in Southern Africa varies greatly from country to country, but same-sex sexual activity is illegal in all countries except Lesotho, Mozambique and South Africa***

As is clear from the country profiles preceding this section, the legal environment for LGBTI people in Southern Africa varies greatly from country to country. Same-sex sexual activity is illegal in all countries except Lesotho, Mozambique and South Africa, either expressly indicated in the penal code or according to common-law. However, the enforcement and degree of punishment in countries where same-sex activity is criminalized is highly

dependent on the sociopolitical context of each country. In Angola, the punishment for homosexual acts is a short term of probation or physical labour. On the other hand, in Malawi and Zambia those convicted can serve up to 14 years in prison.

Country	Same sex sexual conduct (consensual) between men criminalized	Same sex sexual conduct (consensual) between women criminalized	Laws prohibiting discrimination
Angola	Yes	Yes	No
Botswana	Yes	Yes	Yes
Lesotho	No	No	No
Malawi	Yes	Yes	No
Mozambique	No	No	Yes
Namibia	Yes	No	No
South Africa	No	No	Yes
Swaziland	Yes	No	No
Zambia	Yes	Yes	No
Zimbabwe	Yes	No	No

Source: Carrol (2016)

With regards to provisions of anti-discrimination, South Africa – as the clear exception in the region – enshrines and protects the rights of all people, of all sexual orientations and gender identities. Marriage of same-sex couples is legal, as is adoption for same-sex couples. Notably, South Africa is also the only country that promotes equality around gender identity; as of 2003, the law permits trans men and trans women to legally change their sex in the country's population registry, as well as on their identity documents (ARASA, 2014). A recent report, however, argues that while Act 49 (the act in question) is an important piece of legislation because it seeks to legally enable transgender and intersex people to amend their identification documentation from the gender recorded at their birth to reflect their true gender identity, the implementation of the Act through the Department of Home Affairs has been problematic (Legal Resources Centre & Gender Dynamix, 2014).

In the period since 2010, two crucial changes have occurred in national legal frameworks impacting LGBTI people in Southern Africa. In Article 52 of the Lesotho Penal Code Act 2010, which entered into force on 9 March 2012, there is no more mention of sodomy: this article replaces section 185(5) of the 1939 Criminal Procedure and Evidence Act which had previously enumerated [male] sodomy as a punishable act. As such, same-sex sexual relations amongst consenting adult males in Lesotho were decriminalised by this 2010 Act (Carrol, 2016).

On 11 July 2014, the Parliament of Mozambique approved Law 35/2014, by consensus, which replaces their former Penal Code from 1886. The new Penal Code removed Articles 70 and 71, which provided for the imposition of security measures on people who habitually practiced “vices against nature”, and thereby criminalised same-sex acts between consenting adults. The revised Penal Code was published on 31 December 2014 and came into force in June 2015 (Carrol, 2016). These two changes have been listed as important examples for social change in Southern African countries, and are at times seen as important precedents, which could be used at crucial international gatherings to emphasise the need for de-criminalisation (BBC Africa, 2016).

Chanika, Lwanda and Muula (2013) argue that politicians and their supporters use rhetoric that isolates LGBTI rights, dissecting them out of the encompassing concept of human rights. Many constitutions in the region guarantee human rights, though sodomy provisions remain in the penal code. Part of this contradiction in the definition of human rights may stem from how different cultures value and protect the rights of the individual versus the rights of the collective. In Western cultures, the rights of the individual are paramount, whereas in many Southern African cultures, collective rights may be deemed more important. The African Charter on Human and People’s Rights (1981) is a good example of this. In another example, Amtaika (2013) argues that problems arise in Malawi when there is a perceived conflict between the rights of the individual and the rights of the collective. This is one way to potentially understand how so many countries in the region have Human Rights Commissions or other human rights institutions, yet deny these rights to LGBTI individuals. For example, Van Klinken (2015) explores the heated public and political debate over LGBTI rights with reference to the stance and role of the Zambian Human Rights Commission, which issued a statement against the discrimination of LGBTI people, while maintaining their position that sexual orientation should not be recognised in the constitution as grounds for discrimination. The article argues that this can be understood as an attempt to negotiate the tensions between the commitment to human rights, on the one hand, and the politicized Christian character of the country, on the other (Van Klinken, 2015).

Country	Human Rights Commission	Other
Angola	Yes *	An inter-ministerial committee meets regularly to report to UN bodies on human rights
Botswana	Yes *	Ombudsman- investigates maladministration and human rights violations in the public sector
Lesotho	Senate passed Constitutional amendment in 2011 to establish a human rights commission but to date not yet been established	Office of the Ombudsman
Malawi	Yes	Yes
Mozambique	Yes	Yes
Namibia	Yes *	Yes
South Africa	Yes *	Yes
Swaziland	Yes (Though the commission is nearly inactive due to lack of staff and no budget)	No
Zambia	Yes *	No
Zimbabwe	Yes *	Yes

Where marked with a \*, Human Rights Commissions are working on issues of sexual orientation/ LGBTI rights, Source: adapted from ARASA (2014) and Carroll (2016)



Despite the challenges that remain in the legal contexts of many Southern African countries, in his recent article “Sexual Minorities, Human Rights and Public Health Strategies in Africa”, Epprecht (2012, p. 227) poignantly reminds us that “Progress towards the attainment of human rights for sexual minorities may often seem painfully inadequate when seen against headlines of homophobic hate speech and violence” but that “we should not let those homophobias blind us to the very real progress that has occurred in the struggle to broaden acceptance of the notion that sexual orientation and gender identity are human rights” (Epprecht, 2012, p. 243).

Epprecht (2012) highlights how Cape Verde followed South Africa’s lead, becoming the second country in Africa to decriminalize homosexuality. In Southern Africa, Epprecht notes that the High Court in Botswana has begun hearings on the decriminalization of sodomy. Further, he points to the encouraging sign that several countries (including Gabon, Mauritius, Central African Republic, Rwanda, and Sierra Leone) have either signed - or given the indication that they will sign – in support of the UN General Assembly’s resolution to include sexual orientation within the Universal Declaration of Human Rights. In addition, Human Rights Watch (2013a) spotlights many prominent (former) Southern African political leaders who have added their voices of support to defeat homophobia on the continent:

“Sexual preferences are a private matter. I don’t think it is a matter for the state to intervene. I mean what would you want? It doesn’t make sense at all. That is what I would say to the MP. What two consenting adults do is really not a matter for the law.

~ Thabo Mbeki, former president of **South Africa**, January 2012

“The time has come for African leaders to take action against bad laws that stifle our HIV response. This starts with recognizing the rights of women and decriminalizing homosexuality and voluntary sex work, which is vital to protecting the health and dignity of these groups.”

~ Festus Mogae, former president of **Botswana**, July 2012

“We can no longer afford to discriminate against people on the basis of age, sex, ethnicity, migrant status, sexual orientation and gender identity, or any other basis – we need to unleash the full potential of everyone.”

~ Joaquim Chissano, former president of **Mozambique**, January 2014

Problematizing tropes that began emerging in recent years in Southern Africa following Uganda’s Anti-Homosexuality Bill, Thoreson (2014) suggests that speaking about a ‘wave of homophobia’ moving across Africa ignores the political economies that produce various homophobias in different places in the first place (See section on “Queer Imperialism”). Thoreson compares the different ways in which homophobias are produced and perpetuated in different contexts in Africa. He notes that in Malawi, the emphasis on same-sex practising people was largely aimed at them as frivolous, embarrassing to their families/communities, or mentally ill (Thoreson, 2014). This is quite different to other contexts, which place homophobic emphasis on LGBTI people as recruiters, child molesters, and an abominable force that threatens the safety and security of the nation. Another example of how homophobias are shaped by political and economic contexts can be seen in Zambia, where Van Klinken (2013) argues that there is an ‘emerging anti-homonationalism’. Through this mechanism, the opposition to gay rights is central to the defence of a national identity that; homophobia becomes a unifying nationalism through which politicians manipulate power and control.

In particular, arguments of morality and public health are often used to justify the criminalisation of same-sex sexuality. Acknowledging the role that science plays in justifying laws that prohibit same-sex sexuality on the African continent, a landmark report by the Academy of Science of South Africa (2015) assessed the evidence behind such arguments: “Partly because those arguing in favour of criminalising sexual and gender diversity have made explicit appeals to science, this report examines the extent to which science supports any of the arguments that proponents of these new [homophobic] laws make. Drawing on recent scientific evidence and, where possible, on systematic reviews, the report seeks to provide an up-to-date overview of the state of the current biological, socio-psychological, and public health evidence and assess how this supports, or contests, the key arguments made in favour of new laws” (p. 9). According to the report, the five most commonly listed arguments for repressive laws are that (1) homosexuality is “socially contagious, and that people, especially children and teenagers, are ‘recruited’ into same-sex orientations; (2) one of

the means of such recruitment into homosexuality is adult-to-child sex (paedophilia) and that, as such, stringent laws are needed to ‘safeguard children’ and ‘protect families’; that (3) homosexuality ‘reproduces itself’ in such a ‘recruiting’ manner because there is no biological basis or ‘innateness’ for homosexuality; that (4) homosexuality is ‘unnatural’ and, following from this, same-sex sexual acts present health dangers to those who participate in such practices and, by extension, to the general public health, including spreading HIV. New legal prohibitions will thus improve public health; and (5) that as a ‘condition’ that is neither ‘biological’ nor ‘innate’, homosexuality is ‘taught and learned’ and is therefore something that can be prevented and unlearned. To promote this unlearning and prevent ‘recruitment’ from taking place, those with same sex orientations should be offered – or forced – into some form of ‘corrective’ therapy, and the ‘promotion’ of sexual and gender diversity should be criminalised and outlawed.” (p. 15). In assessing the scientific evidence behind each of these arguments, the report finds, in summary, “abundant and robust evidence that more repressive environments increase minority stress and impact negatively on LGBTI health” (p. 11), and concludes that “[a]s there is no evidence that adult sexual orientation is correlated with abuse in childhood, this false connection should no longer be used to justify the marginalisation of LGBTI persons” (p. 11). It further recommends that “[e]fforts should rather be focused on countering the belief systems that create hostile and even violent environments for those who are made to feel alienated within societies that privilege male power across political, social and family domains.” In addition to these regional overview reports, a few country-specific in-depth analyses of legal frameworks have recently been published by the Southern African Litigation Centre.

# International agencies and mechanisms

In addition to the African Charter on Human and People's Rights, other commitments and policies from the region are beginning to mount political precedence for increased human rights for LGBTI people. The report of proceedings from the African Union Commission's 5th Inter-Agency Meeting on Coordination and Harmonization of HIV/AIDS, TB and Malaria Strategies (African Union, 2014), included – for the first time – mention of key populations and even the need for advocacy and support for MSM. Further, the newly proposed minimum standards or Integration of Sexual and Reproductive Health Rights and HIV/AIDS in SADC Region include several provisions that include LGBTI populations. For instance, the document states that gender sensitive responses “must recognize the needs of girls, boys, men, women and transgender people irrespective of their sexual orientation” (SADC, 2014, p. 23). The SADC HIV and AIDS Strategic Framework 2010-2015 also includes MSM as part of its priority interventions, including facilitating and coordinating sharing of information across the region and reviewing evidence from various member states (SADC, 2009).

Building on these provisions, important progress was made at the African Union level since 2014. Resolution 275 (“Resolution on Protection against Violence and other Human Rights Violations against Persons on the basis of their real or imputed Sexual Orientation or Gender Identity”, ACHPR, 2014), passed at the African Commission's 55th Ordinary Session, condemns the “increasing incidence of violence and other human rights violations, including murder, rape, assault, arbitrary imprisonment and other forms of persecution of persons on the basis of their imputed or real sexual orientation or gender identity”. This resolution marks the first official AU document to call for specific protection based on sexual orientation and gender identity. Following the resolution, the African Commission on Human and People's Rights launched a joint report with the Inter-American Commission on Human Rights and the United Nations titled ‘Ending violence and other human rights violations based on sexual orientation and gender identity’ (ACHPR, 2016) at their 58th session in March 2016.

A number of civil society organisations have started to submit shadow reports, focusing on LGBTI rights, for their countries' reviews for accordance with international treaties. For the 2016 periodic report of South Africa and Namibia to the African Commission on Human and People's Rights, civil society organisations in both countries wrote country-specific shadow reports. The South African report, written by two civil society organisations (Gender Dynamix and Iranti-org) in collaboration with the Legal Resources Centre (a not-for profit organisation providing free legal representation), focused on the civil, political and socio-economic rights of transgender and intersex persons in South Africa (Legal Resources Centre & Gender Dynamix, 2016). The Namibian report, submitted by a collective of civil society organisations, including OutRight Namibia, focused on the human rights situation for LGBTI persons and sex workers (OutRight Namibia, Facebook post).

# “Queer Imperialism”: Funding Partners, African Sovereignty and the West

LGBTI research in Southern Africa is widely funded by Western countries through international donor mechanisms. The ideological tension is apparent as, noted by various scholars, it is Western constructions of morality, health, gender, and sexuality that have contributed to the pathologisation of sex, gender, and sexual minorities, as well as the pervasive social stigma and discrimination against them in Southern Africa and beyond.

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There is some variation in how scholars attribute societal homophobia in Africa to colonialism. On the one hand, Ibrahim (2015) argues that pre-colonial Africa accommodated a diverse set of ways in which non-heterosexuality and non-heteronormativity were expressed and that it was colonialism that introduced the now widespread religious and legal norms that police sexuality and gender. Ibrahim (2015) also argues that contemporary homophobia in Africa is also based on Western anti-LGBT rights discourses and, in some parts, is sponsored by Western/American evangelical groups, modern telecommunications, and the spread of global religious fundamentalisms. On the other hand, Hellweg (2015) argues that homophobia in Africa is a result of both external causes, such as colonialism, nationalism, and religious proselytization, as well as internal social dynamics, including the broader sexism and the masculinist orientations of politically repressive nationalisms.

