Trans Rights! Health Rights!

Regional Scan of the level of Access to Sexual and Reproductive Health Rights and HIV services for Transgender people in Botswana, Lesotho, Malawi, Namibia, Uganda and Zimbabwe

ARASA
AIDS & Rights Alliance for Southern Africa

EVERY BODY COUNTS

It is as if people need you to have HIV, to be vulnerable, to be recognised as human

RETURN TO CONTENTS

ACKNOWLEDGEMENTS

The support of the Swedish International Development Agency for supporting the work of ARASA and the production of this report is gratefully acknowledged.

We express our sincere gratitude to the key informants who contributed to this study for their time, energy and commitment. The experiences shared with the researchers during the interviews are testament to the intense and often very precarious nature of the contexts in which trans activism and advocacy takes place. The respondents were not only willing to give up time to be interviewed but also shared experiences, insights and clear, concise visions for change.

ARASA is also grateful to Dr Rebecca Walker and Dr Marlise Richter for authoring this report. We also thank Anthea Taderera, HeJin Kim and Nyasha Chingore members of the ARASA programmes team for reviewing drafts of the report.

Research report commissioned by the AIDS & Rights Alliance for Southern Africa (ARASA)

Final report
2021

ARASA
AIDS & Rights
Alliance
for Southern Africa

RETURN TO CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

RETURN TO CONTENTS

A NOTE ON TERMINOLOGY

Throughout this report, the term LGBTI+ will be employed to refer to the Lesbian, Gay, Bisexual, Transgender, Intersex community and other non-conforming individuals. Other useful terms employed in this report follow below and are taken from Pocket Queerpedia - "an illustrated glossary of LGBTQIA+".

Gender	Gender is a social and cultural construct and practice and often regarded as a core aspect of an individual's identity. A person may identify as a man, woman, non-binary, genderqueer, gender-fluid or androgynous amongst others. How you identify has very real implications for how you are treated and the opportunities you can access.
Gender Expression	This refers to the way someone expresses their gender including in dress, mannerisms, behaviour and interests. Gender expression does not necessarily line up with a person's gender identity, and can reinforce or contradict it. In comparison to Gender identity, which describes who we are, gender expression is something that we do and can change regularly.
Gender Identity	Gender identity refers to an individual's internal sense of their gender which could be 'man' or 'woman' or any of a number of other genders, including agender, gender fluid, gender non-binary or genderqueer amongst others. A person's gender identity does not always match their gender assigned at birth.
Sex Assigned at Birth, Assigned female at birth and Assigned male at birth	The sex assigned to an individual by medical, legal or other social authorities. Assigned sex is often determined to be either – 'male', 'female' or 'intersex' male on the basis of primary sexual characteristics (sexual and reproductive organs) at birth. The acronyms 'AMAB (Assigned male at birth) and 'AFAB' (Assigned female at birth) are used to refer to the idea that gender can be assigned without consultation with the person themselves and that this assignment can be wrong. It is also a way to talk about a person's history and medical needs without misgendering them.
Gender Binary	An understanding of gender that reduces gender to two separate categories and maintains there are two genders -– 'man' and 'woman.' This ignores the socially constructed nature of gender, how people perform and express their gender, and our physical diversity.
Sexual Orientation	This describes the gender(s) you are attracted to, based on your own gender identity. Heterosexual, homosexual, bisexual, asexual and pansexual are terms that fall under sexual orientation. Sexual orientation can also include more specific terms such as: gay; lesbian; straight, bi or pan.
Non-Binary Person	Often used as a term for people who do not experience gender as something that conforms to two categories – man or woman. Non-binary people do not fall within the gender binary. The term can include different and sometimes shifting relationships to gender.
Gay or Lesbian	Refers to an individual who is exclusively sexually, emotionally and/or romantically attracted to someone of the same gender.
Asexual	Refers to a person who does not experience sexual attractions, feelings or desires.

RETURN TO CONTENTS

A NOTE ON TERMINOLOGY

Bisexual	Refers to a person attracted to people of both the same and different gender to themselves.
Transgender	A person whose gender is not the same as the one that they were assigned at birth. A transgender person can be a man, woman or non-binary.
Intersex	A term used to describe when a person's external sex characteristics hormone production and chromosomes don't line up in a way typically understood as being 'female' or 'male'. Sometimes this is visible at birth, or it is revealed at a later stage of life. Intersex does not refer to one particular biological aspect or facet, it refers to a whole variety of different conditions where the persons biological sex is not typically male or female.
Queer	Queer is often used as an umbrella or all-inclusive term for people who belong to the LGBTI+ spectrum. Individuals who identify as 'queer' often do so because they do not want to subscribe to sexual gender categories. Originally used as a slur 'queer' has been reclaimed as a political term that seeks to relate to the world and systematic change in different ways from the current cis-heteronormative ones.
Cisgender	This describes someone as identifying or being the same gender, they were assigned at birth. Cisgender is the opposite of transgender and is a term that helps challenge the idea that one group of people are 'normal' because they reflect the majority while another is 'abnormal' for not doing so.
Heteronormativity	Societal behaviours and expectations that treat heterosexual relationships as the norm and 'natural' and promote an adherence to a strict gender binary.
Gender affirmative Care/gender affirming healthcare	Healthcare provided to support a transgender or gender diverse person's gender affirmation. This can include a range of treatment including hormonal treatment, surgical interventions, as well as psychosocial support, hair removal and speech therapy. It is important to note that the procedures transgender people may or may not chose to undergo have no influence on whether they are transgender or not. Choice may also be influenced by experiences of dysphoria (the feeling that appearance, bodies and social presentation do not represent who you are), health factors, affordability, accessibility and other considerations.
Legal Transition	The change of legal and other documents to a more accurate gender descriptor and name change is one aspect of transitioning that transgender people can pursue. However, this is not an option available in all countries and even where legally allowed it is not always accessible.
Medical Transition	Medical interventions can assist in aligning the body/sex characteristics of a trans person with their gender identity. Although not everyone chooses to transition (and it is an option not everyone is able to due to lack of provision, resources and affordability) it is often beneficial to trans people's mental, emotional and physical health.
Key Populations	'UNAIDS considers gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs and prisoners and other incarcerated people as the five main key population groups that are particularly vulnerable to HIB and frequently lack adequate access to services' (UNAIDS 2016)

RETURN TO CONTENTS

ACRONYMS

AIDS	Acquired immunodeficiency syndrome
BAI	Bodily Autonomy and Integrity
GBV	Gender based violence
HCPs	Healthcare Service Providers
HIV	Human immunodeficiency virus
KP	Key Populations
KPIF	Key Population Investment Fund
LGBTI+	Lesbian, Gay, Bisexual, Transgender, Intersex community and other non-conforming individuals
LGB	Lesbian, Gay, Bisexual
MSM	Men who have sex with men
NGO	Non-Governmental Organisation
NSP	National Strategic Plan
PrEP	Pre-Exposure Prophylaxis
SATF	Southern Africa Trans forum
SDGs	Sustainable Development Goals
SRHR	Sexual and Reproductive Health Rights
STIs	Sexually Transmitted Infections
WSW	Women who have sex with women

EXECUTIVE SUMMARY

This report explores the socio-political contexts of trans men, women and non-binary persons, and the impact of law, policy, and practice on their access to sexual and reproductive health and HIV services in six Southern and East African countries. It is based on a regional scan of Botswana, Lesotho, Malawi, Namibia and Uganda and Zimbabwe and informed by interviews with individuals working for LGBTI+ and trans-led organisations across the six countries. Trans people experience hostility, stigmatisation and violence for being 'different' while simultaneously being *invisible* (in legal frameworks, in healthcare approaches, through NGO and other programming) and hypervisible (when in public, to law enforcement, when at work or accessing healthcare). This results in a unique set of vulnerabilities and forms of discrimination which continue to pervade the law, political rhetoric and interactions with service providers, family members and broader communities.

Centralising the voices and lived experiences of the respondents, this report shows how health interventions designed to specifically meet trans needs as a 'Key Population' may heighten and amplify the marginalisation of transgender people. It shows, through the different experiences of organisations and activists, how a focus on HIV/AIDS in particular has not only ignored the unique and specific needs of trans people to healthcare but also diverts attention from the many simple and effective forms of advocacy that LGBTI+ and trans-led organisations rely upon. These are strategies that have grown from the lived realities of trans people and which, in alignment with ARASA's key principles, centre the rights to bodily autonomy and integrity in addressing social and structural determinants of health while advancing activism and solidarity.

ONE

BACKGROUND TO THE STUDY

RETURN TO CONTENTS

BACKGROUND TO THE STUDY

Over the past decade, there has been notable progress in improving Sexual and Reproductive Health Rights (SRHR) across Southern and East Africa, including the identification of Key Populations (KPs) and targeted interventions to address their specific and heightened vulnerabilities and needs. This has opened up exciting spaces for those working on SRHR and KPs in terms of collaborative opportunities, access to funding and new, innovative partnerships across countries and regions. In particular, the collective aim of the Sustainable Development Goals (SDGs) - global commitments that aim to 'leave no one behind' and promote broad approaches to health, rights and development - present unprecedented opportunities for health and rights advocacy in Southern and East Africa (World Health Organisation 2018).

However, there have also been challenges and failures in improving SRHR, which have limited progress towards achieving the SDGs and other global commitments. In particular, systematic sexual and reproductive rights violations, especially against women and KPs, persist across Southern and East Africa and are often deeply embedded in laws, policies, the economy, social norms and values. In some countries, these violations are escalating. These include laws that restrict women's and adolescents' access to health services by requiring third-party authorisation, laws that require service providers to report personal information, laws that criminalise same-sex relationships and sex work, and criminal laws that prohibit provision of and access to abortion services. Lesbian, Gay, Bisexual, Transgender and Intersex and other non-conforming individuals (LGBTI+) persons, sex workers, people who use drugs, people living with disabilities, women, adolescent girls, and young women face some of the harshest impacts of these punitive laws, policies and practices, entrenched in societal behaviour and attitudes. In particular, new waves of conservatism and fundamentalism that amplify state-sponsored violence and criminalisation and undermine individual agency have severe implications for the right to health and for responses to health (O'Connor 2019; Meer et al. 2016; Angotti, McKay, and Robinson 2019; Okiror 2017).

1.1 Bodily Autonomy and Integrity (BAI)

Promoting the protection of the rights to *bodily autonomy and integrity* (BAI) to reduce inequality, especially pertaining to gender, and to promote health, dignity, and wellbeing for all in southern and east Africa is central to ARASA's 2019-2021 strategy. ARASA identifies promotion of the rights to bodily autonomy and integrity as the key principle that can mobilise and unite diverse movements in addressing the social and structural determinants of health while advancing activism and solidarity. For trans people in particular this is seen as critical given the levels of marginalisation, social and structural violence, and continued barriers to accessing sexual and reproductive healthcare, and healthcare more broadly, experienced by the community on a daily basis (Open Society Foundation 2013).