One of the most oft cited piece of work on homosexuality and imperialism is the 2008 Human Rights Watch Report (recently reprinted in an abridged form – see Human Right Watch, 2013) This Alien Legacy: The Origins of African “Sodomy” Laws in British Colonialism. This report makes a compelling case for the examination of the irony that Christianity – an imported colonial religion – is used as a bolstering mechanism to declare homosexuality as “unAfrican”, despite the fact that the laws against gay relationships in ex-British colonies are products of imperial mechanisms to limit and contain the racial “other”. In a review of 319 articles on same-sex marriage in South Africa, Vincent & Howell (2014) found that homophobic discourse follows three legitimizing tropes: Homosexuality as “unAfrican”, as “unGodly” and as “unnatural” (usually in relation to the ‘naturalness’ of sex for procreation). The authors note that “to cast homosexuality as a foreign import – the unwelcome imposition of ‘white’ sexual norms – raises the spectre of colonialism and apartheid as the legitimising narrative for a politics of homophobia” (479) and homophobia emerges as the protection of the right to culture, to religious freedom and to morality” (480). Similarly, examining a recent declaration by the Zambian Human Rights Commission that prohibits the new constitutions anti-discrimination law being extended to sexual orientation, Van Klinken (2015) argues that constitutional discourse and popular imagination of Zambia as a Christian nation has led to a particular moral geography and political economy in which an anti-Western rejection of LGBTI human rights is not only possible but has become the only possible and moral course of action.

Malawi seems to be at the epicenter of the discussion around homosexuality and 21st century “imperialism”. In December of 2009 two Malawian men, Steven Monjeza and Tiwonge Chimbalanga, attempted to hold a traditional engagement ceremony. They were given a maximum sentence of 14 years hard labour the following May. Eleven days later, during a visit by UN Secretary General Ban Ki-moon, the late President Bingu wa Mutharika pardoned them and ordered their release. This case is deemed by some as an event which captured the public’s attention and began a dialogue which led to a new way of engaging in social and political commentary around “African homophobia” in Malawi and on the continent (Biruk, 2014).

***Perceptions about “queer imperialism” are perhaps especially robust in Malawi, as a result of the level of donor dependence in the country.***

Despite salience across the region, McNamara (2014) asserts that perceptions about “queer imperialism” are perhaps especially robust in Malawi, as a result of the level of donor dependence in the country, and importantly, the widespread public perception that Malawi cannot survive without money from Western donors. McNamara (2014, p. 89) shares the views of

local people on the perceived relationship between homosexuality and Western donors:

*“At first Bingu [wa Mutharika] was a good leader and the country was strong, but then two men tried to marry and when Bingu refused, the azungu were angry and they stopped helping us, now there is no fuel because Malawi is too poor to stand on its own.”*

Another of McNamara’s rural Malawian respondents commented on Mutharika’s successor, Joyce Banda’s position, reiterating the relationship between Western donor money and pressure to accept homosexuality.

*“She needs to make a relationship with UK, she’s after donors and they need to help her because you must have money to become [president] again and JB wants to show that she is different from Bingu and wants to travel the world” (McNamara, 2014, p. 94).*

Late President Bingu wa Mutharika commented publicly in April 2010 on homosexuality, accusing his citizens of ‘aping cultures they do not understand’. Biruk (2014) suggests that the concept of homophobic Malawian “culture”, though presented as African, derived from the ancient, is essentially a product of the relationship between Malawi and the wider world (namely, the West). As donors began to halt or cancel their financial aid commitments to Malawi, the debate became increasingly about the West exerting financial muscle over Malawi in attempt to force them to accept “Western” gay rights (Abbas, 2012; Biruk, 2014). In Zambia, too, homosexuality is viewed as a Western import, which Muhandu (2009) says contributes to the rejection of the idea that being homosexual is a natural state of being – the way a person is born. Executive Director of CITAM+ confirms this challenge of LGBTI being perceived as an element of Western imposition:

*“We don’t talk about LGBT here. You can’t. We’ve tried to talk about it indirectly, but you just can’t, they just won’t take it. That one is out completely. When you bring LGBT, issues of sovereignty start coming up” (Oberth, 2012, p. 24).*

Currier’s (2014) notes that in such a climate HIV/AIDS, human rights, and feminist activists, potential allies to the LGBTI movement face a difficult decision. If these organisations:

*“publicly endorsed LGBT rights, they faced hostility locally from political, religious, and traditional leaders but could reap benefits from representatives of foreign donors and transnational NGOs who would reward their organizations’ support with additional resources. In contrast, if Malawian activists delayed or deferred their public display of support for LGBT rights, they could avoid local hostility from political, religious, and traditional leaders but encounter displeasure from representatives of foreign donors and transnational NGOs who expected HIV/AIDS, human rights, and feminist activist organizations to aid gender and sexual dissidents.” (Currier, 2014: 155).*

Currier (2012b) discusses the concept of “gay-for-pay” in Namibia, whereby sexual minorities are often accused of only engaging in same-sex behaviors, or only claim to have LGBTI identities in order to obtain money from Western donors. One small study of 50 MSM in Lesotho found that a very small proportion (4%) reported money as their rationale for having sex with men; the vast majority (81%) reported having sex with men because that is their choice and their preference (Miller, 2014). Other evidence from Mozambique (Maputo) indicates that circumstances may be different there; just under half (47.7 %) of MSM in the country’s IBBS (2011) reported received money, goods, or services in exchange for anal sex with another man in the past year (Nalá et al., 2014).

In a review of Currier’s recent book *Out in Africa* (2012a), Epprecht (2013a) notes how she finds mixed evidence for

the impact of “queer imperialisms”. He says that the big international development organizations, particularly ones such as Hivos, do not come across as promoting an assertively ‘un-African’ gay identity. Epprecht (2013a) says that organizations like these actually seem cautious in consultation with African activists. The push to create broad pan-African networks has resulted in some localized tensions in the beginning, but Epprecht (2013a) says that this kind of structure will likely be helpful to the interests of African LGBTI in the long run.

McNamara (2014) argues that the conflation of homosexuality with Western dominance is in part the fault of heavy-handed donors. In other words, for countries in Southern Africa, rejecting Western influence through a rejection of LGBTI rights is also a way of reaffirming economic and political independence. Others, however, suggest that this

anti-donor, anti-homosexuality rhetoric was hijacked by politicians for their own political gain (Chanika, Lwanda & Muula, 2013). In what they call ‘the sexualized politics of donor aid in Malawi’ Chanika, Lwanda and Muula (2013) argue that politicians in Malawi used the language of queer imperialism – the idea that donors are bringing homosexuality to Africa - to galvanize political support, even from women’s groups with the “Atikwatira ndani mukamakwatirana? ” campaign (“Who will marry us?”). They also locate this within the politics of poverty – or what they call ‘the homophobia of poverty’ – whereby women sided with the government against homosexuality, since they feared it would mean they would not be financially looked after by a husband. In another perspective, Wroe (2012) argues that the moral issues that are at the centre of many aid conditions (i.e. LGBTI human rights) mean that dissident voices have more room to make demands of their government (Wroe, 2012). This view has significant evidence to the contrary suggesting that LGBTI organizations in Africa do not want LGBTI conditions attached to the support that they receive from donors, as it hurts their ability to convince opposing forces that their movement is an African one, and not one driven by Western agendas (see section on Civil Society).

***The conflation of homosexuality with Western influence is in part the fault of heavy-handed donors - for countries in Southern Africa, rejecting Western influence through a rejection of LGBTI rights is also a way of reaffirming economic and political independence.***

Epprecht (2012) notes how there is widespread perception that human rights discourse is a not-so-subtle form of Western neo-imperialism, which, given the context of devastating structural adjustment programs on African economies and societies brings a very real sense of déjà-vu. If real progress is to be made, programs must adapt and change to disrupt the widespread perception that human rights discourse is a not-so-subtle form of Western neo-imperialism. There must also be sustainable funding for local LGBTI organizations and regional networks. Lastly, programs must continuously seek improved knowledge and evidence-base for more effective interventions, so that all people may enjoy equal rights in Southern Africa.

In her MA thesis, Elenoradotter (2014) demonstrates another consequence of queer imperialism: the increasing use of problematic Western concepts such as binary sexual identities and “coming out” as a strategy to assert non-normative identities and contest homophobia, and she argues the need for financial resources rather than outreaching identity. Whilst much of the writing around anti-LGBTI sentiment, and queer imperialism in Africa focus on same-sex sexuality, it is important to note that homophobia is often used as a catch-all term, for discrimination against LGBTI people. For example, the widely publicised case of Steven and Tiwonge’s marriage and subsequent persecution is characterised as a case of homophobia without acknowledging that Tiwonge identified as a trans woman and the transphobia that accompanied that. In a round table discussion, Boellstorff et al. (2014) note that “decolonization has deep, shared interests with transgender studies in resistance to pathologization by the medical-industrial complex and Western notions of gender and sexuality, which can be understood as systems of control and genocide”. Magubane (2014) provides one such historical overlap between Western notions of gender and sexuality and the colonial project. Focusing on the case of intersex athlete Caster Semenya, Magubane (2014) argues that the concept of gender had an exclusionary racial impulse written into it at its very inception. From the seventeenth century onward, race over-determined whether bodies in doubt needed to be resolved and how that resolution would take place, such that an ambiguously gendered white body needed to be corrected to retain its whiteness, whereas an ambiguously gendered black body confirmed the pathologisation of blackness.

Emerging activism from transgender organisations and transgender individuals across the region (Iranti-org, Gender Dynamix and a number of academics and healthcare providers, see the Cape Town Declaration, 2014) has focused

on rejecting the re-classification of transgender identities as diagnoses in the World Health Organization's draft 11th edition of the International Classification of Diseases. In a recent roundtable discussion with a focus on trans issues (Boellsdorf, 2014), Micha Cárdenas explicitly linked such work to decolonizing trans and intersex experiences—of embodiment, identity, expression, sexuality, and so on—from biomedical regulations. They confirmed that that “these are key times of reform: both DSM-5 (Diagnostic and Statistical Manual) and, in a few years, ICD-11 (International Classification of Diseases)” (Boellsdorf, 2014).

# Civil society, representation and advocacy

There still is a lack of funding for LGBTI organizations – and particularly lesbian women’s and transgender organizations and organisations not specifically focusing on HIV/AIDS - which may in part be due to a lack of data on populations size estimates, health and HIV/AIDS risks and human rights violations (Jobson et al., 2012).

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There is a significant debate about how support for African LGBTI organizations should be carried out. Some African LGBT organizations have expressed that they do not want foreign aid packages to be tied to LGBT rights since conditional aid reinforces the argument that homosexuality is a Western construct (also see section on Public Health vs Human Rights Approaches, and “Queer Imperialism”). They have also argued that conditional aid in this regard distracts attention from shared structural oppressions which affect all Africans (Abbas, 2012; Ekine and Abbas, 2013; Mwakasungula, 2013). Currier (2012a) also highlights how Western donors’ involvement in supporting and LGBTI organizations in Africa has produced disempowering dynamics in some cases. Currier (2012a) says that funding from foreign donors can sometimes deradicalize and co-opt gender and sexuality movement organizations, as well as create systems of dependency where organizations become increasingly reliant on foreign funding. Further, Currier (2012a) notes how the reliance of LGBT movements in Southern Africa on funding from foreign puts them at risk of local discourses perpetuating the myth of homosexuality and fluid gender identities and “unAfrican”.

Currier (2012b) argues that in Namibia, sexualities and gender identities have been used as an index of belonging in nationalist politics and that opposition to the state on these grounds by LGBT movements is a form of continued decolonization. She suggests that – in one sense – LGBTI identities did not really exist as part of the liberation struggle; these identities only gained political salience after independence.

LGBTI civil society faces a number of other hurdles, not least of which is basic survival as organizations due to funding shortages. LGBTI civil society organizations (CSOs) face political challenges of being denied registration or closed down by government, as well as participation obstacles when trying to represent their constituencies in decision-making spaces. However, there has been some progress in this area with CSOs in Botswana and Kenya winning court cases to register their LGBTI organizations (Cameron 2016).

With the themes from the preceding sections in mind – on behaviour, identity, security, legal environment -- Currier and Cruz (2014) argue that configurations of sexual diversity and civil society in Africa shape one another. African LGBTI organizations participate in ongoing and iterative defining and re-defining of genders and sexualities through contesting heteronormative structures in the region. For Currier and Cruz (2014), the sheer proliferation of LGBTI organizations in sub-Saharan African countries confirms that sexual orientation and gender identity has joined the list of significant issues that activists demand in democratizing societies.

However, despite this proliferation of organizations, immense barriers still exist. Currier’s (2012b) book *Out in Africa: LGBT organizing in Namibia and South Africa* highlights some of the strategies that LGBTI organizations employ to make themselves more or less visible at different times in order to forward their cause. Paternotte (2014) says this examination of “unintentional visibility” and “intentional invisibility”, in an array of different circumstances and political contexts helps to illuminate the specific choices made by LGBTI movements in Namibia and South Africa. Understanding these choices is a key factor for programming, which must account for the needs of local organizations to develop in a non-linear way, sometimes increasing visibility in the public eye, sometimes decreasing, as a matter of strategic positioning in a hostile context.



For Currier (2012b), some LGBTI organizations in the region make use of public visibility as a strategy to win rights. Others opt for more discreet forms of organization and political engagement. A key informant with LeGaBiBo echoes this strategy, arguing that in Botswana:

*“It’s about time that we take a softer approach. As you know, in Botswana, it’s like, I would know the attorney general, the next person knows the attorney general, the case is not the same in South Africa where there are a lot of people. There are only two million of us here. So, a lot of the times, the work that is done is just talking to people in parliament, because sometimes some of them are your Uncles! So we’re just doing a lot of negotiations in offices with government officials, and we try to avoid the whole ‘toy-toy’ and what not because it’s not our approach and it’s not working for us. The softer approach has helped a lot” (Oberth, 2013, p. 150).*

Epprecht (2013c) also notes how some LGBTI activist strategies may be perceived as perhaps too confrontational in some contexts and become less effective, as compared to other softer strategies which may be more persuasive. In agreement with the key informant from LeGaBiBo, Epprecht (2013c) says there are contextual complexities which require different struggle strategies at different times and in different places.

Part of this strategy of ‘invisibility’ (Currier, 2012b) or ‘non-confrontation’ (Epprecht, 2013c), is evident in the names of many LGBTI organizations. Epprecht (2012) discusses how the names of LGBTI advocacy organizations have historically used unobtrusive language, which does little to alert any opposing parties to their focus on sexual rights. For example, a leading LGBTI organization in Malawi calls itself “The Center for the Development of People”. Similarly, in Swaziland the largest LGBTI organization is called “Rock of Hope”. However this is not always the case, with counterexamples such as the Sexual Rights Centre in Zimbabwe.

Currier (2015) has recently expanded on her work in Namibia and South Africa by publishing ethnographic observations of the inclusion or exclusion of transgender people in LGBT organisations. She draws on the concept of invisibility to describe the inclusion of transgender issues into LGBT organisations’ work, explaining that while these organisations included transgender people in their missions early on, the same organisations did not actively recruit transgender membership, assuming they would join “later” (Currier 2015, p. 111). However, the same paper highlights recent development of transgender specific organisations and campaigns within LGBTI organisations in Namibia, South Africa and regionally, pointing towards improved inclusion, ownership and visibility for transgender activists.

***Sympathetic organisations may not align themselves as LGBTI allies due to fear of state repression.***

It is also important to note that Currier’s (2012b) examination of circumstances within which Namibian and South African LGBT organizations increase their public visibility or withdraw is not always a choice; many times organizations are forced to take less visible

positions due to political antagonism towards the movement. Evidence from Zimbabwe also confirms this imperative that LGBTI CSOs face. One key informant from SAfAIDS, in an unpublished AIDS Accountability International interview, said “In the work that we do, where there haven’t been any political rallies, or political rhetoric, you can actually work and people can talk. But, the minute there is a speech, then there is an upset” (unpublished interview, May 2012). These processes of visibility, invisibility, and visibility again, are non-linear patterns of development for LGBTI organizations, a dynamic which Paternotte (2014) also highlights as an important dynamic to understand. Further, Currier’s later work (2014) uses Malawi as a case study for intermovement (HIV/AIDS, human rights, and feminist activists) support of LGBTI organisations, demonstrating that otherwise likeminded CSOs may hesitate to align themselves as LGBTI allies in the face of political and social challenges in doing so. The concerns of these otherwise-allies stem from the very real threat of violence against activists and their families, and unwanted trouble with the police and government ministries for their CSOs.

Williams (2012) highlights how difficult it can be for civil society – especially LGBTI organizations - to hold the state to account in criminal matters. She discusses the case of the State vs. Madubaduba and two others, where the South African NGO “OUT LGBT Wellbeing (OUT)” supported the victim of a homophobic attack, Deric Duma Mazibuko, in advocating for harsher sentencing. They were not successful; Mazibuko’s three attackers were sentenced to perform correctional supervision and community service.

An important development in the region was the African Commission on Human and Peoples' Rights Resolution 275,<sup>2</sup> from May 2014. The resolution condemned violence and other human rights violations against persons on the basis of perceived or real sexual orientation or gender identity from State or non-State entities. The resolution encourages prosecution of homophobic attacks (Cameron 2016). However, challenging violence and hate speech remain difficult for CSOs in the region.

For example, a recent linguistic study of a news source in Malawi reveals the commonality of hate speech in the news article comments made by readers, which highlights the importance of engaging with community members to end homophobia (Kamwendo 2015).

Han and O'Mahoney (2014, p. 287) argue that efforts from civil society, including activist networks and NGOs, along with various UN-led initiatives, have "definitely played a tremendous role in pushing for the decriminalization of homosexuality around the world." The recent decision in Mozambique to decriminalize same-sex sexual activity has been proof of the success of such support (also see section on "Legal and policy framework"). However, the ability of LGBTI people to represent themselves and their communities in various national and international platforms remains limited in many parts of Southern Africa. Oberth (2012) highlights the varying degrees to which LGBTI organizations are able to meaningfully engage on Southern African Country Coordinating Mechanisms (CCMs), the national decision-making boards for Global Fund programming. The findings of that research show that in some contexts, CCMs are relatively open to LGBTI organizations and their agendas, but in others, significant challenges remain. A key informant in Malawi relates that "There has been a lot more acceptances that we do have LGBTs in Malawi. But where the reluctance comes is to put marginalized groups on that platform. [...] It's a mindset that has to be broken" (Oberth, 2012, p. 17).

***Resolution 275 of the African Commission on Human and Peoples' Rights condemns violence and other human rights violations against persons on the basis of perceived or real sexual orientation or gender identity from State or non-State entities.***

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<sup>2</sup>275: Resolution on Protection against Violence and other Human Rights Violations against Persons on the basis of their real or imputed Sexual Orientation or Gender Identity. Adopted at the 55th Ordinary Session of the African Commission on Human and Peoples' Rights in Luanda, Angola, 28 April to 12 May 2014.

# Safety and Security

## VERBAL ABUSE, INTIMIDATION AND HARASSMENT OF LGBTI PEOPLE

As a direct result of the hostile legal, political and religious environments in many African countries, many LGBTI people face ongoing hostility and abuse. Often, non-violent human rights abuses are the most common as well as the least visible (Jacques, 2014), and the most consistent over the life course.

Sanger (2015) found that discrimination in the form of bullying at school emerged as a major problem for trans youth, and access to toilets was another serious safety concern. Mavhandu-Mudzusi & Sandy (2015) show how, in a rural South African university, heterosexual peers and staff harassed and discriminated against LGBT students, including denial of services (including financial support and education material), religious strategies against LGBT students (prayers and exorcism rituals), and threats of rape and murder. In some instances, students also experienced physical violence.

Kamwendo (2015) analyses comments from a Malawian online newspaper to show how that it was a significant site for dominant voices to launch linguistic assaults against homosexuals, which he argues can be interpreted as a hate speech. Stahlman et al. (2015) sites that verbal abuse from the broader community is a major challenge faced by MSM in Lesotho. MSM who were open about their sexual identity experienced greater stigma and abuse, but were more self-sufficient and self-confident, hence better able to cope. In addition to MSM community organisations, friends and family members were significant source of social support, but this support could not be accessed by MSM until the risk of disclosing their sexual identity was reduced.

In a recent survey of MSM in Malawi, Namibia, and Botswana, many respondents cited blackmail as one of the most common human rights abuses that they face (10.5% in South Africa, 18% in Malawi, 21.3% in Namibia, and 26.5% in Botswana) (Jacques, 2014). DiDiRi Collective (2013) also cites that 21.3% of MSM in Lesotho report being blackmailed. Phillips (2009) also finds evidence of blackmail, among LGBTI people in Zimbabwe. However, Zahn et al. (2016) found that whilst MSM in Cape Town were less likely to be blackmailed or feel afraid in their communities than MSM in Botswana, Malawi or Namibia, they were not statistically significantly less likely to experience a human rights abuse than their peers in cities in other study countries. This demonstrates that although legal protections may reduce experiences of certain abuses, legislative changes alone are insufficient for protecting MSM.

Jobson et al. (2012) suggest that increased vulnerability to hate crimes and violence – due to a more visible “dissident” form of gender and/or sexual orientation – may be related to the low levels of research for this group of people, since they may be wary of participating in studies that might further expose them.

***Findings show a strong relationship between discrimination and the fear of seeking out health services.***

A recent study of stigma and discrimination among MSM in Malawi, Namibia, and Botswana found that there was a strong relationship between discrimination and the fear of seeking out health services (Fay et al., 2011; as cited in Jacques, 2014). Another study in Namibia found a link between violence and HIV-testing

behaviour, as MSM respondents were reluctant to utilise testing services for fear of discrimination (Stephenson et al. 2014). In Swaziland, a recent study conducted among 20 HIV-positive MSM found that stigma and dual discrimination (being both MSM and HIV-positive) led to delayed entry into care (Kennedy et al., 2013). This study also found that HIV-positive MSM in Swaziland were more likely to travel to more distant clinics in order to avoid stigma from their close communities. In South Africa, too, evidence shows that around 1 in 10 gay men and lesbian women delayed seeking treatment at clinics as a result of fearing discrimination, while others are refused services altogether (Müller, 2014). Stevens (2012) finds that up to 60% of transgender individuals in South Africa report negative experiences in state clinics. Further, recent research conducted in Luanda found that MSM who reported episodes of homophobia were significantly more likely to be HIV positive (Kendall et al., 2014).

Physical Violence against LGBTI People

In addition to harassment and intimidation, physical violence is also a constant threat for LGBTI people. Research from Swaziland shows that many MSM often feel they have no recourse to bring incidents of violence to the police (Kennedy et al., 2013). The same study also found that many Swazi MSM experience refusal from law enforcement to protect them from violence due to their sexuality. Participants in Stephenson et al. (2014) study of MSM in Namibia, suggest that discrimination, violence and the threat of violence are dominant features in daily life, imposing restrictions on their movements and behaviours and affecting men's conception of themselves and their communities. Even in South Africa, where LGBTI people have equality before the law, homophobic hate crimes are on the rise (Epprecht, 2012). While all LGBTI people potentially face safety and security issues as a result of homophobia and transphobia, lesbian and transgender women bear a disproportionate amount of this violence (Evans, 2016). Makofane (2013) draws attention to the problem that some of the literature on the history of homosexual relationships in Southern Africa focuses too heavily on relationships between men, especially pointing to Epprecht's (2008) book *Heterosexual Africa?*. Makofane (2013) says that the thin history on women who have sex with women and lesbian women in Southern Africa is troubling in the face of current challenges associated with the increased burden of homophobic violence carried by these women. In a study involving 592 WSW from Botswana, Namibia, South Africa and Zimbabwe, 31.1% reported experiencing forced sex (Sandfort et al., 2013). This study leads the authors to conclude that HIV/AIDS is a very serious reality for lesbian and bisexual women in Southern Africa, despite the belief of many that these women are not vulnerable to infection. Further, Sandfort et al. (2013) found that forced sex was an important risk factor for HIV infection among the women who have sex with women in their study (Sandfort et al., 2013).

Tamale (2014) also discusses how the bodies of LGBTI people – or any “sexual other” – become sites for violence and political inscription. She uses the example of terms like ‘corrective rape’ or ‘curative rape’ which suggest that one's sexual orientation needs correcting or can be changed, and that there are circumstances when rape can be justified. She echoes the need to speak in terms more appropriate in describing the hateful elements of the crime, such as ‘homophobic rape’. Hames (2011), too, argues that it is important to speak with a critical consciousness whenever referring to any kind of violence.

It is important also to note that sexual violence experienced by WSW is not relegated to situations in which men are the only perpetrators. Something that often goes unconsidered – but that does exist – is forced sex between WSW. Results from Sandfort et al.'s (2013) regional survey show that of WSW who report forced sex, more than 20% of the WSW said they were raped by women only.

Along with lesbian women and WSW, transwomen are particularly vulnerable to physical and emotional violence (Evans, 2016). ARASA (2014) indicate that there is increasing evidence that transmen and transwomen are targeted because of their sexual orientation and/or gender identity and face significant levels of sexual violence. The Global Commission on HIV and the Law (2012) also states that most of the violence amongst LGBTI people is directed towards transgender individuals, especially transwomen. This is echoed by Giovaniello (2013). Transgender individuals may be (comparably) more visible than other members of the LGBTI community, which can lead to an increased vulnerability to violence and hate crimes (Jobson et al., 2012).

In a recent roundtable discussion with a focus on trans issues, Micha Cárdenas says “Year after year, statistics on violence against LGBT communities show that transgender women of color are the number one targets of violence. It is clear to me that transgender women of color exist within a matrix of oppressions that allow us to be murdered on a very frequent basis” (Boellstorff et al., 2014, p. 426). Further, transwomen are more likely to be jailed in holding cells with men, placed at increased risk of rape and further violence. The GCHL also points out that along with WSW, transmen are also subjective to corrective rape (GCHL, 2012).

South Africa is a particular “hot spot” for these kinds of homophobic hate crimes against LGBTI people (Brown, 2012). Sigamoney & Epprecht (2013) share interview and survey data on the subject from more than 1000 respondents from two urban townships in South Africa (Daveyton and KwaThema). Bhana (2014) suggests that in South Africa's history of racial and gender inequalities has combined with cultural, economic, and social practices to produce “anxious masculinities” that perpetuate homophobic violence (78). It is then rather worrying that school curricula in South Africa are doing little to address attitudes towards LGBTI people (Wilmot & Naidoo, 2014), nor are current masculinities programmes that work with boys and men (Viitanen & Colvin, 2015).

Challenges associated with violence are not relegated to individuals, either, but permeate all levels of society (Zahn et

al., 2016). Williams (2012) outlines the shortcomings in the South African government's prosecution of a homophobic hate crime. Supporting Williams' (2012) arguments the Human Rights Campaign Foundation and Human Rights First (2014) cite that there is often a delay in prosecuting homophobic murders in South Africa. In addition to the legal system failing LGBTI people, Epprecht (2012) argues that the government's role as a human rights leader in the region frequently falls flat, and that until very recently South Africa has been noticeably reluctant to incorporate LGBTI human rights into its foreign policy (Epprecht, 2012). Most recently, in September 2014, civil society in South Africa led a #DemandAccountabilitySA campaign to put pressure on the South African representative to the UNHRC to vote in favour of the SOGI resolution (amid rumours that he would not).

In addition to safety concerns for LGBTI people themselves, tense political climates sometimes meant that those organising around them and advocating for their rights are also at risk. Based on a mapping and appraisal of HIV prevention and care interventions for MSM in Kenya, Tanzania, Uganda & Zimbabwe, Bourne et al. (2016) assert that because same-sex behaviour is illegal in each of the countries, the safety and security of MSM organisation staff, volunteers and clients is of critical concern. The social and political situation curtails the range of activities that are safe, threatening the continuity of services and posing a great challenge to delivery of targeted HIV prevention, treatment and care interventions for MSM. Similarly, Currier (2014) notes that in Malawi the costs of promoting LGBT rights included threats of violence against activists and their families, and run-ins with the police and government ministries.

## **PHYSICAL VIOLENCE AGAINST LGBTI PEOPLE**

In addition to harassment and intimidation, physical violence is also a constant threat for LGBTI people. Research from Swaziland shows that many MSM often feel they have no recourse to bring incidents of violence to the police (Kennedy et al., 2013). The same study also found that many Swazi MSM experience refusal from law enforcement to protect them from violence due to their sexuality. Participants in Stephenson et al. (2014) study of MSM in Namibia, suggest that discrimination, violence and the threat of violence are dominant features in daily life, imposing restrictions on their movements and behaviours and affecting men's conception of themselves and their communities. Even in South Africa, where LGBTI people have equality before the law, homophobic hate crimes are on the rise (Epprecht, 2012).