For this reason, a regional scan of the level of access to SRHR and HIV services for trans people – trans men, trans women and non-binary people - was underaken with a focus on Botswana, Lesotho, Malawi, Namibia, Uganda and Zimbabwe. Although these six countries represent a range of different socio-political contexts and legal frameworks regarding LGBTI+ persons collectively, they also reflect the range of challenges that trans people face, world-wide. Framed as 'situated vulnerabilities' (Reisner et al. 2016: 4) the stigma, discrimination, exclusion and violence experienced can have a devastating impact on the mental and physical health and wellbeing of trans people. This is also exacerbated by the number of challenges and barriers faced when accessing healthcare – both general and specific to their gender needs (Winter, Diamond, et al. 2016; Open Society Foundation 2013).

Given the challenging global context, ARASA recognises the need to scale-up and sustain civil society capacity for promoting rights-based approaches and holding governments accountable for their implementation. This includes the respect for, and protection of, the rights to bodily autonomy and integrity of transgender people. Accordingly, this report explores the context in which trans people find themselves, and the impact of law, policy, and practice on their access to services, with a particular focus on access to sexual and reproductive health and HIV services. Findings from the report will inform the advocacy strategies developed by ARASA and its partners at country, regional and international levels.

TWO

METHODOLOGY

RETURN TO CONTENTS

METHODOLOGY

2.1 Methodology design and approach

This was a qualitative and desktop study based on two key areas of work: a.) a literature review of key documents and b.) interviews with key informants in the six countries. Primary data collection took place from January – March 2021. This was at a time where many countries were experiencing COVID-19 surges and/or were in lockdown and all interviews thus took place electronically via Zoom[1], a virtual platform.

2.2 Study population and sampling

The study population was comprised of LGBTI+ organisations, trans-led organisations or support groups focusing on transgender issues. Key informants (referred to as respondents in the report) were identified through purposive sampling based on ARASA's networks followed by a snowball approach to identify further interviewees based on contacts identified by initial respondents. A total of 14 respondents participated: 7 identified as trans men, 2 identified as trans women and 5 did not specify. While a relatively small sample size this was sufficient for the purposes of a regional scan.

Table 1 below outlines the key informants and organisations identified.

Table 1. Key Informants

NO.	Country	RESPONDENTS (pseudonyms)
1.	Botswana	Benjamin Trans-led organisation
2.		Francis Trans-led organisation
3.		Mary Human rights and health organisation
4.	Lesotho	Tokholo Trans-led organisation
5.		Dintle Trans-led organisation
6.	Malawi	Arnold LGBTI+ organisation
7.		Gift LGBTI+ organisation
8		Peter LGBTI+ organisation
9.	Namibia	Jenni Trans-led organisation
10.		Matheus Trans -led organisation
11.	Uganda	Martin Trans-led organisation
12		Mukisa Trans-led sex worker organisation
13	Zimbabwe	Simon Trans-led organisation
14.		Thabo LGBTI+ organisation

1. See Appendix A for Table 1 depicting the research phases.
2. All names have been anonymised in order to protect the identities of those who participated and where the names of the organisations are listed, we do not specific which respondents were from which organisation.

RETURN TO CONTENTS

2.3 Data Collection

2.3 1. Participant consent and anonymity

Key informants were sent an invitation to participate in an interview via email or WhatsApp messages which included basic information about the study. Once a positive response was received informants were sent a participant information sheet as well as a consent form. The consent form could either be signed electronically or the informant would verbally agree over a recording and the form signed by the researcher on their behalf. [3] To maintain anonymity, pseudonyms were assigned to all consenting participants and all identifying information was removed.

2.4. Data Collection and Analysis

Respondents were interviewed via Zoom. This offered a suitable alternative to face-to-face interviews during the pandemic.[4] Interviews were conducted in English and audio-recorded using the Zoom record function. Recordings were then downloaded and transcribed by one of the researchers. A thematic analysis approach and coding via the *Miro* software[5] was used and four key themes were identified.

2.5. Limitations

One of the key challenges of the study was recruiting participants. A number of potential respondents contacted did not respond to interview invitations while a number of potential respondents agreed to interview slots but were subsequently not available at the time of interview. This is understandable given the COVID-19 pandemic and the increased pressure on civil society organisations and constraints of working remotely. Some respondents did not have access to WIFI or data or found themselves unable to connect. In some cases, internet connections were unstable and the 'flow' of the interview was harder, and disrupted throughout. Furthermore, in all six countries targeted individuals working for LGBTI+ organisations can face many challenges and risks. Therefore, they may not be willing or able to participate or may have had second thoughts after initially agreeing to participate.

3. By providing informed consent informants agreed to the following: Participation in the study; audio recording of the interview (for transcription purposes alone); the right to not answer any questions or to withdraw at any stage without consequence; anonymity and confidentiality of information provided, the use of anonymous quotes in the final report.

4. Given the contexts within which many of the individuals worked, the general anonymity offered by the virtual interviews was important and allowed for open discussions that would perhaps not have been possible with in-person interviews.

5. Through Miro themes, sub-themes and key quotes can be mapped out on a visual coding board. This was then used as a basis for the structure of the written report.

THREE

LITERATURE REVIEW

RETURN TO CONTENTS

LITERATURE REVIEW

3.1 Transgender: The marginalised within the marginalised

In all of the countries reviewed here, LGBTI+ people experience hostility, stigmatisation and violence for being 'different' from the accepted heterosexual, cisgender norm. In almost all instances, such discrimination continues to pervade the law, political rhetoric and interactions with service providers, family members and broader communities. That said, there are notable variations in the types of discrimination and violence LGBTI+ people experience whether through public cultures of in/tolerance, in the implementation of laws as well as in overall trends towards - or away from – the inclusion and protection of their rights (HIVOS 2016, 6).

Although all LGBTI+ people in the countries under review have challenges in common and often mobilise collectively - at least nominally - the umbrella term of 'LGBTI+' also disguises significant internal diversity within this 'community' (Currier 2015; Meyer 2001, 856). In particular, as van der Merwe and Padi argue, 'very often the T is silent within that acronym [of LGBTI+]' (van der Merwe and Padi 2012, 5). Trans people seem to diverge from prevalent norms in ways which could be more noticeable or fundamental than those who identify as lesbian, gay or bisexual. In doing so, trans people are regularly met with ignorance, an often-invasive curiosity and lack of knowledge at best, or an overt hostility, violence and dehumanising language and practices at worst (Meer et al. 2017, 18; Winter, Settle, et al. 2016, 318; Divan et al. 2016). Trans people face many specific challenges in navigating institutions, interactions and laws designed thoroughly around cis-normative and heteronormative concepts and assumptions.

Considering that prevalent norms of gender identity and sexual orientation continue to provide strong reference points even for those who don't feel represented by these norms within the group of LGBTI+ people, there are also gradients of exclusion, vulnerability, and risks. These include, inter alia, race, age, socio-economic background, nationality, ethnicity, and citizenship status. As Meyer 2001 remarks, even the term 'transgender' 'refers to such a variety of individuals... that any discussion of transgender people as a group would distort the group's diversity' (Meyer 2001, 856). Accordingly, Gruskin et al state,

> *"[t]ransgender people of colour and those of low socio-economic status, experienced significant barriers to accessing healthcare and a disproportionate burden of preventable morbidity and mortality"*
>
> (Gruskin et al. 2018, 24)

The everyday experiences and personal challenges of trans people can only be fully addressed with attention to the social, cultural, legal, historical, and political contexts in which they are situated. In what follows, we provide a brief scan of the socio-legal context for each of the six countries setting out the key laws and policies which directly and indirectly impact on trans populations and consider and explore issues pertaining to access to healthcare within the context of differences and diversity among transgender people.

3.2 The socio-legal context: persecuted, tacitly permitted or somewhere in between

The laws and practices regarding LGBTI+ persons in each of the six countries reflect a continent where colonial-era laws against same sex relations remain commonplace and where, in some countries, LGBTI+ persons could face the death penalty. Official discrimination, entrenched in laws and policies, in turn fuel and legitimise discrimination among the wider public and ensconce the perception that those seen as 'non-conforming' in their sexual orientation, gender identity, or gender expression, are legitimate targets for abuse (Inman and Jernow 2010).

Of the six countries in our study, Botswana is the only country that has explicitly decriminalised same-sex relations while Namibia has not specified penalties for same-sex relations. On the other end of the spectrum, Uganda, Malawi and Zimbabwe, have legal frameworks that include an array of laws to criminalise and prosecute LGBTI+ persons (Felter and Renwick 2020). [6]

RETURN TO CONTENTS

Table 2: Legal framework and policy overview

The table below provides an overview of the specific laws in each of the six countries. The traffic light system is used to illustrate the similarities and differences for each country: Green indicates a positive law or policy, red indicates negative and yellow shows where the law is not clear and could be subject to interpretation and contestation.

Legal frameworks	Botswana	Lesotho	Malawi	Namibia	Uganda	Zimbabwe
Legal framework for same sex relations	Decriminalised	Decriminalised (but often not in practice)	Criminalised	Criminalised	Criminalised	Criminalised for men
Protection from discrimination in law	Yes	Yes, but not explicit	NO	NO	NO	NO
Is legal gender recognition possible?	Yes	NO	NO	Yes	NO	Unclear
Are there laws that explicitly address transgender persons?	NO	NO	NO	NO	NO	NO

3.2.1 Botswana

Over the past decade, Botswana has made significant progress in acknowledging and protecting the rights of LGBTI+ people (SALC and Nyasa Rainbow Alliance 2020, 23). Based on a bill of rights that guarantees the fundamental rights and freedoms of all people, without discrimination on any grounds, transgender, gender non-conforming and gender diverse people in Botswana, like everyone else, have full access to all rights listed in the Constitution (SALC and LEGABIBO 2020). Its 2010 Employment Amendment Act provides protection from 'wrongful dismissal if based on their sexual orientation or gender identity' (UNAIDS 2020). In 2014, the country's high court ruled in favour of allowing prominent LGBTQI+ organisation LEGABIBO to register as an organisation (HIVOS 2016, 9-11). Although this ruling was subsequently appealed by the government, it was upheld by the Court of Appeal in 2016, leading to LEGABIBO's official registration in the same year (Reid 2017). In 2017, in a case known as ND v Attorney General of Botswana, a trans man was issued with new identity documents after the High Court had ruled that 'that arbitrary interference or embarrassment and the intrusion of privacy faced by the applicant may be avoided or minimised by the State by allowing him to change the gender marker on his identity document' (Southern Africa Litigation Centre 2017; Reid 2017). The case helped to establish that the 'material change' to a person's particulars required by the National Registration Act in order to change a gender marker on an identity documents can include 'a gender identity that does not match the sex assigned at birth' (SALC and LEGABIBO 2020, 25). However, despite the legislative framework allowing for legal gender recognition, research shows that many trans men and women face challenges accessing legal gender recognition. One of these challenges includes being required to provide 'evidence' – medical or otherwise - of their gender identity despite the law stating that a person's gender identity is 'self-identified' (Reid 2017; SALC and LEGABIBO 2020).