***Lesbian women and transgender women bear a disproportionate amount of violence against LGBTI people.***

***Forced sex is an important risk factor for HIV infection among women who have sex with women.***

While all LGBTI people potentially face safety and security issues as a result of homophobia and transphobia, lesbian and transgender women bear a disproportionate amount of this violence (Evans, 2016). Makofane (2013) draws attention to the problem that some of the literature on the history of homosexual relationships in Southern Africa focuses too heavily on relationships between men, especially pointing to Epprecht's (2008) book *Heterosexual Africa?*. Makofane (2013) says that the thin history on women who have sex with women and lesbian women in Southern Africa is troubling in the face of

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# Socio-cultural Context

## LGBTI SEXUAL BEHAVIOURS AND IDENTITIES

Intricately interwoven within the variety of different partnerships, LGBTI people in Southern Africa also embody a spectrum of diverse gender identity. There is a growing body of evidence that highlights the disconnection between gender identity and sexual orientation in Southern Africa (Baral et al., 2013; Wirtz et al., 2013; Kennedy et al., 2013). In other words, behaviour and identity are often de-linked in the Southern African context. This means a man may have sex with other men, but not identify as gay or homosexual.

Understanding the complexity and diversity of sexual orientation and gender identity is critical, in any effort, to provide better programming for support, health care, and social protection for LGBTI people (Van Vollenhoven & Els, 2013). For example, Gerber and Gory (2014) problematize discourse by UN bodies that essentialize fixed Western concepts like “homosexuality” which may not reflect the more fluid forms of gender identity and sexual behaviour that have existed for centuries in Africa. Understanding the diversity of African LGBTI identities and how they change or stay the same, and how they align or do not align, with behaviour is critical to effective rights-based programming (Kerrigan, 2013). Jacques (2014) illustrates how definitions and experiences of different kinds of sexuality are steeped in personal and cultural frames of reference. This means that within the region, experiences are vastly different; Jacques (2014) asserts how being gay or lesbian in Botswana is very different from being gay or lesbian South Africa. Marc Epprecht’s (2013b) *Hungochani: The History of a Dissident Sexuality in Southern Africa* (Second Edition) is an excellent resource on the subject. Epprecht (2013b) meticulously documents examples of same-sex relationships and alternative gender identities in pre-modern Zimbabwe, South Africa, and Lesotho. His intention is to gather empirical evidence to disrupt the political myth that homosexuality in Africa is a Western import.

However, there is little qualitative work that delves into specific contemporary localised LGBTI identities, practices and their meanings. The literature that is available, however, demonstrates that LGBTI people in Southern Africa identify across the gender spectrum and practice a variety of sexual behaviours that often defy both heteronormative and homonormative conceptions.

## SEXUAL BEHAVIOUR

Many LGBTI people have participated in heterosexual sexual behaviours. Some may identify as bisexual, and others may feel and act on both same-sex and opposite sex attraction, whilst identifying as lesbian, gay or even straight. Miller’s (2014) study reveals that while 37% of the MSM surveyed reported having sex with women because it was what is expected of them, 58% suggested that it was instead because they enjoyed it. Further, in a study among MSM in Swaziland, 34.8% self-identified as bisexual and 12.1% had children (Risher et al., 2013). In Swaziland, self and external stigma prevents bi-MSM from disclosing their sexual orientation or HIV status to their female partners (Government of Swaziland, 2014). WSW in the region report a comparably higher rate of strictly homosexual attraction and identity: 76.9% of the 591 WSW from Botswana, Namibia, South Africa and Zimbabwe said they identify as lesbian (Sandfort et al., 2013).

Alternately, some LGBTI people may have heterosexual relationships out of social pressure or their own desire to marry and have children (Sandfort and Reddy, 2013). McNamara (2014) highlights how in Malawi, homosexuality is commonly perceived as an act rather than an identity, which shapes the way motivations for other partnerships are formed. Further, among those self-identifying homosexual men and women, he notes how family lineage may be a stronger force than personal identity. One of the lesbian women he spoke to mentioned that she planned to cease “practising” homosexuality soon and would return to her village to have children. Similar findings from research in Lesotho show that almost half of MSM reported future plans to marry a woman. Of those who said this, the majority (64%) said they wanted to do so in order to please their families, while the others (36%) indicated that they wanted to marry in order to have children (Miller, 2014).

Female partnerships are quite common for MSM in Southern Africa for a number of reasons, not limited to societal

pressures to marry or have female, a separation homosexual identity and homosexual acts, bisexuality, and strong desires to pass on lineage through childbirth (McNamara, 2014; Miller 2014). In McNamara's (2014) research in Malawi, all the gay men he interviewed or interacted with had concurrent female partners. Miller (2014) found that 34% of MSM surveyed in Lesotho had had sex with a woman in the past year. Miller (2014) also found that concurrent partnerships among MSM in Lesotho were common. In his research, 82% of MSM reported multiple concurrent partnerships in the last year, 33% of which indicated that their multiple partners included both men and women. Evidence from Mozambique also indicates that many MSM there have female partners (Nala et al., 2014). In Maputo, just 11.4% of 496 MSM reported that they had never had sex with a woman, and just 15.9% of 353 MSM in Nampula/Nacala had never done so (Nala et al., 2014). This evidence also points to lower condom use among MSM when they have sex with their female partners, as compared to their male partners. For example, in Maputo, 86% of MSM used a condom the last time they had sex with a male partner, but only 66.6% of MSM used one the last time they had sex with a female partner (Nala et al., 2014).

One study among WSW in Lesotho found that the women felt very strong pressure to marry from their parents for cultural reasons, as well as financial gain:

*"I don't have children because I don't really have the desire for a man, but then because of the pressures of culture you can end up falling in that trap" (Lebohang, 24 years, Maseru)" (Poteat et al., 2014, p. 123-124).*

*"In earlier times I could see that my mother now was raising me well, raising me for the benefit that in future her money that she spend for me to go to school, I will refund by means of me getting married and she would get cows" (Matsheliso, 30 years, Maputsoe) (Poteat et al., 2014, p. 124).*

Among the self-identifying lesbians in Matebeni et al.'s (2013) study, which covered Namibia, South Africa, and Zimbabwe, the majority had children from previous relationships with men, and some had current male partners. Further, 38% reported of the WSW in the Matebeni et al. (2013) study reported getting HIV from previous male partners. In Lesotho, the Poteat et al. (2014) study found that 43% of the 221 WSW they surveyed reported having a regular male sexual partner, such as a husband or boyfriend.

## GENDER IDENTITIES

In Malawi, 17% of the MSM surveyed reported they identified as female, and a further 2.8% said they were transgender (Wirtz et al., 2013). In Swaziland, 15.7% of MSM reported identifying as female and 1.8% said they were both male and female (Wolf et al., 2013). In both of these contexts, Wolf et al. (2013) caution that it is not clear whether those surveyed identified as female in terms of their identity or in relation to their behaviour as MSM.

Other work points to this complex manifestation of gender identity, sexual identity, and sexual behaviour in Southern Africa. Two noteworthy books which discuss same-sex sexualities in the region convey this in their titles: Tommy boys, lesbian men, and ancestral wives: female same-sex practices in Africa (Morgan & Wieringa 2005) and Boywives and female husbands: studies in African homosexualities (Murray & Roscoe 1998).

Reid (2013) delves in to the relationship between gender and male same-sex sexual expression in the South African context very comprehensively, addressing notions of masculinity and femininity. Sandfort and Reddy (2013) discuss the identities of partners of transgender individuals.

Milani (2014) suggests that Queer Theory is a more useful lens in the African context, where – more than in the Western context – identity and behaviour are frequently incongruous. Spurlin (2013) agrees, putting forward that "queer" has had particular cachet in the context of post-Apartheid South Africa, as a form of resistance to - and transcendence from - fixed identities and norms which were previously prescribed by the state. However, Milani (2014) also recognizes and submits that language is a very important component of discussions around LGBTI identity in Africa, and words like "queer" may carry connotations of whiteness or middle-class that would not resonate in many parts of Africa. Milani (2014) also points to Msibi (2013; 2014) and Sigamoney and Epprecht (2013) who offer other critiques of language and identity categories.



For example, as trans identities are more widely articulated in Southern Africa, it is worth paying attention to both the ways that the term is able to create solidarities and express previously invisibilised identities, as well as how it subsumes individual expression into a new normativity. Currier (2015) shows that through LGBT organising, transgender collective identity may invisibilise complex and fluid identities, and render a hegemonic understanding of what transgender means as organisations simplify and “fix” the boundaries of their transgender constituency, “normalising and privileging collective-identity categories as templates of how gender-variant persons should use identity categories that correspond to collective-identity categories” (111). Similarly a report by the Legal Resources Centre, Iranti-org & Gender Dynamix (2016) states that the diverse gender identities and gender expression of people under the trans umbrella remain marginalised, invisibilised and oppressed in South Africa due to cisnormative and heteronormative conceptions of gender.

Problematizing binaries and oversimplifications of sexual identity, Moolman (2013) also argues that sexuality within the post-Apartheid South Africa must necessarily come with parallel analyses race, class, ethnicity, culture, and gender. Significantly, across Southern Africa, a person’s sexual orientation and gender may not be the most important way that person identifies. Trystan Cotton aptly notes “In Africa (and the diaspora), gender and gender transitioning form only one dimension of people’s lives. And it’s not always the most salient thing in their daily struggle to feed and house themselves” (Boellstorff et al., 2014, p. 431).

## SEX WORK

For some LGBTI people sex work is a profession, a form of income, and a right. However, in some instances, sex work may create situations of increased vulnerability which further subjugate LGBTI people to risks of discrimination, harassment and violence. There are also a lot of overlaps between and among different kinds of violence LGBTI people experience. For instance, Lewis (2012) found that discrimination and intimate partner violence among WSW co-occurs. In the same vein, violence associated with sex work is layered with other forms of violence towards LGBTI people, including discrimination, harassment, denial of health services and abuse. In a recent report, female sex workers from Swaziland reported high levels of physical violence and fear of accessing health services because of their work and sexual behaviour (Ministry of Health, Swaziland, 2015). Although not all of these women were transgender or WSW, it is likely that those who are struggle from a double impact of stigma both from being sex workers and LGBTI.

The frequency of sex work among the LGBTI community is not well-documented. One study found that 18.7% of the 591 WSW surveyed from Botswana, Namibia, South Africa and Zimbabwe had engaged in transactional sex at some point in their life (Sandfort et al., 2013a). Some of these women engaged in sex work with men only (3.4%), some with women only (8.1%) and some with both men and women (7.1%). Though the Sandfort et al. (2013a) study finds that transactional sex is not associated with an increased likelihood of self-reporting HIV, other studies show that

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sex work is associated with many other health and safety risks, especially for male and transgender sex workers (Scorgie et al., 2013). Others have identified sex workers, particularly transgender sex workers, to be particularly vulnerable to HIV in settings where both sex work and homosexuality (which impacts transgender heterosexual sex) are criminalised,

calling for decriminalisation of sex work alongside decriminalisation of homosexuality (UN Women & OSISA, n.d.). Security risks such as stigmatization and breaches of confidentiality from health care providers are perhaps most often encountered by transgender sex workers (Scorgie et al., 2013). Tracey, a 25-year old transgender sex worker from South Africa, recounted the following experience after being gang-raped by clients:

*“I go to report to the police, they told me to go to the hospital and I was still wearing my jeans, wig and with my breast. When the doctor examined me and find out that I am a she-male, he called other doctors and nurses. They left their work to come and see that a man got raped. It was like a mockery [...] The doctor told me I was not raped but I was sodomised because I am a man. The way I was dressing they said “what kind of a woman [are you]?” I just walked from the hospital without being treated. It was not fair because I was raped the whole night” (Scorgie et al., 2013, p. 455-456).*

Further research revealed that transgender individuals may be more reliant on sex work than other LGBTI people (Johnston, 2014; Scorgie et al. 2013). Scorgie et al. (2013), who interviewed female, male and transgender sex workers from Kenya, Zimbabwe, Uganda and South Africa, found that none of the transgender sex workers in their study had another form of employment, while 25% of the 26 male sex workers did.

Scorgie et al. (2013) also highlight the dual stigma of being both gay and in sex work, sharing the experiences of Vuyo, a male sex worker from Bulawayo, Zimbabwe, who says the stigma he feels forces him to lie about his orientation and his profession, meaning he does not get the help he needs:

*“When we go to the clinic we will be scared to tell the nurse because they will start asking you, Where did you get it? How did you get it? So it will be really painful for me to say I got it like this or I was doing this. So I will end up lying which will make me not to get the right medication” (Scorgie et al., 2013, p. 456).*

It should be noted that Scorgie et al. (2013) did find some examples of good health care for at least one male and one transgender sex worker in their sample, who described experiences of quality care. However, these two instances were at private hospitals. Fred, a male sex worker from Zimbabwe said:

*“I had an STI last month and I went to a private clinic. They treated me well and even I had told them that I am gay and a sex worker, they were still friendly. I even now know my HIV status because they encouraged me to get tested” (Scorgie et al., 2013, p. 459).*

Among WSW in Namibia, South Africa and Zimbabwe, accessing private healthcare may be a slim reality for most; Matebeni et al. (2013) found that among the 24 lesbian women living with HIV interviewed in these countries, only 29% had full time employment and only 17% had private health insurance. This means that sex work may become an economic imperative, and few will have the ability to afford the kind of care that Fred (Scorgie et al., 2013) can.

A new qualitative study by Samudzi and Mannell (2016) from South Africa included a comparative analysis of the experiences of cisgender men and transgender women who are sex workers. The findings illuminate both positive and negative in-depth experiences of the transgender women sex workers. Exclusion from social spaces—be they women-only spaces, public spaces or discursive spaces—was pervasive, even within the LGBTI movement. However, participants also spoke about their stigmatised identities as sources of empowerment, stemming from their positive feelings about themselves as transgender women, sex workers and as advocates of sex work. This work also touches on the intersectionality of gender identity, work as a sex worker, and nationality; while more commonly discussed among the cisgender men in the study, a Ugandan transwoman shared that she had been shouted at, “You are a moffie, you must go back to your country” while in a public space (Samudzi & Mannell 2016, p.7). LGBTI sex worker experiences must therefore also take into account other aspects of identity, such as nationality or race, in order to fully understand their needs, vulnerabilities and agency.

## RELIGION

One of the major recurring themes in much of the recent literature on LGBTI rights in Southern Africa is the relationship between religion, sexuality, and homophobia (Epprecht, 2013c; Lee, 2013; Sandfort & Reddy, 2013; Tamale, 2014; Van Klinken & Gunda, 2012; Vincent & Howell, 2014; Ibrahim, 2015; Hellweg, 2015). While it is oft cited as a barrier and a challenge to LGBTI rights, it is also a potential context to foster acceptance and understanding.

Sandfort and Reddy (2013) argue that religion indeed reinforces the low levels of social acceptance of homosexuality in Africa. They discuss several reasons why this is true, including the strong impact religion has on the lives of most people in the region, including endorsing religion, attending religious services (high levels of religiosity), and the large number of faith-based organizations. They also point to the historical and colonial legacy in most countries in Southern Africa, which create a context where people are motivated to carve out and define independent national identities, fuelling the creation of myths that same-sex sexuality and alternative gender identities are “unAfrican” or not part of ‘African sexuality’.

In agreement with Sandfort and Reddy (2013) is Sylvia Tamale (2014), who argues that religion plays a central role in shaping both 'African sexualities'<sup>3</sup> as well as homophobias. She points out that 86% of the continent's population subscribes to the "imported religions" of Islam and Christianity, also exposing the irony in how those who condemn homosexuality as alien rest their arguments on rationale from the 'foreign' religions of Christianity and Islam. In addition to shaping homophobias, Tamale (2014, p. 155) makes a compelling case for the importance of cultural and religious forces in shaping a person's sexuality:

*"Contrary to popular belief, sexuality is not exclusively driven by biology; a very significant part of it is socially constructed through legal, cultural, and religious forces driven by a politico-economic agenda."*

There is empirical evidence to support Tamale's (2014) assertion. Tinarwo and Pasura (2014, p. 521) examine a Zimbabwean diaspora community in Britain who discover lesbian, gay, and bisexual identities, finding that the different religious and cultural contexts mean that the "boundaries of gendered practices and sexual behaviours deemed 'acceptable' and 'unacceptable', 'good' and 'bad' also seem to be shifting."

Epprecht (2013c) too, illustrates the roots of homophobia in Southern Africa through traditional spirituality, Christianity, and Islam. However, as Lee (2013) points out, Epprecht (2013c) argues that the recent surge in homophobia in Africa is not as much due to religion and religious doctrine per se, as it is related to particular fundamentalist interpretation of Christianity and Islam, most often promoted by foreign groups who come to Africa with an agenda. Tamale (2014) agrees, contending that the American Christian Right is using Africans and African churches as proxies for American culture battles, working closely with African religious and political leaders to oppose progress in the rights of LGBTI persons. For example, Van Klinken (2015) shows how Pentecostal forms of Christianity have informed the politicization of homosexuality in Zambia by shaping a popular, constitutionally embedded sense of national identity. This has had a direct impact on the political climate in the country, seeing the Zambian Human Rights Commission explicitly warning against an inclusive formulation of the anti-discrimination clause in the new constitution to prevent it from being applied to sexual orientation.

Epprecht (2013c) makes the case for harnessing Southern African values of Ubuntu in order to shape the way religious leaders and communities interpret religious dogmas to include LGBTI rights. Similarly, van Klinken and Gunda (2012, p. 114) explore the opportunity for acceptance among African religious traditions. They argue that "African theologians are varying from silence and rejection to acceptance. Although many African theologians have taken up the cudgels against gay rights, some "dissident voices" break the taboo and develop more inclusive concepts of African identity and African Christianity."

In the South African context, Vincent and Howell (2014) find that homophobia in the era of human rights discourse has been framed significantly by notions that homosexuality is 'unGodly'. They remind us that for the majority of South Africans, the church is a highly significant space for community and social engagement; it is where attitudes and ethics are formed. Mavhandu-Mudzusi & Sandy (2015) demonstrate how such religious attitudes and ethics are the basis of stigma and discrimination of LGBT students in a rural South African university. Heterosexual peers and staff viewed LGBT students as "sinners, satanic or demon possessed", and discrimination ranged from the denial of services (including financial support and education material), to religious strategies against LGBT students (prayers and exorcism rituals), to threats of and actual violence.

Given the pervasiveness of such beliefs it is important that human rights discourses act to envision LGBTI rights as congruent with religious beliefs and ethics.

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<sup>3</sup>African sexuality is a term Tamale (2014) uses. She does, however, offer the caveat that she is not suggesting Africa is a homogeneous place, but she wants to draw attention to the shared experiences of colonialism, capitalism, imperialism, globalisation and fundamentalism.

# HIV/AIDS Prevalence, Policy and Progress

Almost 30 years into the HIV/AIDS epidemic in Southern Africa, very little is known about how it might be disproportionately impacting LGBTI communities (Jacques, 2014). The failure to recognize LGBTI communities as key populations at the policy level is something Marc Epprecht (2012, p. 231) calls a “two-decade blind spot in HIV/AIDS strategic Plans.” Further, while there is a renewed focus on the HIV vulnerability of MSM in the region, there is very little attention paid to WSW in this regard, even by organizations of HIV-positive women (Jacques, 2014). Others suggest that while there is a focus on the epidemiology of HIV among MSM, there has been very little research done on the lived experiences of MSM living with HIV in the region (Kennedy et al., 2013).

*While there is a focus on the epidemiology of HIV among MSM, there has been very little research done on the lived experiences of MSM living with HIV in the region.*

Several African countries have officially sanctioned a more liberal approach in principle, including Zimbabwe, the country that, according to Jacques (2014), initiated the process of political homophobia in the mid-1990s. However, including LGBTI people in national strategies is sometimes just paying lip service to foreign donors and multi-lateral organizations. In an alternative explanation, these strategies are often written by international consultants and are perhaps not even read by political leaders who might oppose the inclusion of LGBTI people in national policy documents. For example, one key informant from Malawi quips “MSM is also explicitly in government’s national prevention policy, which was launched by the President. I don’t think he read it though [laughs]” (Oberth, 2013, p. 142).

**Table 3:** Mapping of National Strategic Plans and National Composite Policy Indices in Priority Countries

Country	KPs Included in Current National Strategic Plans			KPs Included in Multi-sectoral Strategy According to National Composite Policy Index (2012)		
	MSM	WSW	TG	MSM	WSW	TG
Angola (2007-2010)	Yes	No	No	Yes	No	Yes
Botswana (2010-2016)	No	No	No	Yes	No	Yes
Lesotho (2010/11-2015/16)	Yes	No	No	Yes	No	Yes
Malawi (2015-2020)	Yes	No	No	No	No	No
Mozambique (2010-2014)	Yes	No	No	Yes	No	No
Namibia (2010/11-2015/16)	Yes	No	No	Yes	No	No
South Africa (2012-2016)	Yes	No <sup>4</sup>	Yes	Yes	No	Yes
Swaziland (2014-2018)	Yes	No	No	No	No	No
Zambia (2014-2016)	No	No	No	No Data	No Data	No Data
Zimbabwe (2011-2015)	Yes	No	No	No	No	No

## HIV AMONG MSM

From Table 3, it is clear that MSM are well-recognized by National HIV/AIDS Strategic Plans in the region as compared to WSW, transgender or intersex people. However, though these policies may address MSM, knowledge about prevention and behaviour change remains low among MSM populations in Southern Africa, indicating that there is still opportunity to better engage them in the response. For example, one Master's thesis in Lesotho found that some

**While 88% of MSM in Lesotho claimed to know three ways of preventing HIV, when asked to name them, only 37% actually could.**

MSM were not at all aware that unprotected sex between two men posed an HIV risk, and these men expressed that there is a need for including men who have sex with men in HIV knowledge and prevention campaigns (Miller, 2014). The same study suggests that multiple concurrent partnerships may be much

more common among the MSM community than among the general populations. Eighty-two percent of the 51 MSM respondents reported having more than one partner in the last year, compared with 35% in the general population (Government of Lesotho, 2012). Miller (2014) also found that while 88% of respondents claimed to know three ways of preventing HIV, when asked to name them, only 37% actually could. The findings report that of MSM who reported sexual activity with women in the last year, 28% reported inconsistent condom use or no condom use at all. These findings of low HIV knowledge and links to risk behaviours have been echoed in other settings. In Angola, few HIV positive MSM knew their status, were appropriately linked to care, or taking antiretroviral therapy (Kendall et al, 2014).

Qualitative evidence from MSM in Malawi suggests low levels of HIV prevention knowledge coupled with low perceptions of HIV risk (Wirtz et al., 2014, p. 4):

*"A lot of people do not believe that when you have sex with your fellow man you can contract infections. They think that amongst men you cannot infect one another. They think that you can get infection only if you have sex with a woman- that is when you can contract infections. It's just a few people who are in the know that if you have sex with your fellow man you can infect one another."*

There has been recent movement towards gaining a deeper understanding of factors that may improve knowledge and risk reduction behavior among MSM. Recent research suggests that depression and/or experiences of sexuality-related discrimination could be associated with having higher levels of unprotected sex in MSM; however, more research is needed to fully understand and expand upon these associations (Tucker et al. 2014). Further, disclosure to healthcare providers about being MSM, having a high sense of self-worth, and utilizing condom negotiation scripts may be linked to improved condom use (Brown et al. 2015; Siegler et al. 2014). Uptake of HIV testing among MSM has also received some recent study, suggesting that social participation and cohesion improves rates of HIV testing (Grover 2016), while fear of being HIV positive and lack of routine testing in general among MSM were deterrents from testing in other settings (Sandfort et al. 2015b). While these studies give some indications that stigma, socialisation, and mental health may play a role in MSM HIV prevention, this evidence alone is insufficient for making broad generalisations regarding MSM throughout Southern Africa and their relationship to HIV knowledge and risk behaviour. Exploration of the role of sexual violence in HIV transmission in MSM could also yield important evidence to motivate for victim/survivor support and connection to HIV prevention interventions such as post-exposure prophylaxis for MSM (Ministry of Health, Swaziland, 2015).

Surprisingly, there has been little published intervention research specifically examining MSM in Southern Africa. An exception is an epidemiological modelling study that considered a four component package—antiretroviral therapy for HIV infected persons with CD4, PrEP for high risk uninfected persons, behavioural interventions to reduce rates of unprotected anal intercourse, and campaigns to increase HIV testing—and found that the package could prevent 33.9% of HIV infections in South Africa over five years, articulating the importance of designing interventions that include both behavioural and biomedical components (Brookmeyer et al. 2014). Some research has also examined “approach” to HIV/AIDS programming for MSM. A programmatic evaluation in four African countries found that fear of disclosure and stigma are important factors as they may hinder the MSM programme's success (Bourne et al. 2016). As a possible

<sup>4</sup> While South Africa's NSP does not include WSW, a number of the Provincial Strategic Plans do.

response to dealing with fear and stigma, other research has shown that a human rights approach was both acceptable and transformative for MSM (in Zambia) (Muzayamba et al. 2015).

Part of the challenge in addressing these gaps is the lack of data on LGBTI populations in Southern Africa. A key reason for the lack of data, apart from the lack of political will to commission studies, is the lack of international commitments. There are UNGASS indicators for MSM and sex workers, which obliges countries to collect data, but no indicators for WSW, transgender or intersex individuals. The lack of UNGASS indicators for these populations has a significant hampering impact in improving the HIV response to vulnerable and marginalized populations (Oberth & Tucker, 2013).

***In the most recent Global AIDS Response Progress Reports, seven out of the ten countries in this analysis reported HIV prevalence data for MSM (Angola, Botswana, Lesotho, Malawi, Namibia, South Africa and Swaziland), one reported data for WSW (Lesotho) and none reported data for bisexual, transgender or intersex individuals.***

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**Table 4:** Mapping of Data Reporting from Global AIDS Response Progress Reports (GARPPR) in Priority Countries

Country	MSM Indicators				WSW	TG
	Prevalence	Prevention	Condom Use	Testing		
Angola (2014)	Yes	Yes	Yes	Yes	No	No
Botswana	Yes	Yes	Yes	Yes	No	No
Lesotho	Yes	No	No	Yes	Yes	No
Malawi	Yes	Yes	Yes	Yes	No	No
Mozambique (2014)	No	No	No	No	No	No
Namibia	Yes	Yes	No	No	No	No
South Africa (2012)	Yes	No	No	Yes	No	No
Swaziland (2014)	Yes	Yes	Yes	No	No	No
Zambia	No	No	No	No	No	No
Zimbabwe	No	No	No	No	No	No

Source(s): Global AIDS Response Progress Reports (2015)

Despite consensus that MSM are more likely to be HIV-positive than the general population (Baral et al., 2007; Beyrer et al., 2012; Beyrer et al., 2013; Kennedy et al., 2013; UNAIDS, 2014), the data reported by the governments in many Southern African countries (Botswana, Lesotho, Namibia, South Africa and Swaziland) do not suggest this is true. There are a number of reasons why this might be the case. It is possible that HIV prevalence among MSM in these specific countries is lower than in other countries or regions. However, this is unlikely due to the wealth of evidence previously cited suggesting that higher prevalence among MSM is a universal phenomenon. Harvey (2012) offers an alternative explanation, arguing that there is a bias in the scientific data on HIV among sexual minorities in Southern Africa – especially government data – since the political and social contexts within which it is collected, analyzed and published is not inclined to recognize this group of people. He says “Trepidation over Western liberalism may well discourage these nations from collecting data geared towards prevention from “the gays” or even MSM” (Harvey, 2012, p. 72). By way of example of this point, although the government of Botswana reports 13.1% HIV prevalence among MSM, recent studies found it to be much higher, at 19.7% (Beyrer et al., 2010). Beyrer et al. (2010) also find HIV prevalence among MSM in Zambia to be much higher than in the general population, at 32.9%, as compared to 15.7% in all adults 15-49.