In 2019 Botswana's high court finally and unanimously ruled in favour of decriminalising homosexuality, declaring unconstitutional the criminal laws that had been in place since 1964. One of the judges explained that "sexual orientation is not a fashion statement. It is an important attribute of one's personality" (BBC 2019). The High Court further stated that previous laws "do not serve any useful public purpose" (LEGABIBO 2019). However, this ruling was also appealed soon thereafter by the attorney general of Botswana (LEGABIBO 2019; Reuters, Gabarone 2019).

6. More broadly across Sub-Saharan Africa in 2015, Mozambique decriminalised same-sex relations followed by the Seychelles in 2016 and Angola and Botswana in 2019. Like Namibia, Mauritius has not specified penalties for same-sex relationships. Recent court rulings in favour of LGBTIQ+ advocacy groups have occurred in Kenya, Uganda and Zambia although sometimes this has occurred on the basis of technicalities rather than the merit of the case itself (Al Jazeera 2014). Meanwhile South Africa is the only sub-Saharan African country where same sex couples can legally get married and where the Constitution explicitly protects people against discrimination on the basis of sexual orientation (SALC 2016a). Yet, despite having some of the most progressive laws in the world that prohibit discrimination on the basis of sexual orientation and gender enshrined in the Constitution, South Africa also exemplifies the discrepancies between a progressive legal code and a largely conservative society (Müller 2016). Subsequently, a strong, proactive civil society is matched by widespread abusive, violent intolerance of LGBTI+ persons (Marnell, Oliveira, and Khan 2020; Müller 2016).

3.2.2 Lesotho

There is no mention of gender identity or sexual orientation in chapter II of Lesotho's Constitution (which deals with the protection of fundamental rights and freedoms). While gender identity and sexual orientation are absent, the United Nations High Commisioner for Refugees (UNHCR) suggests that the reference to 'sex' and 'other status' as in section 4(1) of the Constitution should be interpreted to include protection from discrimination based on gender identity and sexual orientation (S. L. Reisner et al. 2016).

The Penal Code Act of 2010, promulgated in 2012, decriminalised homosexuality (Equaldex n.d.). However, there remains a popular perception that the consensual same-sex sexual acts remain criminalised under common law (SALC 2016b). In addition, 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 (Kale 2018). While there is no explicit mention of transgender people in the Constitution or in other laws, trans people are targeted using other laws such as Section 56 of the Penal Code which deals with public indecency. (SALC 2016b).

There is also no law that makes provision for trans persons to change the gender marker in their identity document. This means that a trans person who uses a passport that does not match their gender expression could be charged with committing an offence (SALC 2016a). However, rights set out in the Constitution including the rights to equality, freedom of expression and to personal liberty do protect trans people, in theory. Furthermore, in 2011 new regulations pertaining to national identity cards - The National Identity Cards Act 9 of 2011, stated that 'the Director shall take reasonably practicable steps to ensure that personal information entered into the register is complete, accurate and updated where necessary' (SALC 2016b). It is yet to be seen whether this provision can be leveraged to ensure that transgender people have access to accurate documentation, that has been updated to reflect their identities.

3.2.3 Malawi

Through its penal code, Malawi's law provides a broad array of laws to prosecute homosexuality and other actual or attempted 'unnatural offenses...against the order of nature' (see Sections 153, 154, 156) (Global Legal Research Center, 2014, Carroll & Itaborahy, 2015, Johnston, 2014). However, this has not been enforced since 2012 (Equaldex n.d.). In 2009, the government prosecuted a trans woman and a cisgender man for committing sodomy, which the country's president at the time called a 'crime against Malawi's culture, religion and laws' (AFP 2019b). The accused were arrested and sentenced to 14 years in prison, despite the fact that 'there was no evidence of the couple having engaged in anal sex' (AFP 2019b; SALC and Nyasa Rainbow Alliance 2020, 9). Following international pressure, including from donors, the Malawian government reversed the judgement and the pair was eventually pardoned and released in 2010 (AFP 2019; SALC and Nyasa Rainbow Alliance 2020, 10).

In 2012, there was a short-lived reprieve under Malawi's next president, Joyce Banda, who 'promised widespread reforms to the colonial-era legislation and even announced a moratorium on arrests for those breaking laws that criminalise consensual same-sex conduct' (SALC and Nyasa Rainbow Alliance 2020, 10). However, when President Banda lost the next presidential race, these changes were stalled or reversed: now, 'activists have been waiting since 2013 for the courts to set a date for a hearing to repeal the anti-gay laws' (AFP 2019b). The moratorium was suspended in 2016, leading to ongoing uncertainty, which, 'seems to have encouraged private individuals to attack LGBTI+ people with impunity, while health providers frequently discriminate against them on the grounds of sexual orientation' (Human Rights Watch 2018).

Although Section 22 of the Constitution (dealing with family and marriage) does not explicitly state that marriage is between a heterosexual couple the Marriage, Divorce and Family Relations Act of 2015 prevents a transgender person from marrying someone who has the same sex as the transgender person's sex assigned at birth (SALC 2016a).

3.2.4 Namibia

In Namibia, homosexuality remains criminalised, but '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 and the constitution is silent on the human rights of transgender people (Johnston, 2015).

According to the apartheid-era South African law - Act 81 'Sex Reassignment Policy' 1963 - gender reassignment surgery is permitted. However, 'very few trans people are able to access this provision even though sex reassignment surgery is covered in government medical aid' (Reagan 2017, 10). The changing of identity documents is also permitted 'if the necessary medical documents are available' (ibid.). This means that for a trans person 'legal transition' via changing the gender marker in documentation depends on medical 'proof' of a gender different to the one assigned at birth. Overall, Namibian leaders have adopted a hostile stance to the LGBTI+ community (Currier 2011) although shifts have been noted in societal attitudes. Namibia-based LGBTI organisations have forged regional and continental networks of African LGBTI+ activists to bolster solidarity and support and advocacy for same-sex civil unions or civil marriage has increased (Reagan 2017; Currier 2015).

3.2.5. Uganda

Amongst the countries reviewed, Uganda occupies the most discriminatory and hostile end of the spectrum. Although homosexuality was already illegal and punishable by up to 10 years in prison since 1950, the Ugandan government introduced even more extreme laws in early 2014, when President Museveni signed the Anti-Homosexuality Act (AHA) into law. The act criminalised not only homosexual activity but also 'to aid homosexuality, touch with the intent of homosexuality, and promote homosexuality' (AFP 2014; Smith 2014a). It included sections on 'extraditing' homosexuals (Government of Uganda 2014). These changes rendered 'aggravated homosexuality' a crime warranting imprisonment for life - a sentence that was originally intended to include the death penalty, which is why the bill was colloquially referred to as the 'kill the gays' bill (AP, Reuters 2013). Following intense international pressure, this was however converted into life imprisonment (Amnesty International 2014). While the country's Constitutional Court ruled the act invalid a few months later, it did so based on a technicality rather than on merit (Smith 2014). Furthermore, homosexuality remains explicitly illegal in Uganda and punishable by up to 7 years in prison.

While there is no explicit mention of transgender and gender-non conforming individuals in the laws, the common conflation of gender identity with sexual orientation means that trans people are detained and charged under the same laws (Outright Action International 2019).

3.2.6 Zimbabwe

Like Uganda, Zimbabwe has historically adopted a stance of intolerance towards LGBTI+ people. Famously describing individuals engaging in same sex relationships as 'worse than dogs and pigs' Robert Mugabe shaped perceptions of homosexuality as 'Western' behaviour that corrupted 'pure' African culture (Muparamoto 2020). Mugabe's utterances set an agenda for a long-lasting campaign against recognition of the human rights of LGBTI+ people. This is backed by the Criminal Code which has provided legal cover, for targeting, arrest, extortion and harassment of LGBTIQ people, particularly gay and bisexual men and transgender women, at the hands of law enforcement and government officials ('LGBT Rights in Zimbabwe' n.d.; Muparamoto 2020).

Section 73 of the Criminal Law (Codification and Reform) Act 2004, as amended criminalises all sexual acts between men, which includes any physical contact that "would be regarded by a reasonable person as an indecent act." ('LGBT Rights in Zimbabwe' n.d.). This could include two men holding hands, hugging or kissing and could carry an extended prison term (Refugee Legal Aid Information for Lawyers Representing Refugees Globally n.d.). These acts carry a maximum penalty of one year imprisonment, or the possibility of a fine, or both. Sexual acts between two women are not explicitly criminalised. Although the Constitution protects the rights and freedoms of all citizens and prohibits against discrimination on a number of grounds, including sex and gender this protection is essentially undercut by the criminalisation of homosexuality (SALC 2016a).

In a case that led to far-reaching implications for the promotion and protection of rights of trans people in Zimbabwe, the high court in 2014 found that transgender people have the same rights as all citizens. Ruling against the unlawful arrest and detention of a trans woman the court affirmed the rights and freedoms of trans people. Stating "it is nothing but delusional thinking to wish away the rights of transgender people" in Zimbabwe, the Court contributed to ongoing public discourse concerning LGBTI+ people and organisations in Zimbabwe (Esterhuizen and Nathanson 2019).

7. The presiding judge at the Constitutional Court states that not enough lawmakers had been present to vote on the bill thus rendering it "null and void" (BBC news 2014)

Zimbabwe does not have a specific law that allows transgender people to change the gender marker on their birth documents, or other official documents. However, it is possible to rely on fundamental human rights that are guaranteed under the constitution. That said, where the Births and Deaths Registration Act 11 of 1986 allows a change to forenames and surnames for a 'lawful purpose' it is unclear if this could be used when trying to change a gender marker (SALC 2017).

3.3 Access, rights and key vulnerabilities

3.3.1 Access to Gender Affirming Care

In the countries under review, those seeking to undergo gender affirming care have very few options. With gender affirmation surgery not available at government hospitals in the countries under review, people have little choice but either take the risk of 'artisanal procedures, such as the injection of industrial silicone oil for breast augmentation' or - for those who can afford it - turn to expensive private health care facilities in their own country or abroad (OHCHR 2018, SALC 2016a, 22,25, 29, SALC 2016c). Hormone therapy, with the exception of Botswana, is only accessible at private health care providers. In government hospitals in Botswana, hormone therapy is offered, however, this is typically 'at the discretion of medical staff, who often have transphobic views' (SALC 2016a, 22). In addition, trans persons 'often…have to undergo invasive tests before they can access hormone therapy' (SALC 2016a, 22). In Namibia, 'transgender persons in need of gender affirmation surgery may be able to access a specific fund for 'special medical treatment' provided by section 51(2) of the National Health Act (emphasis added, SALC 2016c).