Another challenge in national LGBTI HIV/AIDS data is the lack of age-disaggregated data available in the GARPPRs. This masks possible differences in HIV prevalence among different groups of MSM. Often, MSM recruited for studies are young MSM. Evidence from most prevalence studies shows that HIV prevalence increased significantly with age among MSM. For example, a study conducted by Wirtz et al. (2013) among 338 Malawian MSM found 12.5% overall prevalence of HIV among their sample, yet, among MSM 26 years and older, prevalence of HIV was much higher, at 28.1%. Further, among Malawian MSM 30 years and older, HIV prevalence has been found to be 35.3% (Baral et al., 2009). Baral et al., (2009) find similarly high HIV rates among older (30+) MSM in Namibia (31.4%) and Botswana (46.7%). However, a recently published “mini-review” includes two studies on LGB youth (not limited to MSM), both of which pointed to higher HIV prevalence and engagement in risk behaviours among youth (Evans et al., 2016). Regardless, older MSM have been cited as an important population to target in future HIV intervention planning (Bourne et al., 2016). Both younger and older MSM should be carefully considered in HIV intervention planning.

Risher et al. (2013) instead suggest that rather than comparing MSM to the general population, a more useful comparison is to look at MSM vulnerability to HIV as compared to other men, which helps to control for the reality that the Southern African HIV epidemic is female-predominant. Wolf et al. (2013) show that studies from South Africa, Swaziland, Lesotho, Malawi, Namibia, Botswana and Zimbabwe have shown MSM to have equal or greater disease burden of HIV, syphilis and hepatitis B, when compared to other men in the general population. Further, Wolf et al. (2013) indicate that HIV prevalence among MSM in Southern Africa appears to be seemingly isolated from recent overall declines in prevalence, which suggests that MSM require continued attention in HIV prevention efforts.

## **HIV AMONG WSW**

There has been very little new research with WSW and HIV since the first edition of this literature review. A recent “mini-review” of the evidence in South Africa found three WSW studies that met inclusion criteria, all of which were previously included in this review (Evans et al. 2016; Cloete, Sanger & Simbayi, 2011; Matebeni et al., 2013; Sandfort et al., 2013). An ethnographic internet study of South African LGB women has added additional contextual insight to WSW experience with HIV, such as being referred to as not being “real lesbians” when wanting to engage around the topic of HIV (Muranda et al. 2014). Findings from a new pilot study around dental dams are also included at the end of this section (Spilka et al., 2016).

Four studies which examine HIV behaviour and experience among WSW in Southern Africa all show that WSW are at greater risk for HIV infection than was previously believed (Cloete, Sanger & Simbayi, 2011; Matebeni et al., 2013; Poteat et al., 2014; Sandfort et al., 2013). A recent study from Zimbabwe (Ndondo, Maseko, Ndlovu, 2013) shows that HIV risk among LGBTI women is elevated by a lack of access to services; their research results demonstrate the need for HIV/AIDS policy in Zimbabwe to address HIV prevention, care, and support for LGBTI women. HIV prevalence among WSW varies greatly from country to country in the region. Sandfort et al. (2013) find that 13.3% of WSW self-reported being HIV positive in Namibia, 10.9% in South Africa, and 5.8% in Zimbabwe. The Government of Lesotho reports that 7.1% of WSW are HIV positive in the Mountain Kingdom (Government of Lesotho, 2012), though as previously noted with MSM reporting, this may be an underestimate.

Matebeni et al. (2013) argue that the findings of their research indicate that lesbian women cannot be regarded as a ‘no-risk’ group within the context of HIV in Southern Africa . In fact, previous research conducted in South Africa with 72 HIV positive WSW, demonstrated that same-sex desire offered no protection from HIV (Cloete, Sanger & Simbayi, 2011). Echoing this finding, Poteat et al. (2014, p. 130) argue that their data from 250 WSW in Lesotho

show that “self-identity as a lesbian was not associated with a lower likelihood of HIV or STIs.” WSW may have unprotected oral sex during menstruation or share sex toys after vaginal or anal penetration, placing them at higher risk for HIV infection (Richardson, 2000). However, in the Sandfort et al., (2013) study of 591 WSW in Botswana, Namibia, South Africa, and Zimbabwe, the conclusion reached by the authors is that the most important factor for self-reported HIV infection was not risky behavior with female partners, or even sex with men (per se). Instead, Sandfort et al. (2013) find that forced sex is the most important risk factor for self-reported HIV infection among the WSW in their study (see section on Safety and Security).

***Lesbian women cannot be regarded as a ‘no-risk’ group within the context of HIV in Southern Africa.***

The erasure of WSW from the global policy, data collection, and research agenda is to completely ignore an entire population that may be more at risk of HIV than previously thought. Recent research focusing on African lesbians living with HIV in South Africa, Zimbabwe, and Namibia uncovers widespread misperceptions that WSW are not an at-risk group and that African lesbians often hold wide-ranging misconceptions about risk (Matebeni et al., 2013).

There is a pervasive assumption among policy makers, researchers, and the public that sexual identity and sexual behaviour are closely linked, but for lesbian women in Southern African contexts, their identities may not preclude previous, current, or future sexual relationships with men. For example, among the self-identifying lesbians in Matebeni et al.'s (2013) study with 24 women, most of the WSW from South Africa, Zimbabwe, and Namibia had current male partners or had previous relationships with men. Another study conducted in Lesotho also found that almost half of the WSW had a boyfriend or husband (Poteat et al., 2014). The results of the Matebeni et al. (2013) study show that the majority of lesbians surveyed point to male relationships and sexual violence as the reason for their HIV positive status; 38% reported getting HIV from previous male partners and 33% reported acquiring the virus from being raped. Although the small sample size means that these results are not necessarily representative of all WSW in the region, the findings do suggest that sexual activity with men (whether consensual or forced) may be an important HIV risk factor among WSW.

Interestingly, five out of the twenty-four women (21%) in the Matebeni et al. (2013) study reported that they believe they may have been infected by their female partners since they had never been with male partners, been exposed to medical transmissions, or injected drugs (though it is possible that they were born with HIV). The women reported being shocked by their diagnosis since they believed they were safe as they had only ever been with women. Lebo, a young South African lesbian shares her experience:

“It’s the way you get infected as a lesbian because it’s really confusing how it is possible. Other women know that they get it from their partners during penetrative sexual intercourse but then as a woman who is a lesbian who also sleeps with other women – it’s very confusing” (Matebeni et al., 2013, p. S40).

Survey data from Poteat et al. (2014) among WSW in Lesotho sheds further light on how WSW can contract HIV, possibly related to low use of HIV protection commodities. They find that among WSW in their study, 48% used a condom the last time they had sex with a man, and only 13.4% used protection (dental dam) the last time they had sex with a woman (Poteat et al., 2014).

Knowledge of HIV prevention, too, has been shown to be low among WSW, in no small part due to lack of information targeting these women through government and NGO campaigns. Among WSW in Lesotho surveyed by Poteat et al. (2014), the majority (74%) had some knowledge about preventing HIV/STIs during sex with men, but only 38% had received any information about prevention during sex with other women. As a way of exploring an HIV prevention intervention specific to WSW, a recent pilot study from Spilka et al (2016) with women from eight Southern African countries examined use of dental dams with LGB women. Dental dams are not widely available or distributed in Southern Africa. As part of this research, dental dams were distributed to LGB women through partner organisations and these participants then completed a questionnaire about their experience a few months later. While there were some methodological limitations to the pilot study, key findings suggest that the WSW in the study would likely use dental dams if available, but that some WSW may also resist using dental dams due to fears that their partner may not trust that they are monogamous or because they feel that as WSW they are not at risk for HIV. Interestingly, the findings also suggest that dental dams should be explored and marketed among MSM and trans diverse people as an HIV prevention intervention, suggesting that dental dams may be an underutilised HIV prevention mechanism among a broader spectrum of LGBTI people (Spilka et al., 2016).

The general assumption (and misconception) that lesbians are insulated from HIV makes it all the more difficult for lesbians and WSW to reconcile their realities, disclose their status, and seek appropriate care. The participants from Matebeni et al. (2013) also suggested that their inability to disclose their sexuality due to stigma hampers their ability to access safe sex information:

“I have never mentioned that [I’m a lesbian] because of the stigma associated with disclosing your sexuality. Some of the [HIV] organisations I am involved with for example - is a Christian organisation. Talking about my sexuality to them would be so hard” (Tambu, 40 years old, Zimbabwe) (Matebeni et al., 2013, p. S42).



This perception also affects service providers, ultimately making it even more difficult for WSW to access health services. Anecdotal evidence from South Africa shows that lesbian women have been refused HIV tests because as WSW they “did not qualify for an HIV test” and were told to go home (Müller, 2014). Findings from Zambia suggest that considering the approach to WSW HIV programming may be important as results revealed that a human rights approach helps challenge some harmful practices (such as domestic abuse), but may also need to be re-examined as participants criticised how the human rights approach conflicted with traditional values at times (Muzayamba et al., 2015). How to respectfully engage and draw WSW into HIV prevention efforts should be carefully considered.

Poteat et al.’s (2014) study among 250 WSW in Lesotho found a self-reported HIV prevalence of 7.7%, of which only 33.3% were receiving treatment. However, this is comparably a much lower treatment uptake rate than was found in Matebeni et al. (2013), where the majority of WSW in their sample from Namibia, South Africa, and Zimbabwe were receiving ART (75%).

## **HIV AMONG TRANSGENDER PEOPLE**

While there is relatively sufficient MSM data, and some WSW data, there is a very significant lack of research with transgender populations in Southern Africa, and almost no data on how HIV/AIDS impacts these individuals (Jobson et al., 2012). For example, while MSM and WSW HIV research has been available most commonly from South Africa, a recent a “mini-review” by Evans et al. (2016) of peer-reviewed empirical social and behavioural articles on HIV prevalence and risk focusing on MSM, WSW, and LGBT populations in South Africa published since 2006, did not yield any articles on transgender population and HIV in South Africa. Similarly there is no specific data on HIV amongst intersex people.

Jobson et al. (2012) argue that transgender Africans are currently invisible in epidemiological research and they are almost certainly being ignored in HIV service provision. This is worrying given that gender identity affects sexual choices (or lack of choices). For example, transwomen may elect to be the receptive sexual partner as a way of reaffirming their gender identity, though this behaviour places these people at elevated risk of infection (Jobson et al., 2012).

This invisibility stems in part from the tendency to subsume transgender individuals into MSM or WSW categories within HIV data and research (UN Women & OSISA, 2013) This is highlighted by the fact that the one academic study that has emerged from this literature review is the Mpumalanga Men’s Study (MPMS), where Lane et al. (2014) assess Project

***In HIV data and research, the invisibility of transgender people stems from the tendency to subsume transgender individuals into MSM or WSW categories.***

Boithato HIV prevention for South African MSM. The study found that in the Gert Sibande community, HIV prevalence is higher among self-identified gay and transgender MSM. However, literature searchers may miss this and other such studies because participants are framed exclusively in the language of MSM, pointing to the need to trans-specific data.

However, a report from the COC Netherlands (2014) documents that transgender people could be an extremely vulnerable population in the HIV epidemic in Southern Africa. Behaviours and factors contributing to high risk of HIV identified in the report (from nine countries) included 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. Half of the transgender and intersex people interviewed reported not accessing health care services due to their fear of stigma, discrimination, and humiliation by service providers based on their gender identity (Johnston, 2014). Another report from UN Women and OSISA (2013) further voices the call to action for including transgender people as vulnerable populations when designing interventions in response to HIV in Southern Africa and beyond. However, little research has yet to be done examining interventions for these populations in Southern Africa.

A recent study, which documented sexual experiences and assessed HIV vulnerabilities among LGBTI women in Bulawayo, Zimbabwe, sought to explore how the lack of research and policy for this group affects health outcomes (Ndondo, Maseko & Ndlovu, 2013). Among the 29 LGBTI women in the study, perception of HIV risk were very low despite

frequent sexual activities that involved an exchange of bodily fluids. The majority of Zimbabwean LGBTI women in the study never practised safe-sex, in part because they lacked awareness of LGBTI-specific prevention methods.

Ndondo, Maseko and Ndlovu (2013) also found that women rarely sought HIV counselling and testing services, despite reporting frequent forced sexual experiences.

The authors conclude that heteronormative assumptions around HIV and STI vulnerabilities as well as heteronormative service provision were major barriers to care, along with stigma and discrimination at health centers.

It is critically important that the link between gender identity and HIV risk be better understood in Southern Africa. Research on HIV vulnerability among trans men in Africa, in particular, is a significant need and a gap in our current knowledge (Jobson et al. 2012). Whilst intersex people frequently identify as trans, research that delineated the two identities would also go some way to establishing a literature on intersex people and HIV.

***Half of the transgender and intersex people in a recent report reported not accessing health care services due to their fear of stigma, discrimination, and humiliation by service providers based on their gender identity***

# Access to healthcare, including sexual and reproductive health care

## HEALTH CONCERNS OTHER THAN HIV

Very little published literature speaks about health concerns other than HIV among LGBTI people in Southern Africa. A systematic review on WSW health in the region concludes that the vast majority of recent WSW health research (since

***Sexual minority youth were not more likely than heterosexual youths to have had sex, but when they did have sex, however, they engaged in riskier sexual behaviours.***

2010) focuses on HIV and sexual health, while the scant research conducted in South Africa before 2008 mostly focused on mental health (Müller & Hughes, 2016). Of the three recently published articles, two focused on South Africa and one on Namibia. Both South African studies looked at the dynamics between mental well-being and sexual risk behaviour. Tucker et al. (2014) explored the relationship between

homophobic stigma, mental health and sexual risk taking behaviour among a sample of 169 men in South Africa, of whom 55% reported unprotected anal intercourse over the previous six-month period. Participants who had higher levels of depression were more likely to engage in unprotected intercourse, and participants who reported more homophobic discrimination also reported more depression and less self-efficacy. The study concludes that there is an association between homophobia and risk of unprotected intercourse for South African township MSM. However, it is not always a straightforward one: seemingly being mediated by other variables and not following a linear pattern. A study by Thurston et al. (2014) analysed the psychosocial correlates of sexual risk among heterosexual and sexual minority youth in South Africa. The findings reveal that sexual minority youth were not more likely than heterosexual youths to have had sex, but when they did have sex, however, they engaged in riskier sexual behaviours. Sexual minority youth were at higher risk for mental health and psychosocial difficulties, which stemmed from stressors at the individual,

***MSM describe the power dynamics within same-sex male relationships as mirroring 'traditional' heterosexual relationships, including the use of violence as a way to maintain power.***

family, peer, and partner levels. The observed higher rates of sexual risk behaviours among sexual minority and male youths indicate that male sexual minority youth are a very vulnerable group. In the third study (Stephenson et al., 2014), male participants who have sex with other men described the power dynamics within same-sex male relationships as mirroring

'traditional' heterosexual relationships, including the use of violence as a way to maintain power. In this study population, respondents consistently referred to themselves in feminine terms, while referring to their partners as 'the man', reinforcing the notion that traditional power dynamics of masculinity are being maintained in Namibia through frequent abuse at the hands of their partners.