In Lesotho, trans persons face widespread discrimination within the healthcare system and hormone therapy as well as gender affirmation surgery is unavailable. Trans people who wish to begin hormone therapy have to go elsewhere to access it, which is a financial, logistical and emotional burden. In Uganda there is no access to gender affirming treatment in the public health system. While there are some options within the private sector this depends on the patient having money to pay for treatment. This thus excludes the majority of trans people who struggle to secure employment (Amnesty International 2014).

3.3.2 Access to Health Services including for HIV treatment

With regard to health more broadly, the multiple forms of exclusion and discrimination that LGBTI+ people face manifest in different ways. On the one hand, exclusion contributes to increased health risks, including a 'high vulnerability to HIV transmission' (Poteat, Reisner, and Radix 2014; AMFAR Aids Research 2008; Poteat et al. 2016). On the other hand, exclusion and discrimination create major obstacles to accessing health care (SMUG 2018, 21). Thus, homophobia, transphobia, a lack of health care worker sensitivity and competency as well as the absence of supportive policy guidelines to address the specific needs of LGBTI+ people both create high vulnerability and often sheer insurmountable hurdles for accessing care (Baral et al. 2011, 3; King et al. 2019, 727; SALC and Nyasa Rainbow Alliance 2020, 15–16). A study from Malawi 'found that some healthcare providers report sexual and gender minority people under section 153 of the Penal Code, despite the fact that there is no legal obligation to do so. This makes seeking healthcare a dangerous gamble for many LGBTI+ Malawians' (SALC and Nyasa Rainbow Alliance 2020, 15–16).

In Botswana, 'more than 75% of services for Men who have Sex with Men (MSM) and trans people are provided for by civil society' (HIVOS 2016, 9-11). A study of trans women in Kampala also found that 'participants were…able to highlight organisations in Kampala that specifically provide assistance to trans women. These included those that provide services such as HIV testing, counselling, condom provision and antiretroviral therapy as well as others that give assistance such as shelter or legal advice' (King et al. 2019, 736).

3.4 Hyper-visibility and invisibility: a dangerous combination

> *"When you're a trans woman, you ready yourself for war every day."*
>
> (Trans woman from Lesotho, quoted in Kale (2018))

RETURN TO CONTENTS

Within the LGBTI+ community in the countries reviewed here, trans people are the most marginalised amongst the marginalised (SALC and Nyasa Rainbow Alliance 2020, 16, King et al. 2019). As van der Merwe and Padi put it 'when one steps outside the confines of what they ought to be, based on physical appearance', this 'challenges' widely held legal, social and cultural norms (van der Merwe and Padi 2012, 2).

Trans people thus face specific challenges related to a unique vulnerability that is the paradoxical result of both *hyper-visibility and invisibility*, simultaneously. Their 'difference' is hyper-visible in the public sphere, including places of work, socialising, consumption, leisure and education. Visibility (Meer et al. 2017, 55) all too often translates into vulnerability, whether it is in activism, legal action and litigation (Camminga 2020, 3) or from seeing a doctor (Arnott and Crago 2008, 22) or engaging with law enforcement (Arnott and Crago 2008, 20). Yet, they are largely invisible in terms of representation - not only in NGO programming and public health strategies but also in research, organisations, activist movements and advocacy spaces (Meer et al. 2017, 18; van der Merwe and Padi 2012, 1; Gruskin et al. 2018, 23). However, given the often outrightly punitive and violent nature of responses, the term invisibility is perhaps misleading – to a large extent, this is not an oversight, but rather an active and often hostile *making* invisible, a *making* irrelevant, making less human.

3.4.1 Intersecting vulnerabilities

There are further nuances to the levels of hyper-visibility and invisibility and subsequent risks. Trans women are more severely impacted than trans men: 'transgender men and transgender women will mirror patriarchy and heteronormative frameworks and expressions within society' (van der Merwe and Padi 2012, 4). Where van der Merwe and Padi (2012, 6) note that 'social problems such as gender-based violence (GBV), HIV and AIDS, unemployment, discrimination and other inequalities seem exclusively reserved for cis-gender women' a transilience study on violence against trans women in South Africa showed that '85% of trans women have experienced violence in one way or the other, and the picture is worse for trans women of colour' (S. Reisner, Keatley, and Baral 2016, 329). This highlights the significant overlaps of heightened vulnerabilities for all women, transgender or cisgender. After all, 'transgender men make their transition into the privilege of patriarchy' (van der Merwe and Padi 2012, 6).[8]

In Malawi, 'transgender women are particularly at risk… yet their existence is not acknowledged in any important national strategic documents' (Frontline AIDS 2019, 2). Bandawe explains this in the following way:

> *HCSPs [Health care Service Providers] are not aware of the distinctions between the different groups within the LGBTIQ community…Malawi has only recently begun to open up to the realisation of the existence of lesbians and gays within the country, let alone embrace the intersex and transgender persons. Most interventions have targeted MSM and a few are now starting to target WSW [women who have sex with women]. The TIQ have been much marginalised.*
>
> (Bandawe 2015, 7)

This is similar to other countries in this review: where acknowledged and included, this is typically MSM and 'issues that pertain to lesbians and gays', whereas other groups within the LGBT+ community are much less or not at all referred to in policy documents, research and programming (The Other Foundation 2017, 18; HIVOS 2016, 11–16; SALC 2016b, 25).

8. Camminga reports about two different legal cases relating to changing gender markers in documents in Botswana which clearly illustrate this point. Lawyers made the strategic decision to split the cases up rather than keep them as one, and to start with the case of the trans man. The case was won, as Camminga notes, due to the successful mobilisation of 'the notion of common or shared manhood…the image of ND [the claimant] as a just a man with his girlfriend by his side, a very normal, wholesome and heteronormative image' (Camminga 2020, 14–15). Camminga argues that this gave the claimants a competitive advantage that was unlikely to be had if they would have frontloaded the case of the trans woman.

3.5. Main themes of the literature review

Despite a growing body of literature covering issues faced by LGBTI+ communities and their needs with regards to SRHR and HIV, an understanding of the experiences of trans people, in particular referring to BAI, is missing. In fact, there is a critical absence of knowledge on some of the most basic demographic and health characteristics of transgender people as well as a lack of qualitative data on the experiences, challenges and strategies of transgender people, activists and organisations working on trans issues. This absence interlocks with a lack of governmental health policies in three ways. Firstly, there is little recognition that trans people are a distinct group with needs separate from Lesbian Gay and Bisexual (LGB) and MSM populations. Second, they do not recognise the need to extend health and other services to trans people as a specific group. Finally, they do not accommodate differences between and among transgender people i.e., between trans men and trans women and non-binary persons.

It is also evident that the entry point for much of the literature is HIV/AIDS and the associated vulnerabilities and risk behaviours. While it is recognised that trans people are vulnerable in terms of SRHR and HIV/AIDS, there is a general failure to understand how these vulnerabilities are different to those of the other Key Populations. This gap in the literature has three key effects. The first is that defining key populations through 'risk behaviours' ignores transgender as a *gender identity* rather than a behavioural category akin to MSM or sex workers. The second outcome is that there is very little sense of the importance of gender affirming care and BAI – and what it means for trans people within the context of health and wellbeing. Finally, issues of sexual and gender diversity are narrowed to a narrative around violence and disease, with little interrogation of the broader structural barriers rooted in the denial of BAI, that are core to the marginalisation of transgender people. At stake here is the critical absence of diverse voices from trans persons, trans-led organisations and other organisations and groups where trans issues are addressed.

In what follows we aim to partly address this absence by creating space for the diverse voices from amongst the group of 14 respondents interviewed – to describe the challenges, successes and ideas for meeting the needs of trans people, with specific focus on access to healthcare. We also identify three case studies from the respondents that highlight some of the most successful rights-based programmes/interventions discussed and/or key issues raised by the respondents.

FOUR

FINDINGS

RETURN TO CONTENTS

FINDINGS

4.1 Legal frameworks render transgender people non-existent

Respondents discussed the legal frameworks in their countries in terms of the erasure of trans persons and the subsequent risks posed to them. For many, this erasure meant trans people being subsumed under laws criminalising same-sex relationships, as the literature review also shows. Mary, a director of an organisation dealing with health and human rights in Botswana and with many years of experience working with the law and LGBTI+ groups captured this issue:

> *"Trans [people] don't exist according to laws and policies [in Botswana], the laws and policies are silent declaring them [trans persons] non-existent."*

The consequences of being erased or rendered 'non-existent' in the eyes of the law are multiple with the lack of access and protection of rights at the center. Benjamin, working for a trans and intersex organisation in Botswana captured this in stating, *"there is no legislation that criminalises trans yet no law to protect one who identifies as trans."*

4.1.1 Invisibility/hyper-visibility

The respondents articulated ways in which the invisibility of trans people in law leads to exposure (hyper-visibility) and specific vulnerabilities due to the absence of protective laws, and subsequent discrimination and persecution. Martin, a clinic manager for a trans-led organisation in Uganda noted that although trans people are not referred to in the legal framework, they are still arrested for being *"visible and different"*:

> *"They go about charging them [trans persons] however they like. Law enforcers have to find a charge – they can't write same-sex on the charge sheet so they will put theft, assault or they won't bother to say."*

Gift, who works for an organisation focused on the diversity of all sexual orientations and gender identities in Malawi claimed that an absence of awareness about trans persons leads to isolation, denial, rejection and, also increases risks of violence. This violence according to many of the respondents (and confirmed in the literature) comes from a place of ignorance, a lack of education about gender identities and sexual orientations, and prejudices shaped by religion, assumptions and - significant here, an erasure of trans people in law. Matheus from Namibia also put this simply:

> *"...laws are killing us – null and void, we are not there; societal level is mostly stigma and discrimination…we are very visible by default – by how we express ourselves… if people only choose to know gay and lesbian – then they don't know trans."*

RETURN TO CONTENTS

4.1.2 Legal change alone is not enough

Several respondents pointed out that although there was an urgent need to address the legal framework in their country this would only be effective if people were educated and therefore 'ready' to recognise and accept trans people. Thabo for example argued, *"policy change is not relevant when the people are not ready."* **(Thabo, Zimbabwe).** Comparing Botswana with South Africa, where discrimination against LGBTI+ persons continue despite the community being protected by law Mary supported Thabo's point:

> *"In South Africa the legal context is conducive [for trans people] but experiences on the ground are worse – worse than in countries where being trans is illegal."*

This scepticism about the transformative power of law reform alone lies in understanding that the protective legal frameworks are limited if they are not supported by education and change in the wider society. Therefore, although law reform was identified as a key strategy for change it was also seen as dependent on other necessary changes. This is a point that we return to in section 4.6.1 when discussing promising and successful strategies.

4.2 Documentation defines who you are and what you can do

The importance of legal gender recognition was confirmed by the respondents:

> *"Transgender lives are affected by these legal documents as they only accommodate for heteronormative. Your passport, your ID – all are attached to the sex assigned to you at birth – and socially this determines who I am and what I can do. There is no freedom of choice… In the Malawian experience it is about the pronoun issue, gender marker issue, conflict between conformity and being oneself, registration of IDs and passports – who they say you are, access to health and gender affirming services …"* **(Arnold, Malawi).**

The interdependency of legal documentation, restricted social worlds and the significance of being able to prove *"who I am and what I can do"* as highlighted by Arnold was expressed in various ways by the respondents. Benjamin working with a trans and intersex organisation in Botswana spoke of the importance of an identity document (ID) as legitimising who you are thus providing a form of protection and helping to change the attitudes of society *"… if the law permits you to have an ID then this speaks up for who you are – and then the community gets to follow. If the law continues to oppress you – you have no way in society but if the law changes then that can change society too".*

Francis a community mobiliser for the same organisation described the impacts of having an Identity Document (ID) that does not match your gender identity including being unable to secure employment: *"IDs in Botswana are the most important thing…. you apply for a job and come for the interview but now you look one way and the ID says different* **(Francis, Botswana).**

Respondents from Botswana and Namibia where legal gender recognition is available confirmed, as the Literature Review shows that this option was dependent on a specific state-defined criterion for what counts as having "transitioned" from one gender to another. In Botswana Mary described how, despite the law stating that gender identity is 'self-identifi ed' (see page 16) trans men and women face a "diagnosis" process through which they were required to prove a testosterone or estrogen "imbalance" respectively, as evidence of their need to transition **(Mary, Botswana)**. This meant that trans people have to learn how to *"beat the system"* in order to access medical support and change their gender marker *"Most trans will use hormonal treatment before they approach the [healthcare] system so that by the time they are seen their estrogen will be higher and they can qualify for further treatment"* **(Mary, Botswana)**.

This exposes the role of the state in deciding what constitutes 'legitimate proof' to change one's gender marker – dependent on 'medical transitioning' alone – and thus ignoring the realities and diversities of all transgender people.

4.3 Healthcare and wellbeing: Unsafe spaces and limited access

Many of the respondents talked about healthcare as a key challenge for trans people in two ways. First, lack of provision and access to gender affirming care, and what this means in terms of the subsequent risks' taken to access treatment. Second, the dominance of the HIV/AIDS focus on trans people and how this can obscure an understanding of other often more pressing health issues for trans people.

4.3.1 Accessing healthcare

Jenni, a trans woman and director of a trans-led organisation in Namibia described health care services as *"unsafe spaces"* for trans people. These are spaces, where trans people are scrutinised, judged and misgendered:

> *"From the point of leaving the house a trans person will face stigma and discrimination… they end up spending time having to explain sexual orientation, gender identity and still get misgendered… they [people] will shove religious prejudice down your throat"* **(Jenni, Namibia)**

Matheus also argued that the health system needed to *"nuance health language"* to be gender affirming rather than discriminatory while Jenni explained: *Right now, the language is very violent and aggressive so then trans people will not access care. Instead, they end up using each other's painkillers to treat STIs.* **(Jenni, Namibia)**.

Jenni also described how trans women have specific needs such as prostate screenings and yet the healthcare services are not responsive to these as *"... the material out there only speaks to maleness"* **(Jenni, Namibia)**. Benjamin supported this view in stating that in Botswana there was *"no real desire to invest in [the] specific needs of trans women and trans men."*

A number of respondents described the barriers and humiliation involved in accessing necessary health procedures such as screenings for cancer. Thabo, for example, spoke about the exposure faced when having to queue for a PAP smear and the challenges being so great that most trans men will not even try to access this kind of screening.

4.3.2 Risking health

The lack of access to care produces several risks that trans people are forced to take in the absence of any official options for treatment especially hormonal treatment and gender confirmation surgery. Martin, for example explained that the prejudicial attitudes of service providers and the refusal of doctors to provide hormones for trans people in Uganda, meant that clients access hormones informally, and in doing so, risk their own health. Thabo shared this concern and described how hormones and steroids are procured through fitness gyms in Zimbabwe and then taken without proper advice and awareness about correct dosages and side effects. Recalling a conversation with a doctor concerned about the steroid use amongst trans men, Thabo noted that the prescribed monthly dosage was often taken on a weekly basis. Thus, in the absence of gender affirmative care, the risks taken by trans people, to access the treatments that they need can ultimately endanger their lives.

Text box 1: Key issues: The impact of Covid-19

The impact of Covid-19 on transgender marginalisation

All respondents referred to increased challenges and marginalisation created by lockdowns imposed as a result of the Covid-19 pandemic in all six countries. The key challenges identified were:

- Access to medications due to stock outs
- Exposure and subsequent abuse in screening queues
- Blaming of the LGBTI+ community for spreading Covid-19
- Having to return 'home' to less-safe and more exposed spaces
- Increase in unemployment, homelessness and extreme poverty

Lack of safety net in Botswana

Mary described the risks posed to trans people in Botswana forced to go home during lockdown: *"... these are the families they left when things didn't work out – they weren't accepted. And now they go back."* Noting that this had led to increased levels of stigma, discrimination, violence and subsequently for trans people, desperation, Mary pointed out that there were two suicides amongst the trans community in Botswana during lockdown. The importance of considering the impact of Covid-19 on trans people lies in recognition of the nature of intersecting and layered vulnerabilities, which, when compounded by a further issue can lead to desperate and sometimes tragic outcomes. Thus, as Mary argues showing, "*the need for a safety net for trans people."*

4.4 HIV programmes fail transgender bodies

> *"HIV programmes fail when it comes to trans bodies… they are not dealing with identity or expression… trans people transcend the HIV realm"* **(Jenni, Namibia)**

Respondents were very clear about what they saw as an *"over-emphasis"* **(Benjamin)** or *"preoccupation"* **(Thabo)** with HIV/AIDS interventions for trans people. Many argued that this focus ignores other, more pressing healthcare needs while reducing trans health to addressing so-called "risk-behaviours." Acknowledging that SRHR remains important, Thabo noted, *"although we cannot talk of SRHR without HIV – the trans community have bigger issues than HIV."* Meanwhile Jenni argued, *"HIV has turned into a project. We are on the receiving end but not a part of the programme design."* In this way a focus on HIV prevents recognition of the diverse needs of different trans people.

4.4.1 Key Populations – key problems

Overall respondents were critical of how trans people have been categorised as a Key Population. Many discussed their problems with the conflation between gender identity and sexual orientation and how their work has been affected by the focus on KPs. Benjamin in Botswana referred to how the language of KPs *"defines a specific community and lumps it together"*. Explaining his organisation's focus on gender identity, Benjamin explained *"trans and sexual orientation is not necessarily linked – you can be any sex, any preference, gay or bi or whatever but the HIV field does not see this."* For Benjamin this point emphasised not only what he saw as the absence of recognition for trans and intersex people but also how this focus limits access to funding and partnerships.

Of all the respondents, Thabo spoke most candidly about this conflation– and what he described as the *"self-serving work of funders"* – funders who define key populations through research which is invariably designed to gather information on specific groups. Talking through this, Thabo used the example of work taking place within communities in Zimbabwe by LGBTI+ organisations based on funding through the Global Fund, focused primarily on gay men:

> *"Global funding – this is given for MSM as a key population – while the NSP [National Strategic Plan] for our country speaks to MSM and trans it does not specify. So trans men are missing from the conversation…but these conversations are based on research…and then you realise the criteria – biologically born male. With trans women – when in play – this is as male sex workers. So, everything is all under one bracket. WSW are a sub-population because they 'might be' at risk but there is no evidence…so, as long as there is no data that represents other groups they will always be excluded."*
>
> **(Thabo, Zimbabwe)**

Thabo here succinctly captures the key challenge described by many of the respondents – that the diversity and the specific needs of trans people when it comes to SRHR and healthcare more generally - cannot be met as long as interventions are designed around HIV/AIDS and key populations which exclude trans men and recognise trans women only in terms of their gender assigned at birth. As Jenni states, *"we are included in research because of our male bodies not because we are women"* **(Jenni, Namibia).**

Providing the example of trans women who were prescribed pre-exposure prophylaxis (PrEP) to prevent HIV but who then stopped taking it because they find that it slows down their changes and prioritise taking the *"feminising hormone"*, Simon also pointed out that in conflating MSM and trans women an important opportunity was missed to understand the specific needs of trans men and women. However, as Thabo, Jenni and others pointed out if the data sought on key populations continues to focus on MSM and both subsume and ignore the specific needs of trans people – in their diversities - then it will only ever justify a limited approach and ultimately "*…fail transgender bodies"* **(Jenni, Namibia).**

4.5 Gender Affirmative Care and Bodily Autonomy and Integrity

> *Recognising transgender [people] is to acknowledge key hurdles…not condoms, lubes…talk to a trans person this is the least of their issues. They want hormonal therapy. Make me feel like the women I am and want to be.*
>
> **(Jenni, Namibia)**

Responses in the interviews directly linked to the need for gender affirming care. Jenni, argued that "*[G]ender affirming healthcare [is] not seen as a priority yet it is the key element for a trans body to thrive – for you to become the body you've always wanted to be*" **(Jenni, Botswana)**. She explained that gender affirming healthcare needed to be seen in two parts – the first, access to hormone therapy and gender affirming surgery and the second, changes in mainstream health systems to become more welcoming to trans people. Martin and Matheus echoed this view:

> *It's about creating conducive space for trans and non-binary persons – space for other people to feel comfortable. Both bodies – be comfortable with bodies including trans men who haven't transitioned – their bodies are also legitimate*
>
> **(Martin, Uganda)**

> *We are talking "my body my rights" …the ability to explore…how you can present yourself as you want to and feel ownership of your body without seeking the consent of others. We need community-led advocacy, sharing stories and [to] initiate support systems…*
>
> **(Matheus, Namibia)**

Central to discussions about gender affirmative care was the importance of a rights-based approach and in particular, recognition and respect for BAI. Drawing attention to the practicalities of applying a rights-based approach to healthcare Mary, described the challenges faced:

> *So, we need a rights-based approach – trans people have rights – to recognise those rights we have to acknowledge key hurdles. But it is difficult to place the advocacy in the landscape of human rights….it is difficult to engage with stake-holders as this approach is outside of the healthcare providers areas of interest. It's a human rights perspective – so then which ministry is interested? No ministry!*
>
> **(Mary, Botswana)**

RETURN TO CONTENTS

4.6 Strategic Advocacy: finding new ways forward

As a part of the focus on BAI respondents were asked to identify strategies that they felt were successful in meeting the needs of trans people and/or effect change. They were also asked to think about how they might build on these strategies to support trans needs in terms of healthcare and overall well being if they had the funding and resources at hand (a "dream" project). These questions elicited many examples and ideas which have been captured here under three broad, interrelated strategies.

Text box 2: Case study 1. Malawi putting LGBTI+ issues on the funders' map.