The gaps in LGBTI health literature are significant: other than HIV and, to a certain extent sexual health, many key health topics are not explored in research. Key gaps, when compared to international literature on LGBTI health disparities, include regional evidence of LGBTI mental health concerns, LGBTI individuals' cancer risk and preventive health system use, literature on LGBTI adolescents, their well-being and coping mechanisms, as well as any literature on older LGBTI populations.

## ACCESS TO HEALTH CARE SERVICES

As is evident from the previous section on HIV, access to HIV-related healthcare remains a critical issue for LGBTI people in Southern Africa. Several studies particularly highlight this issue as it pertains to MSM, who commonly report fear of discrimination, being outed, or violence, as well as limited knowledge, attitudes, and skills of healthcare providers in relation to LGBTI health (Ministry of Health, Swaziland, 2015; Bourne et al. 2016; Zahn et al., 2016; Mprah, 2016.). However, the challenges for LGBTI people in accessing healthcare in Southern Africa extend beyond HIV-related

healthcare into most health services. In fact, one of the two key findings of a participatory health research project with LGBTI organisations in nine African countries was LGBTI people's tendency to not seek healthcare as a barrier to receiving needed healthcare (Johnston, 2014). In Lesotho, multiple factors have been identified as barriers to accessing reproductive healthcare for LGBTI people, including lack of privacy for clients to disclose their sexual orientation or gender identity to providers, negative or intrusive comments or questions from providers about their sexual orientation or gender identity, and a lack of knowledge from the providers about LGBTI people's health needs (Mats'ela et al., 2014/2015).

WSW in Southern Africa have been found to face challenges such as fear of discrimination, but also seem to have disproportionate knowledge about sexual health as compared to their heterosexual peers that keeps them from accessing necessary preventative healthcare such as pap smears (Müller & Hughes, 2016). One qualitative study from South Africa found that while some WSW had positive experiences accessing healthcare, those accessing care in the public sector reported more negative experiences, suggesting that the low income WSW who rely on the public system may struggle to access healthcare from supportive providers (Smith, 2014).

Transgender people's challenges in navigating heteronormative healthcare settings in South Africa have also been documented, particularly their exclusion from the South African National Health Act as a vulnerable population, and their subsequent exclusion from healthcare service delivery (Newman-Valentine & Duma, 2014a; Newman-Valentine & Duma, 2014b; Sanger, 2015). Many countries do not offer gender affirming treatment for transgender people, creating the ultimate barrier to such care. Even in South Africa, where gender affirming treatment is available, such services struggle to keep up with the demand due to limited resources (Wilson et al., 2014). Recommendations from the literature support a broad approach to improving access to healthcare for transgender people, by engaging healthcare professionals, school teachers, and the Department of Health (Theron, 2014; Sanger, 2015). While literature specific to intersex people and healthcare access is limited, research from a Master's thesis in South Africa also suggests that intersex people may face similar difficulties, including healthcare providers with little knowledge of their needs, poor surgical outcomes, and experiencing social exclusion (Van Rooyen, 2015).

## **THE IMPACT OF CRIMINALISATION ON ACCESS TO HEALTHCARE**

The criminalisation of same-sex sexual relations poses crucial barriers to care for LGBTI individuals in countries where such provisions are upheld in the legal framework. A report by UN Women and OSISA (2013), titled "Silenced and Forgotten. HIV and AIDS agenda setting paper for women living with HIV, sex workers and LGBT individuals in southern African and Indian Ocean states" reports the following key legal challenges and barriers for Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe, and highlights the intersection between LGBTI identity, HIV status, and sex work:

- In countries where the criminalisation of HIV transmission, sex work and/ or same sex relations are criminalised, these laws are usually structured to target women living with HIV, sex workers and LGBTI individuals, who are wrongfully labelled as 'drivers' of the epidemic.
- Poor access to justice – reports of violations of the rights of women living with HIV, sex workers, and LGBT individuals are often not investigated or taken seriously by both state and non-state parties.
- Lack of protective policies and their implementation – where policies exist to mitigate and address the HIV and AIDS epidemic, they often exclude women living with HIV, sex workers, and LGBT individuals.
- Lack of freedom of association and expression – some groups, such as sex workers and LGBT groups, are often unable to register as legal entities and are therefore denied legal status, which deprives them of the liberty to collectively demand both their rights and tailor-made sexual and reproductive health and HIV and AIDS services.
- Lack of legal recognition of gender identity – transgender people cannot access identity documents in their chosen name and identity, which negatively impacts on their access to services and justice.

## **ENGAGING HEALTHCARE PROVIDERS**

Healthcare provider knowledge, attitudes, and training, as seen above, have been documented as barriers to care for LGBTI people. While the literature is limited, two approaches are emerging for training healthcare providers: education on LGBTI health as part of curricula for medical and nursing students (Müller, 2015), and in-service training for qualified healthcare providers (Brown, B., Duby, Z. and van Dyk. D., 2013). The only evidence available for student curricula shows that the medical curriculum at the University of Cape Town in South Africa does not adequately cover LGBTI health related topics, and that as a consequence, medical students do not receive training on, among other fields, providing sexual health services to LGBTI individuals or providing care to LGBTI people struggling with mental health concerns because of their sexual orientation and gender identity and consequent social exclusion and stigmatisation (Müller, 2013). To remedy this, Müller (2015) offers recommendations for improving healthcare professionals' training in this regard, such as taking an interdisciplinary approach and ensuring that educators are mindful of not reinforcing heteronormativity in the classroom. While the evidence overwhelmingly shows that healthcare providers currently struggle with providing sensitive, evidence-based healthcare to LGBTI people, the 2013 position statement from the Psychological Society of South Africa offers an alternative way of encouraging healthcare professionals to be sensitive to LGBTI people's needs. The statement encourages normalisation of the entire LGBTI community and moves away from pathologising their identities and behaviour (Nel, 2014; Victor et al., 2014).

# Access to education

Access to education is a multi-layered issue when it comes to LGBTI rights. It must be acknowledged that access to education remains a critical issue for people of all sexualities and gender identities in Southern Africa. However, LGBTI people may face specific difficulties in heteronormative educational institutions, such as absence of LGBTI topics from the curriculum, discrimination from students or teachers and policing of gender expression (in the case of school uniforms). These challenges are relevant from primary school to university level.

***LGBTI people may face specific difficulties in heteronormative educational institutions, such as absence of LGBTI topics from the curriculum, discrimination from students or teachers and policing of gender expression***

Discrimination and homophobia in educational institutions can take many forms. One South African study of a rural university found that religion-related stigma was central to the negative experiences of LGBTI students. Participants reported that LGBT students are stigmatised and discriminated against by the university community, who label the LGBT students as “sinners, satanic or demon possessed” (Mavhandu-Mudzusi & Sandy 2015, p.4). LGBT students were not only discriminated against by their heterosexual students, which included threats of rape, but also by the academic staff who held strong religious affiliations (Mavhandu-Mudzusi & Sandy, 2015). Research from another South African university focused on student residence spaces, identifying the heteronormative nature of the spaces as problematic for LGB students who either resisted, by moving in with their same sex partners for example, or replicated heterosexuality for their safety and comfort (Msibi & Jagessar, 2015).

In research from a South African primary school setting, the author argues that South Africa’s history of racial and gender inequalities combined with cultural, economic and social practices has produced “anxious masculinities” that work to spread homophobic violence (Bhana 2014, p.78). Therefore, specific local contexts must be taken into account in understanding homophobia in school settings and how it intersects with racism and sexism. However, the same article also emphasizes the progress that has taken shape in South African schools in acceptance of sexual rights. While some information about sexual orientation has been included in South African sexuality education, an analysis of a widely used textbook revealed low coverage of the topic, as well as heteronormative assumptions about families, relationships and safe sex (Wilmot & Naidoo, 2014). Qualitative research in South Africa with transgender youth has further documented the gap in school (and university) curriculum, which rarely addresses the topic of gender identity (Sanger, 2015). Another primary school study, from Botswana, highlights how the generational divide between teachers and students can impact education about sexual orientation; the teachers were uncomfortable discussing the topic while students greatly enjoyed learning about sexuality (Mhlauli & Muchado, 2015). These impositions of heteronormativity in primary and university level education create a hostile environment, impeding LGBTI students’ ability to learn and access education.

Further, little support is in place for LGBTI educators themselves. There is also little institutional encouragement for educators (LGBTI or not) to include LGBTI health topics in their teaching, which has been well-documented as a gap in South Africa as well as regionally, particularly for university level education (Müller, 2015; Sanger, 2015; Mavhandu-Mudzusi & Sandy, 2015; Müller & Hughes, 2016; UN Women & OSISA, n.d.).

Overall, there is little information in the current literature that highlights the intersections of access to education and LGBTI rights. What little is available is predominantly located in South Africa, arguably the Southern African country with the most progressive laws related to sexual orientation and gender identity. This is a significant gap in understanding educational needs both for LGBTI people and for all people in relation to issues of sexual orientation and gender identity. It is concerning that more than one study documented experiences of bullying, violence, and threats of violence towards LGBTI students in South Africa, impeding access to education at primary and university levels (Mavhandu-Mudzusi & Sandy, 2015; Sanger, 2015; Legal Recourses Centre, Iranti-org & Gender Dynamix 2016.), and that similar levels of violence towards other LGBTI students in the region is widely undocumented.

# Transgender individuals and rights

LGBTI people in Southern Africa also embody a spectrum of diverse gender identity. There is a growing body of evidence that highlights the disconnection between gender identity and sexual orientation in Southern Africa (Baral et al., 2013; Wirtz et al., 2013; Kennedy et al., 2013).

However, this distinction is still poorly understood in the region, including in many LGBTI circles, who largely focus on issues of sexuality (LGB groups), often with the effect of excluding people who fall within the trans spectrum, even though they increasingly make-up the LGBT constituents of the region. In Malawi, 17% of the MSM surveyed reported they identified as female, and a further 2.8% said they were transgender (Wirtz et al., 2013). In Swaziland, 15.7% of MSM reported identifying as female, and 1.8% said they were both male and female (Wolf et al., 2013). In both of these contexts, Wolf et al. (2013) caution that it is not clear whether those surveyed identified as female as an identity, or in relation to their behaviour as MSM.

While all LGBTI people potentially face safety and security issues as a result of homophobia and transphobia, lesbian and transwomen bear a disproportionate amount of this violence.

Along with lesbian women and WSW, transwomen are particularly vulnerable to physical and emotional violence. ARASA (2014) indicate that there is increasing evidence that transmen and transwomen are targeted because of their sexual orientation and/or gender identity and face significantly levels of sexual violence. The Global Commission on HIV and the Law (2012) also states that most of the violence amongst LGBTI people is directed towards transgender individuals, especially transwomen. This is echoed by Giovaniello (2013). Transgender individuals may be (comparably) more visible than other members of the LGBTI community, which can lead to an increased vulnerability to violence and hate crimes (Jobson et al., 2012).

In a recent roundtable discussion with a focus on trans issues, Micha Cárdenas said “Year after year, statistics on violence against LGBT communities show that transgender women of color are the number one targets of violence it is clear to me that transgender women of color exist within a matrix of oppressions that allow us to be murdered on a very frequent basis” (Boellstorff et al., 2014, p. 426). Further, transwomen are more likely to be jailed in holding cells with men, placed at increased risk of rape and further violence. The GCHL also points out that along with WSW, transmen are also subjective to corrective rape (GCHL, 2012).

Though the Sandfort et al. (2013) study finds that transactional sex is not associated with an increased likelihood of self-reporting HIV, other studies show that sex work is associated with lots of other health and safety risks, especially for male and transgender sex workers (Scorgie et al., 2013). Security risks such as stigmatization and breaches of confidentiality from health care workers and policy is perhaps most extreme among transgender sex workers (Scorgie et al., 2013).

***In South Africa, transgender women from other African countries experience vulnerability at the intersection of xenophobia and transmisogyny.***

Further, research revealed that transgender individuals may be more reliant on sex work than other LGBTI people. Scorgie et al. (2013), who interviewed female, male and transgender sex workers from Kenya, Zimbabwe, Uganda and South Africa, found that none of the transgender sex workers in their study had another form of employment, while 25% of the male sex workers did. Drawing on twenty-one interviews with cisgender men and transgender sex workers receiving services from SWEAT in Cape Town, South Africa, Samudzi & Mannell 2016, show that transgender women often feel victimised and discriminated against when navigating public space, and also experience exclusion in discursive spaces, including difficulties in gaining access to platforms in advocacy spaces and hostile LGBTI spaces. Further, transgender women from Burundi, Kenya, and Uganda had concerns about immigration and being deported from South Africa. Due to their more visible non-conforming gender expression they experienced vulnerability at the

Further, research revealed that transgender individuals may be more reliant on sex work than other LGBTI people. Scorgie et al. (2013), who interviewed female, male and transgender sex workers from Kenya, Zimbabwe, Uganda and South Africa, found that none of the transgender sex workers in their study had another form of employment, while 25% of the

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Stevens (2012) finds that up to 60% of transgender individuals in South Africa report negative experiences in state clinics. Wilson et al. (2014) also assert that transgender people may be more likely to be denied health care in general medical settings as the perception is that they must be treated by psychiatric specialists.