"We took the challenge – they said Malawi is not ready for LGBTI organisations to implement so we defeated that"

In Malawi, Peter, who works for an LGBTI+ organisation described the work of the Diversity Forum, a group of LGBTI+ organisations who had come together to address LGBTI+ issues and mobilise resources collectively. Peter explained how the Diversity Forum had campaigned to ensure the inclusion of LGBTI+ organisations in the PEPFAR – funded 'Key Populations Investment Fund' (KPIF) as well as the Global Fund initiative 2021 by using the "label of HIV" as their entry point. *"When we found out that they planned to implement the KPIF without LGBTI involvement then we were forced to make a noise…to protest…and this was a strategy that worked because we raised the issue, we made ourselves heard and now all of the organisations in the forum are involved…we made sure they all get a piece of the cake."*

Key to this strategy, Peter argued was recognising that as an LGBTI+ organisation they would not be listened to. **But if they framed themselves in terms of HIV and targeted interventions then they stood a chance of being included:** Explaining that the Global Fund had contracted an International NGO with no experience of Key Populations to implement programmes targeting LGBTI+ persons rather than including organisations within the forum Peter argued: "…they say they can't work with us because it's an issue of capacity but yet they need is to mobilise the people…there is nothing like zero capacity …we can be capable of implementing."

"We took the challenge – they said Malawi is not ready for LGBTI organisations to implement so we defeated that. They have no interface with the LGBTI organisations, so they talk as if this issue doesn't exist. But we are here on the ground and we can give the common picture that we are a part of this country. We know the way."

In this way the Diversity Forum in Malawi, despite not even being able to officially register and lacking in resources have identified strategic ways to push the trans-voice and needs even by using the label of HIV to access funding.

4.6.1 Strategic impact litigation and education

Acknowledging the importance of litigation through the successes in Botswana[9], Mary argued that for a focus beyond the legal case itself to understand how it can impact further in terms of education and awareness: *"We use the case in court to bring out the lived experiences of populations – you see those personally affected by laws – even the judges, it gives them time to look around"*

9. Including of advocating for changing the gender marker as well as in a court case challenging the prevention of an LGBTI organisation from registering

Gift supported this view in describing the need for "social change and legal change combined" and explained how recognition and exposure is key, "So, if you go to court- many eyes are on you at first but then from the court there are many voices. You are visible but through that you can gain solidarity" (Gift, Malawi).

BAI-centred approaches to education

Mary argued that BAI must be at the centre of civic education, which could ensure that people would be engaged and become part of the discussion and discourse on LGBTI+ issues.

> *"People just don't understand, it's a foreign concept to them. People have not thought about rights around the body and what happens so we need a massive education campaign – civic education is therefore number one on my list."*

She further noted that the target would be to reach out across all sectors to create a movement that "*...provides documentation of experiences and, by extension, how people are affected on a day-to-day basis*" **(Mary, Botswana)**.[10] Simon expressed a similar idea providing a two-step approach based on education and understanding followed by an approach to "holistic health" that addresses all trans health needs:

> *"The first step is understanding...the lived realities of trans and gender diverse people [and] the issues affecting trans and gender diverse persons – so engage Home Affairs, engage members of parliament – to change rights of citizenry."*

For Peter, interactions with religious leaders in Malawi highlighted a lack of LGBTI+ narrative and language as one of the key stumbling blocks:

> *"The first thing is – they [religious leaders] don't know LGBTI – we don't have the narrative in our own language – it's a foreign concept … when we meet with religious leaders, we ask them do you have such people? [LGBTI] and they do – they just don't have the language for it…we do have the words but they are negative words so let's start with words we can be proud of and that I would love to be called."*

Peter explained that to start writing narratives on LGBTI+ people, to give them their own words and language could help to create connections and push for change.

10. This idea aligns with existing BAI campaigns such as Gendered Intelligence 'Bodily Autonomy for Every Body' (BAEB) in which the focus is on ensuring that "all young people – including but not limited to young trans people – have their enshrined rights to bodily autonomy" ('Gendered Intelligence - BÆB - Bodily Autonomy for Every Body' 2009)

RETURN TO CONTENTS

4.6.2 Quiet advocacy

Several respondents described the successes of creating connections with people, building relationships and quietly pushing change in the form of what Benjamin referred to as 'quiet advocacy'. Tokholo described this strategy in Lesotho in the following ways: *"It must be trans led but you need someone to reach out to and then they make it easy for you to reach out – that's how we quietly ensure inclusion and change."*

Martin focused on the idea of connections for change: *"how we operate is to create connection with people around us – in societies, in families, we are hiding and living in isolation, but we rely on these connections for change…when they see our existence, they will know we are there"* **(Martin, Uganda)**. For Matheus this focus was part of *"trying to change hearts and minds"* an idea that also fits with the points raised around strategic impact litigation and being visible enough to create a connection or start a conversation: *"laws are slow to change so find ways to catch people off guard…plant the seed in someone's head"* **(Matheus, Namibia)**.

Thabo identified one of the most effective strategies in his work with an LGBTI+ organisation in Zimbabwe as *"strategically identifying champions"* – finding someone who has influence and impact and building a relationship with them to create networks of support. As an example, Thabo cited matrons and sisters in charge of clinics and hospitals in Zimbabwe and explained that if you target the junior staff for training and awareness around trans people and healthcare this had limited, if any, impact: *"although you may get a lot of enthusiasm and ideas, they don't have the power and may face a backlash."* However, targeting someone in a superior position means that if you have their support then they can ensure changes are made from top down.

Text box 3. Case study 2: A person-centred approach to healthcare in Botswana

"Interventions should start with the person – when ready we work with the journey"

(Jenni, Botswana)

Jenni, described the importance of pushing for a gender sensitive approach in healthcare systems and described work being done in Botswana to help make healthcare facilities more welcoming. Based on the observation that trans people do not access healthcare due to feeling unsafe and feeling threatened by "violent and aggressive language" Jenni identified personal connections and safe spaces as paramount. She described how her organisation worked directly with the clinics and involved members being present in the clinics on certain days to both sensitise the staff and provide support to trans persons accessing treatment. Jenni noted that on the days she is working in the clinics then "more queer people will come in."

Benjamin also noted that a key strategy for their organisation in Botswana was to target key people within the healthcare system to ensure that referred clients received the help they needed. He described how, over the past three years they had made a breakthrough in accessing *"out of reach"* key people and attributed this to *"informal relationships"* where *"we know when we refer who to send the client to and then we know that client will be assisted."* However, he also explained that this becomes problematic when healthcare providers and key people are reshuffled from one ministry to another, meaning *"the process of connecting must begin all over again."* Similarly, Francis working for the same organisation explained that healthcare facilities will remain unsafe and avoided by trans people unless the facilities are better sensitised and, trans people have a better idea of their rights. Supporting this point, Jenni set out a clear idea for how sensitisation should work:

We need gender affirming healthcare with BAI at the centre. This means 1, don't assume my name and don't read it from my medical card - ask me my pronoun, 2, ask me the names of my body parts- each trans person develops a language around their body to feel comfortable. Your anatomy is yours - my penis is what it is to me…make a person comfortable and to feel validated.

Reflecting on the successes in Malawi, Gift also noted that change had been brought about by building alliances with key influential people and gave an example within the police sector:

> *"When we first started [the organisation] we were arrested for practicing homosexuality, then we have been raided by the police but in the past five years I have seen change. We work with the police- even if people don't agree, if we get the OK from the inspector general then that is social change for us."*
>
> **(Gift, Malawi)**

Thabo also highlighted the challenge of getting senior people in positions of power to attend sensitisation workshops with the Department of Health or Home Affairs in Zimbabwe. Noting that they would usually only have support staff in attendance Thabo suggested that LGBTI+ rights continued to be viewed as politically difficult and therefore *"people do not want their names tainted or to be associated with the stigma – they think it is catching."* This final point here underscores the broader context and challenges to many of the strategies shared.

Text Box 4: Case study 3: Reaching out to religious leaders

Reaching out to religious leaders in Malawi and Lesotho

One of the key strategies identified in at least two of the countries was to work through religious institutions and in particular, to **target religious leaders** who could be seen as allies in the fight for trans recognition and acceptance. In Malawi Peter explained how his organisation had reached out to religious traditional leaders and leaders of the church after finding that they could not any support from the Government or from the media, who are largely state-sponsored. Noting that most religious leaders do not support LGBTI+ people in general, Peter described finding a connection through a focus on ending violence against all people: "*we knew they would say they were guided by the bible so we gave them pictures of people in our communities who had been brutally assaulted for being gay or trans and asked 'is this fair'...we know people discriminate due to a lack of information and often have the wrong picture...so our message was fight violence using the concept of Ubuntu"* For Peter, it did not matter that the starting point was violence in general rather than LGBTI+ specific issues as he noted, *"with time we will get there. Getting religious leaders in a meeting is a huge start...so with time we will get there."*

In a similar way, Dintle, explained the strategy of developing relationships with clerics in Lesotho and the possibility of opening spaces for dialogue with the Christian Council of Lesotho (CCL). This, as Dintle noted, was a huge step for her LGBTI+ organisations and their work. She accredited it to *"reaching out, raising awareness and forming partnerships with key stakeholders"* which included clerics whom they had identified as more willing to engage and to listen (Dintle, Lesotho).

The importance of networking and building relationships across and beyond LGBTI+ organisations was raised by all respondents as an effective and critical strategy. Dintle explained that as an organisation they relied upon, *"collective efforts – [we] need to get together and have one voice and pitch them forward to see where we get to...we need lots of involvement"* **(Dintle)**. Tokholo of the same organisation also described the *"movement-building process"* explaining: *"Funding comes and goes..., but there are intersectional issues like GBV that unite us – we are asking people to speak out – engaging community members."*

A number of respondents also spoke about the role of the working group the Southern African Trans Forum (SATF). Simon who plays a key role in the forum for example explained, that the SATF is composed of organisations across 11 countries and based on a strong peer-exchange model through which *"organisations are strengthening one another... and making visible issues of the trans community through linkages with stake-holders..."* He also noted the challenge of dwindling funding and the need to strengthen the capacity of channelling the funding because *"some institutions are stronger than others and we need to work as a collective."* Overall, he highlighted what he saw as *"proactive engagement...though which they need to build space to think about learnings and framings and documentation of cases in a traceable way...and interject that language into the SATF"* **(Simon, Zimbabwe).**

Jenni, who also holds a key role of the SATF underlined the significance of the forum as being *"trans-specific and trans-led."* She noted that this was an important framing that enabled *"trans voices to be heard on the issues that are about us."* Similarly, the example given by Peter in the first case study highlights the importance of the Diversity Forum in Malawi and their success as a collective voice asking the government and other collectives, *"why are you talking about us without us?"* **(Peter, Malawi).**

However, for many of the respondent's experiences of working collectively were also shaped by discrimination and especially, transphobia. Dintle, gave an example of working with the Lesotho Council of NGOs explaining that there were many different partners involved but some of them had issues around the involvement of the LGBTI+ organisation she is a part of:

> *"It was a painful experience; some partners pull out because they can't be around trans people – they find if you are a trans woman you are not enough of a woman and if [you are] a trans man you are not enough of a man. It's a challenge and can be very painful – it's like – I feel like I am a woman but now I am not accepted."*
>
> **(Dintle, Lesotho)**

Peter noted how to even exist as an LGBTI+ organisation in Malawi they had to *"crash in uninvited"* on discussions organised around KP issues. He explained, *"People didn't really like us, we forced our way in – people accepted that they have to live with us but that's hard especially because we don't have the language – our own narrative of LGBTI"*

Finally, reflecting on the extent of the challenges that organisations and activists face when pushing for even the most basic recognition of rights for trans people across the region Jenni summarized the way forward in the following way: *"We just need a sustainable model not where we have to keep starting again"* **(Jenni, Namibia).**

Text Box 5: Key issues: Examples of advocacy campaigns

Campaigns to raise awareness of trans people and trans issues

Across the internet and media there are a number of strong examples of how the sharing of stories, forming relationships and finding points of connection have become key advocacy strategies. Examples of these include:

Pocket Queerpedia: a resource developed by the activists, educators and the queer community to assist in teaching on queerness

I Am Trans: (Trans people speak) which aims to raise awareness about the diversity that exists within trans communities though trans people's own stories

ThisIsMe (Ireland): A Transgender health Campaign. Media article profiling the lives and successes of trans people including in Ireland.

Transgender Lives: A series of editorials about transgender experiences in which personal stories that reflect the strength, diversity and challenges of the trans community are featured.

Transgender and Gender Identity Respect Campaign: developed by the DC Office of Human Rights

FIVE

CONCLUSION

RETURN TO CONTENTS

CONCLUSION

> *My body should not belong to the state – but this is just one piece of the puzzle. The human rights approach is central – advocating our recognition, protection and respect. It's simple – I want society to know that before you beat me, I am a human being like you – I have a right to dignity and a right to life…*
>
> (Gift, Malawi)

Charting the shift in global efforts on HIV/AIDS by shifting the category "gay" to "MSM", under which trans people were also included, Camminga and Wairuri outline the 'failure to respect the self-identity of transgender people' and, in doing so, conflating gender with sex and behaviour with identity, negating trans women's positions and experiences as women and marginalising all other trans identities (Camminga and Wairuri 2021: 102).

These assertions reflect and underline the findings of this report. They are captured in Gift's words above. Gift sets out the importance of a rights-based approach to gender identity but, perhaps more critically here, locates this within a broader and basic need to acknowledge transgender people and listen to what they need in order to feel recognized, protected and protected. Gift, like other respondents throughout this report, directs us away from the medicalised lens in which trans bodies are viewed as 'complex', 'problematised' and 'at risk', to bodies that can be recognised as they are and as the person who inhabits them wants them to be seen. This does not mean ignoring the specific vulnerabilities and risks that people may face due to the presentation of their bodies or the contexts in which they might live including to HIV/AIDS. Instead, it means making this one part of a more nuanced and more layered response to both the general and specific healthcare needs of trans people shaped by gender affirmative care.

The findings of both the literature review and empirical data show that the marginalisation of trans people is shaped by discrimination, stigma and violence that extend from legal frameworks, to work places, to public facilities to healthcare services. Furthermore, they illuminate the ways in which health interventions designed to specifically meet trans needs as a 'Key Population' may heighten and amplify this marginalisation. In fact, taking HIV as the starting point for understanding trans lived realities and health has not only ignored the unique and specific needs of trans people when it comes to healthcare but may also have diverted attention from the many simple and effective forms of advocacy that LGBTI+ and trans-led organisations have developed. These are strategies that have grown from the lived realities of trans people and which, in line with ARASA's strategic goals are directed by the need for respect for, and protection of, the rights to bodily autonomy and integrity of trans men, trans women and non-binary persons. Given the myriad challenges and risks faced by trans people across Southern and East Africa this final point highlights the ways in which BAI should form the entry point, the guiding framework and the end result of gender affirmative healthcare for trans people.

References

- AFP. 2014. 'Uganda Anti-Gay Law Challenged in Court'. The Guardian. https://www.theguardian.com/world/2014/jul/31/uganda-anti-gay-law-constitutional-court. 'Uganda Court Annuls Anti-Homosexuality Law'. BBC News, 2014, sec. Africa. https://www.bbc.com/news/world-africa-28605400.
- Currier, Ashley. 2015. 'Transgender Invisibility in Namibian and South African LGBT Organizing'. *Feminist Formations* 27: 91–117. https://doi.org/10.1353/ff.2015.0000.
- Esterhuizen, Tashwill, and Ricky Nathanson. 2019. 'High Court Decision Affirms Human Rights of Transgender People in Zimbabwe'. The Mail & Guardian, 2019. https://mg.co.za/article/2019-11-26-high-court-decision-affirms-human-rights-of-transgender-people-in-zimbabwe/.
- 'LGBT Rights in Zimbabwe'. n.d. Equaldex. Accessed 17 March 2021. https://www.equaldex.com/region/zimbabwe.
- Meyer, I H. 2001. 'Why Lesbian, Gay, Bisexual, and Transgender Public Health?' *American Journal of Public Health* 91 (6): 856–59.
- Muparamoto, Nelson. 2020. 'LGBT Individuals and the Struggle against Robert Mugabe's Extirpation in Zimbabwe'. *Africa Review* 0 (0): 1–16. https://doi.org/10.1080/09744053.2020.1812042.
- Outright Action International. 2019. 'Uganda.' Text. At A Glance. 2019. https://outrightinternational.org/region/uganda.
- Reagan, Finn. 2017. 'Canaries in the Coal Mines.An Analysis of Spaces for LGBTI Activism in Namibia, Country Report'. Johannesburg, South Africa: The Other Foundation. http://theotherfoundation.org/wp-content/uploads/2017/06/Canaries_Namibia_epub_Draft2_CB2.pdf.
- Refugee Legal Aid Information for Lawyers Representing Refugees Globally. nd. 'Zimbabwe LGBTI Resources | Rights in Exile Programme'. nd. https://www.refugeelegalaidinformation.org/zimbabwe-lgbti-resources.
- Reid, Graeme. 2017. 'Victory for Gender Identity in Botswana'. *Human Rights Watch*. https://www.hrw.org/news/2017/10/03/victory-gender-identity-botswana.
- SALC. 2016a. 'Laws and Policies Affecting Transgender Persons in Southern Africa'. 2016b. 'Transgender Rights in Lesotho'. Laws and Policies Affecting Transgender Persons in Southern Africa. https://www.southernafricalitigationcentre.org/wp-content/uploads/2017/08/Transgender-rights-in-Lesotho.pdf. 2017. 'Transgender Rights in Zimbabwe'. Southern Africa Litigation Centre. https://www.southernafricalitigationcentre.org/wp-content/uploads/2017/08/Transgender-rights-in-Zimbabwe.pdf.
- SALC, and LEGABIBO. 2020. 'Legal Gender Recognition in Botswana: An Analysis of Law and Policy in the Context of International Best Practice'. 2020. https://www.southernafricalitigationcentre.org/wp-content/uploads/2020/11/Botswana-Gender-Marker-Report.pdf.
- UNAIDS. 2016. 'Global AIDS Update 2016'. https://www.unaids.org/en/resources/documents/2016/Global-AIDS-update-2016.
- 'Fear and Stigma Mark Life for Gays in Conservative Malawi'. France 24. https://www.france24.com/en/20190615-fear-stigma-mark-life-gays-conservative-malawi. 2019b.
- Al Jazeera. 2014. 'Uganda Court Overturns Anti-Gay Law | Denmark News | Al Jazeera'. 2014. https://www.aljazeera.com/news/2014/8/2/uganda-court-overturns-anti-gay-law.
- AMFAR AIDS Research. 2008. 'MSM, HIV, and the Road to Universal Access — How Far Have We Come?' https://www.jhsph.edu/research/centers-and-institutes/center-for-public-health-and-human-rights/_pdf/amfAR_ReportMSM_Aug2008.pdf
- Amnesty International. 2014. 'Rule by Law: Discriminatory Legislation and Legitimized Abuses in Uganda'. *Amnesty International* Ltd, 96.
- Angotti, Nicole, Tara McKay, and Rachel Sullivan Robinson. 2019. 'Lgbt Visibility and Anti-Gay Backlash'. *Sociology of Development* 5 (1): 71–90. https://doi.org/10.1525/sod.2019.5.1.71.