Newman-Valentine & Duma (2014b) explore the services to trans women of the single public clinic dedicated to assist transsexual women, noting the long waiting lists of about 25 years. The clinic only provides trans women with endocrine and plastic surgery services, and not the rest of their general health. In another paper, Newman-Valentine & Duma (2014a) also found that, as a result, trans women have to negotiate care in a hetero-normative health care system that treats people either as male or as female – which leads to an exclusive and discriminatory health care system and poor access to care. They also point out that trans women often suffer from side-effects from their sexual re-alignment treatment (cardio-vascular problems, endocrine problems, poor mental health, and vulnerability to HIV infection) and have poor access to health care. Neither article addressed the health care needs or conditions of trans men.

As outlined in the Psychological Society of South Africa sexual and gender diversity position statement (Psychological Society of South Africa 2013), and emphasised by Nel (2014) and Victor et al. (2014), trans people also face considerable mental health issues due to homophobia, transphobia, heterosexism, prejudice, and stigma. The marginalised position of transgender people can have serious effects on their quality of life.

Wilson et al. (2014) argue that the combined stigma of being transgender and being classified as having a mental disorder, when attempting to access gender affirming care, creates a doubly burdensome situation for an already vulnerable population, compromising their health and human rights. Drawing on the experiences of seventeen young trans people, Sanger (2015) found that bullying at school and access to toilets emerged as a serious concern for trans youth given the impact on their mental and general health. This study also raised concerns about trans persons' engagement in the health care sector, for both trans-related as well as general health issues.

Arduous legal and bureaucratic process in South Africa related to the legal recognition of people's chosen sex/gender identity, that affect the ability to work and access to services, may also have mental health consequences. These include the difficulty in having their sex legally changed in official documents, and the consequences that successful changes have for the validity of marriages, as outlined in a report by the Legal Resources Centre & Gender Dynamix 2015, and as exemplified in a Mail and Guardian newspaper article (Kings, 2014) about a transgender woman who goes on a hunger strike in protest after struggling to get an identity document that reflects her name and gender. In her MA thesis on the emotional experiences of a parent of a transgender child, Mohadien (2015) shows that care-givers and family members also struggle with stigmatisation and isolation.

Further, trans people are often marginalised within the LGBTI sector. In an ethnographic observation of Namibian and South African LGBT organisations, Currier (2015) finds that the activists did not first recruit transgender-identified people to join their organisations.

In his exploration of the gender identity and sexuality of a "lesbian man", school teacher Francis (2014) troubles the common typification of men solely as either hegemonic (white men) or subordinate/marginalised men (gay men), as well as emerging understandings of trans identity. The life history account he provides is much more fluid and the subject variously describes themselves as "born as a woman, identify as a man and who has sex with women", as "transgender," and most frequently "a lesbian man". However, Currier (2015) shows that through LGBT organising, transgender collective identity may invisibilise these complex identities, and render a hegemonic understanding of what transgender means as organisations simplify and "fix" the boundaries of their transgender constituency, normalising and privileging collective-identity categories as templates of how gender-variant persons should use identity categories that aligns with collective-identity categories (111). Similarly a report by the Legal Resources Centre, Iranti-org & Gender Dynamix (2016) states that the diverse gender identities and gender expression of people under the trans umbrella remain marginalised, invisibilised and oppressed in South Africa due to cisnormative and heteronormative conceptions of gender.



A report by UN Women & OSISA (2013) asserts that overall, high HIV infection rates, inaccessibility of health services, high incidence of sexual violence and murder, and vulnerability to societal ills, such as substance abuse, can all potentially reduce the life expectancy of transgender people in Africa. Many of these issues are summarised in the report on the second trans health, advocacy and research conference “Rooted in the past. Reaching for the future” (Theron, 2014), which addresses the issues of trans-affirming health services, sexual and reproductive health and rights, and trans movement and community; and in a report on the civil Legal Resources Centre, Iranti-org & Gender Dynamix 2016 on the civil, political and socio-economic rights of transgender and intersex persons in South Africa under the African charter on human and peoples’ rights.

Their relative marginality in the LGBTI sector is also borne out in the relative funding available to do trans specific work in Southern Africa. While there is some money for LGBTI organizations in general, this does not necessarily go towards special services that the trans community needs (Jobson et al., 2012). The Open Society Initiative of Southern Africa (OSISA) is one of the only organizations to separate their funding streams for trans organizations and trans initiatives, due to the unique nature of the needs of that programming.

Part of the challenge in addressing these gaps is the lack of data on LGBTI populations in Southern Africa. A key reason for the lack of data, apart from the lack of political will to commission studies, is the lack of international commitments. There are UNGASS indicators for MSM and sex workers, which countries are obligated to collect data for, but no indicators for WSW, trans or intersex individuals. The lack of UNGASS indicators for these populations has a significant hampering impact in improving the HIV response to vulnerable and marginalized populations (Oberth & Tucker, 2013).

In the most recent Global AIDS Response Progress Reports, seven out of the ten countries in this analysis reported HIV prevalence data for MSM (Angola, Botswana, Lesotho, Malawi, Namibia, South Africa and Swaziland), one reported data for WSW (Lesotho) and none reported data for bisexual, transgender or intersex individuals.

# Intersex individuals and rights

Trans and intersex issues are often tightly bound up, partially because they share many of the same issues around gender, bodily diversity, and self-determination, and partially because some people identify as trans due to historical misclassification of their intersex bodies. As a result, the intersex and trans movements in Southern Africa have largely shared organizational bases, advocacy strategies, and research agendas. Whilst this has proven beneficial in terms of creating a wider constituency, and sharing resources, this combined with the relative marginalization of intersex people within the wider LGBTI framework, and social stigma, has led to a situation where little is known about the status of intersex people in the region, and intersex issues are often subsumed into wider LGBTI issues, or at best trans issues. This review did not yield any published empirical studies that focus on the circumstances of intersex people in Southern Africa. The literature that it did produce all pertains to South Africa.

*Little is known about the status of intersex people in the region, because intersex issues are often subsumed into wider LGBTI issues, or at best trans issues.*

Van Rooyen's (2015) MA thesis describes a study conducted by AFSA Culture and Health Programme to assess the knowledge, attitudes, and perceptions of people living in rural areas towards intersex people. Survey data collection from six provinces (n=2788), showed that 71.4% of participants lacked knowledge about intersex people, 41.9% felt that intersex was a natural variation, and the rest attributed it to bad experiences, ancestral curse, bewitching, or psychological imbalance. This data was supplemented with telephonic interviews with four intersex people who expressed that society's limited knowledge, including within the health care system, translated into limited and ineffective support for them.

Two qualitative essays also provide context for the circumstance of intersex people in South Africa specifically. Magubane (2014) uses controversy around athlete Caster Semenya to discuss the historical role of race and nation in defining intersex bodies and determining their treatment, arguing that black intersex people affirmed the pathologisation of black bodies. Mokoena (2015), reflecting on the intersex movement in South Africa and on her own experiences of being intersex, reveals problems in accessing health care and the social stigma around being intersex, as well as the marginality and limited resources for intersex issues.

This personal account is supported by a report by the Legal Resources Centre, Iranti-org & Gender Dynamix (2016) which describes intersex persons as subject to intersexphobia, including verbal and psychical violence, as well as violations in the medical sector, including non-consensual, medically unnecessary treatments and surgeries, harmful and stigmatizing clinical language, and being put on medical display and treated as a curiosity. The report asserts that they face even greater obstacles of invisibility, isolation, misunderstanding, stigma, secrecy, shame, and pathologisation than transgender persons.

The only other documentation on intersex issues since 2014 are: the Sexual and Gender Diversity Position Statement issued by the Psychological Society of South Africa (2013), which expressly promotes encouraging parents to look for alternatives to surgical intervention for intersex infants; Victor et al. (2014) commentary on this statement describing it as contributing to transforming and redressing silences in South African psychology; and a report by the Legal Resources Centre & Gender Dynamix (2015) outlining the difficulties of intersex and trans people in amending their identification documentation from the gender recorded at their birth to reflect their true gender identity

# Identification of knowledge gaps

This section presents identifications of knowledge gaps based on the data from this literature on LGBTI human rights in Southern Africa from 2014-2016, along with recommendations for focal areas going forward. Whilst these suggestions have been divided into distinct themes to be addressed, it is important to emphasise that these do not stand in isolation, they are interrelated and affect the lives and experiences of LGBTI individuals.

## **HIV AND WSW:**

There is a recent small emergence of studies on WSW and HIV, but this body of research is still very limited, especially compared to the research that exist on HIV and MSM.

## **MENTAL HEALTH, SUICIDE AND SELF-HARM AMONG LGBTI PEOPLE:**

Information on mental health, suicide and self-harm remains a significant knowledge gap. More research is needed to explore the mental health impact of heteronormativity on LGBTI people. Further exploration could lead to the development of comprehensive mental health promotion, stigma reduction, risk prevention, and sexual minority support interventions.

## **TRANSGENDER AND INTERSEX INVISIBILITY:**

Transgender and intersex research is a growing research area, but there is still a lot to be investigated. Recent literature reveals the extent to which transgender and intersex people remain largely invisible in LGBTI organisations (Currier, 2015). The social dynamics that hinder the integration of transgender and intersex people in research, in grassroots LGBTI organisations and broader society must be addressed.

## **THE INTERSECTION OF RACE, SEXUALITY AND COLONIALISM:**

More attention in understanding sexuality and gender diversity in relation to the legacy of colonialism is needed. There is a need to challenge the widely spread social and cultural assumption in Southern Africa that justifies homosexuality as “un-African”. The influence of colonialism and Apartheid has tied race and sexuality in ways where blackness and sexual/gender non-normativities become a double marginalisation. These intersections need more attention in order to dismantle the effects and structures of colonialism that continues to permeate the lived experience of LGBTI people today.

## **ACCESS TO HEALTHCARE PROVISION:**

Barriers to access to healthcare continue to be extremely prevalent amongst LGBTI people in Southern Africa. LGBTI people’s access to healthcare persists as a critical point of investigation for future research.

## **ACCESS TO LGBTI EDUCATION:**

Research on education for LGBTI individuals along with education in understanding sexual orientation and gender identity is marginalised within the LGBTI literature in the region.

# Recommendations for focal areas going forward

## **HIV AND WSW:**

Without taking WSW populations into account when implementing HIV research, policy, and programs, the response will remain inadequate and may silently contribute to the high prevalence of HIV (Brown et al., 2015). Further research about WSW and HIV is recommended to better understand the modalities of women-to-women HIV transmissions. The existing empirical studies on WSW consists of small sample sizes (Muranda et al., 2014; Evans et al., 2016; Reddy et al., 2014). Recommendation for future research is to place empirical studies at a local community level or to use larger sample sizes. Muranda et al. (2014) bases recommendations on the need to fill the information gap on WSW and HIV by using online spaces as “a means of pushing for the inclusion of WSW within the African healthcare rights realm” (Muranda et al., 2014:785). Online spaces can seek to further the idea that WSW should form a part of the conversation surrounding HIV in order to ensure that they have the same protection and information enjoyed by other groups. As misinformation or no information is a huge barrier to these rights, the online space can work as a way towards informing this problem.

## **LAW, POLICY AND SOCIAL CLIMATE:**

Decriminalisation of same-sex sexual behaviour is a critical first step, but it must be accompanied by comprehensive efforts to normalise same-sex behaviour, provide legal protection from discrimination, and systematic efforts to dislodge socially, culturally and religious prejudices.

## **ACCESS TO LGBTI EDUCATION:**

Literature have shown that there is a lack of education about gender identities and sexualities in both primary and high school (Sanger, 2015). Advocacy and recommendations include teaching about sexual orientation and gender identity by incorporating these concepts into curricula in schools of all levels and various disciplines. It is important to note that the kind of education that is referred to here needs critical dismantling of assumptions that re-inscribes “queer imperialism”.

## **TRANSGENDER AND GENDER DIVERSE CHILDREN, ADOLESCENTS AND YOUTH:**

Theron (2014) calls for education and support for families and parents to facilitate early recognition of trans and gender diverse children’s identities, needs and rights. Recommendations is to develop a way forward for education regarding transgender and gender diverse children in schools, advocating for children not to be pathologised, and working closely with school principals and school management teams in order to advocate for transgender and gender diverse children’s rights.

## **HEALTHCARE PROVISION FOR LGBTI PEOPLE:**

Improving the health of LGBTI people in Southern Africa is an important site of investigation, which will require new social attitudes and new political will (Müller & Hughes, 2016). There is a need for future research to address the considerable “sexual-orientation-related health disparities and invisibilities” in Southern Africa (Müller & Hughes, 2016). Further recommendations are to improve the knowledge, attitudes and skills of healthcare providers in order to ensure appropriate care to LGBTI people. This includes strategies of incorporating sexual orientation and gender identity into the curricula of medical schools, nursing colleges, and the allied health sciences (Müller, 2015). Medical and health sciences curricula should guide students in developing non-heteronormative, non-cisnormative, supportive professional attitudes by including LGBTI content and examples.

## **QUEER IMPERIALISM:**

There is a need for critical examination of the way in which foreign organisations and foreign donors implement programming and conduct advocacy. The western incursion comes from a particular understanding of sexuality and gender diversity which does not necessarily match the understandings of the population from Southern Africa. In order to understand and support the decolonising project in Southern Africa, there is a need for research to question western constructs of sexuality and gender and how these concepts of white queer theory might limit the ways coloured queers exist (Milani, 2014). Research into strategies of avoiding or disrupting the problem of queer imperialism is therefore vital. Suggested recommendations are the need for context dependent research, strategies and interventions along with the production of informed community-based research.

## **TRANSGENDER AND INTERSEX RIGHTS:**

Future research should focus on the health problems transgender and intersex people experience whilst on the journey of gender affirmation. Existing literature brings to the fore important recommendations about providing gender-affirming healthcare through decentralising hormone therapy and addressing the waiting lists at tertiary healthcare institutions (Theron, 2014). The development of context-specific, state-endorsed clinical guidelines seems to be a key step towards achieving improved access to care. Additionally, further research is recommended in order to advocate for gender dysphoria to be removed from the Diagnostic and Statistical Manual of Mental Disorders (DSM) as this serves to pathologise transgender and intersex people (Mohadien, 2015), and limits their access to healthcare provision.

## **TRANSGENDER PEOPLE IN RESEARCH:**

Recommendations are to ensure that trans women are not conflated with MSM in research, programme design and projects. It is also recommended to include trans men in MSM studies, programmes and projects (Theron, 2014).

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