- AP, Reuters. 2013. 'Uganda Introduces 'Kill the Gays' Bill'. 2013. https://www.dw.com/en/uganda-introduces-kill-the-gays-bill/a-50797504.
- Arnott, Jayne, and Anna-Louise Crago. 2008. 'Rights Not Rescue: A Report On Female, Trans and Male Sex Workers' Human Rights in Botswana, Namibia and South Africa', 17.
- Bandawe, Chiwoza. 2015. 'A Survey on Alternative Sexual Reproductive Health Services Available for LGBTIQ in 3 Districts of Malawi'. 2015. https://www.rutgers.international/sites/rutgersorg/files/SDTools/DEF%20Survey%20on%20Alternative%20SRH%20services%20for%20LGBT%20in%20Malawi.pdf.
- Baral, Stefan, Darrin Adams, Judith Lebona, Bafokeng Kaibe, Puleng Letsie, Relebohile Tshehlo, Andrea Wirtz, and Chris Beyrer. 2011. 'A Cross-Sectional Assessment of Population Demographics, HIV Risks and Human Rights Contexts among Men Who Have Sex with Men in Lesotho'. *Journal of the International AIDS Society* 14 (July): 36. https://doi.org/10.1186/1758-2652-14-36.
- BBC. 2019. 'Botswana Decriminalises Homosexuality in Landmark Ruling'. BBC News, 2019, sec. Africa. https://www.bbc.com/news/world-africa-48594162.
- Camminga, B. 2020. 'One for One and One for All? Human Rights and Transgender Access to Legal Gender Recognition in Botswana'. *International Journal of Gender, Sexuality and Law* 1 (1). https://www.researchgate.net/publication/343832816_One_for_one_and_one_for_all_Human_rights_and_transgender_access_to_legal_gender_recognition_in_Botswana.
- Camminga, B, and K Wairuri. 2021. 'Merely Revealing: Transgender People and the Shift from "MSM" to "Key Populations" in HIV/AIDS Programming in Africa'. In Liberating Comparisons'. In *Liberating Comparisons*, 99–109. York: York Tree Publications.
- Currier, Ashley. 2011. 'Representing Gender and Sexual Dissidnce'. *Qualitative Sociology* 32: 463–81. 2015.
- Currier, Ashley. 'Transgender Invisibility in Namibian and South African LGBT Organizing'. *Feminist Formations* 27 (1): 91–117. https://doi.org/10.1353/ff.2015.0000.
- Divan, Vivek, Clifton Cortez, Marina Smelyanskaya, and JoAnne Keatley. 2016. 'Transgender Social Inclusion and Equality: A Pivotal Path to Development'. *Journal of the International AIDS Society* 19 (July): 20803. https://doi.org/10.7448/IAS.19.3.20803.
- Equaldex. n.d. 'LGBT Rights in Lesotho'. Equaldex. Accessed 3 February 2021a. https://www.equaldex.com/region/lesotho. .n.d. 'LGBT Rights in Malawi'. Equaldex. Accessed 3 February 2021b. https://www.equaldex.com/region/malawi.
- Felter, Claire, and Danielle Renwick. 2020. 'Same-Sex Marriage: Global Comparisons'. https://www.cfr.org/backgrounder/same-sex-marriage-global-comparisons.
- Frontline AIDS. 2019. 'HIV Prevention Shadow Report Uganda'. 2019. https://frontlineaids.org/wp-content/uploads/2019/11/FrontlineAIDS_-Uganda_SR_WEB.pdf.
- 'Gendered Intelligence - BÆB - Bodily Autonomy for Every Body'. 2009. Gendered Intelligence. 2009. http://genderedintelligence.co.uk/campaigns/baeb.
- Government of Uganda. 2014. 'The Anti-Homosexuality Act'. 2014. https://www.refworld.org/pdfid/530c4bc64.pdf.
- Gruskin, Sofia, Avery Everhart, Diana Feliz Olivia, Stefan Baral, Sari L Reisner, Eszter Kismödi, David Cruz, Cary Klemmer, Michael R Reich, and Laura Ferguson. 2018. '"In Transition: Ensuring the Sexual and Reproductive Health and Rights of Transgender Populations." A Roundtable Discussion'. *Reproductive Health Matters* 26 (52): 21–32. https://doi.org/10.1080/ .2018.1490624.
- Hall, Leila. 2013. 'Small March Is a Big Step for LGBTI in Lesotho'. *The Hub* (blog). 2013. https://thehubatmorija.co.ls/2013/06/17/small-march-is-a-big-step-for-lgbti-in-lesotho/.
- HIVOS. 2016. 'Hivos2016_Final_report_lowres.Pdf'. 2016. http://www.ghjru.uct.ac.za/sites/default/files/image_tool/images/242/PDFs/Hivos2016_Final_report_lowres.pdf.
- Human Rights Watch. 2018. '"Let Posterity Judge"'. Human Rights Watch. 2018. https://www.hrw.org/report/2018/10/26/let-posterity-judge/violence-and-discrimination-against-lgbt-people-malawi.
- Inman, Derek, and Allison Jernow. 2010. *Sexual Orientation and Gender Identity in Human Rights Law: References to Jurisprudence and Doctrine of the United Nations Human Rights System*.
- Kale, Mamofuta. 2018. 'Transgender in Lesotho – Key Correspondents'. 2018. https://www.keycorrespondents.org/transgender-in-lesotho/.
- King, Rachel, Justine Nanteza, Zubayiri Sebyala, Joy Bbaale, Enos Sande, Tonia Poteat, Herbert Kiyingi, and Wolfgang Hladik. 2019. 'HIV and Transgender Women in Kampala, Uganda – Double Jeopardy'. *Culture, Health & Sexuality* 21 (6): 727–40. https://doi.org/10.1080/13691058.2018.1506155.

- LEGABIBO. 2019. 'LEGABIBO Is Disappointed by the Attorney General's Decision to Appeal the Unanimous Decision of the Botswana High Court to Decriminalise Consensual Adult Same-Sex Acts'. Southern Africa Litigation Centre.
- Marnell, John, Elsa Oliveira, and Gabriel Hoosain Khan. 2020. '"It's about Being Safe and Free to Be Who You Are": Exploring the Lived Experiences of Queer Migrants, Refugees and Asylum Seekers in South Africa:' *Sexualities*, March. https://doi.org/10.1177/1363460719893617.
- Meer, Talia, Marie Lunau, Gemma Oberth, Kristen Daskilewicz, Alex Müller, and Lunau, Lunau. 2017. 'Lesbian, Gay, Bisexual, Transgender and Intersex Human Rights in Southern Africa: A Contemporary Literature Review 2012-2016. Johannesburg: HIVOS.' 2017. https://open.uct.ac.za/handle/11427/28329
- Merwe, L van der, and T Padi. 2012. 'Thematic Focus: Transgender Issues Transgender Feminism'. 2012.
- Meyer, I H. 2001. 'Why Lesbian, Gay, Bisexual, and Transgender Public Health?' American Journal of Public Health 91 (6): 856–59.
- Müller, Alexandra. 2016. 'Health for All? Sexual Orientation, Gender Identity, and the Implementation of the Right to Access to Health Care in South Africa'. Health and Human Rights 18 (2).
- NAFOPHANU. 2019. 'PLHIV-Stigma-Index-Report-Uganda-2019.Pdf'. https://www.stigmaindex.org/wp-content/uploads/2019/11/PLHIV-Stigma-Index-Report-Uganda-2019.pdf.
- O'Connor, Naomham. 2019. 'Framing Reproductive Justice in the Context of Institutionalized Transphobia Globally > SRHM'. SRHM. 2019. http://www.srhm.org/news/framing-reproductive-justice-in-the-context-of-institutionalized-transphobia-globally/.
- OHCHR. 2018. 'OHCHR | End of Mission - Visit to Mozambique'. 2018. https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=24002&LangID=E.
- Okiror, Samuel. 2017. '"No Gay Promotion Can Be Allowed": Uganda Cancels Pride Events'. The Guardian. https://www.theguardian.com/global-development/2017/aug/21/no-gay-promotion-can-be-allowed-uganda-cancels-pride-events-lgbt.
- Open Society Foundation. 2013. 'Transforming Health: International Rights-Based Advocacy for Trans Health'. Public Health programme. https://www.opensocietyfoundations.org/uploads/29ab7a11-c8c1-49dc-9c6c-1d8401905639/transforming-health-20130213.pdf.
- Poteat, Tonia, Sari L. Reisner, and Anita Radix. 2014. 'HIV Epidemics among Transgender Women'. *Current Opinion in HIV and AIDS* 9 (2): 168–73. https://doi.org/10.1097/COH.0000000000000030.
- Poteat, Tonia, Ayden Scheim, Jessica Xavier, Sari Reisner, and Stefan Baral. 2016. 'Global Epidemiology of HIV Infection and Related Syndemics Affecting Transgender People'. *JAIDS Journal of Acquired Immune Deficiency Syndromes* 72: S210. https://doi.org/10.1097/QAI.0000000000001087.
- Reid, Graeme. 2017. 'Victory for Gender Identity in Botswana'. Human Rights Watch. 2017. https://www.hrw.org/news/2017/10/03/victory-gender-identity-botswana.
- Reisner, Sari, JoAnne Keatley, and Stefan Baral. 2016. 'Transgender Community Voices: A Participatory Population Perspective'. The Lancet 388 (10042): 327–30. https://doi.org/10.1016/S0140-6736(16)30709-7.
- Reisner, Sari L., Tonia Poteat, JoAnne Keatley, Mauro Cabral, Tampose Mothopeng, Emilia Dunham, Claire E. Holland, Ryan Max, and Stefan D. Baral. 2016. 'Global Health Burden and Needs of Transgender Populations: A Review'. *The Lancet* 388 (10042): 412–36. https://doi.org/10.1016/S0140-6736(16)00684-X.
- Reuters, Gabarone. 2019. 'Botswana Government to Appeal against Law Legalising Gay Sex'. *The Guardian*, 2019, sec. World news. http://www.theguardian.com/world/2019/jul/06/botswana-government-to-appeal-against-law-legalising-gay-sex.
- SALC. 2016a. 'Laws and Policies Affecting Transgender Persons in Southern Africa'.
  2016b. 'Transgender Rights in Lesotho'. Laws and Policies Affecting Transgender Persons in Southern Africa. https://www.southernafricalitigationcentre.org/wp-content/uploads/2017/08/Transgender-rights-in-Lesotho.pdf.
  2016c. 'Transgender Rights in Namibia'. 2016. https://www.southernafricalitigationcentre.org/wp-content/uploads/2017/08/Transgender-rights-in-Nambia.pdf.
- SALC, and LEGABIBO. 2020. 'Legal Gender Recognition in Botswana: An Analysis of Law and Policy in the Context of International Best Practice'. 2020. https://www.southernafricalitigationcentre.org/wp-content/uploads/2020/11/Botswana-Gender-Marker-Report.pdf.
- SALC, and Nyasa Rainbow Alliance. 2020. 'We Get Traumatised in Different Ways'.
- Smith, David. 2014. 'Uganda Anti-Gay Law Declared "null and Void" by Constitutional Court'. *The Guardian*. http://www.theguardian.com/world/2014/aug/01/uganda-anti-gay-law-null-and-void.
- SMUG. 2018. '"Even If They Spit at You, Don't Be Surprised" Health Care Discrimination for Uganda's Sexual and Gender Minorities'. 2018. https://sexualminoritiesuganda.com/publications/blog/even-if-they-spit-at-you-dont-be-surprised-2017-health-report/.

- Sonke Gender Justice, and Health-E News. 2017. 'Reporting on Gender-Based Violence: A Guide for Journalists and Editors'. https://www.saferspaces.org.za/uploads/files/Reporting-on-GBV.pdf.
- Southern Africa Litigation Centre. 2017. 'Botswana Registrar Changes Transgender Man's Identity Document from Female to Male'.
- The Other Foundation. 2017. 'Canaries in the Coal Mines An Analysis of Spaces for LGBTI Activism in Mozambique COUNTRY REPORT'. 2017. http://theotherfoundation.org/wp-content/uploads/2017/06/Canaries_Mozambique_epub_Draft2_CB2.pdf.
- Tshisimani Centre for Activist Education. 2021. *Pocket Queerpedia - an Illustrated Glossary of LGBTQIA+ Terms*. https://www.tshisimani.org.za/2021/02/16/pocket-queerpedia-download/.
- UNAIDS. 2020. 'Country Progress Report Botswana. Global AIDS Monitoring 2020'. https://www.unaids.org/sites/default/files/country/documents/BWA_2020_countryreport.pdf.
- Winter, Sam, Milton Diamond, Jamison Green, Dan Karasic, Terry Reed, Stephen Whittle, and Kevan Wylie. 2016. 'Transgender People: Health at the Margins of Society'. *The Lancet* 388 (10042): 390–400. https://doi.org/10.1016/S0140-6736(16)00683-8.
- Winter, Sam, Edmund Settle, Kevan Wylie, Sari Reisner, Mauro Cabral, Gail Knudson, and Stefan Baral. 2016. 'Synergies in Health and Human Rights: A Call to Action to Improve Transgender Health'. *The Lancet* 388 (10042): 318–21. https://doi.org/10.1016/S0140-6736(16)30653-5.
- World Health Organisation. 2018. 'Report on Key Populations in African HIV/AIDS : National Strategic Plans, July 2018'. 2018. https://apps.who.int/iris/bitstream/handle/10665/275494/WHO-AF-CDS-HIV-02.2018-eng.pdf?ua=1.