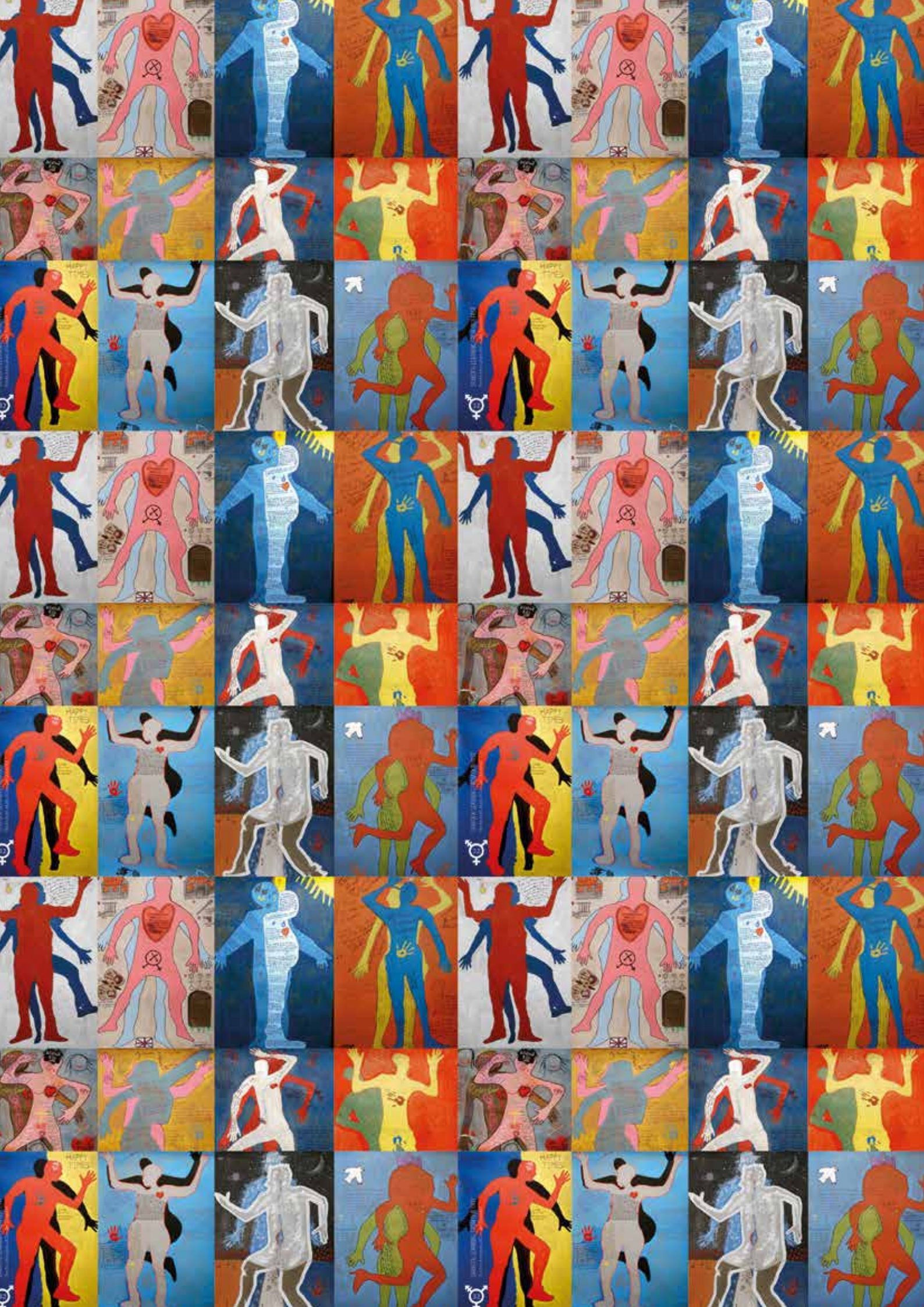
Southern Africa
Trans Diverse Situational Analysis

Accountability to reduce barriers to accessing health-care | 2016

Holding Leaders Accountable

AIDSAccountability International

SOUTHERN AFRICA TRANS FORUM



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Section 1: Executive Summary

The trans diverse communities in the four countries studied (Botswana, Namibia, Zambia, Zimbabwe, and Swaziland) represent a remarkable constellation of communities characterised by extreme vulnerability because of their intersectional location as among their countries' most excluded – unemployed or criminalised, susceptible to disease and despair, targeted for sexual assault and hate crimes, and cut off from education, housing, health-care, sports and social activities, and many the basic benefits of citizenship and amenities of society.

And yet trans diverse people are possessed of remarkable strengths in terms of their survival skills and tenacity in overtly hostile environments where because of having to either face social erasure, or are actively persecuted as a group that "should not" exist. The power of trans diverse agency should not be underestimated, as two remarkable examples will make clear: a) although many members of the trans* community who answered this survey have experienced prejudice in, including expulsion from, their childhood homes, 38% of those surveyed started their own families; and b) although many trans diverse persons experienced prejudice in, including expulsion from, school, fully 18% of those surveyed completed tertiary education – higher than the national average in at least three of the countries surveyed.

However, a total policy vacuum regarding the existence, nature and needs of the trans diverse community mars all the countries studied. This invisibility not only allows for blanket ignorance to reign among officialdom and the broader populace, on the one hand disabling trans persons' ability to access ordinary (and specialised) health-care and legal remedies, while on the other hand enabling casually vicious discrimination up to and including violent hate crimes and police home invasions (the latter experience restricted to Zambia). Even the protections that the trans diverse supposedly possess under constitutional equality/human rights legislation appears to fall away in most real-life circumstances.

There appears from the study to be a simple and brutal equation to this prejudicial exclusion (note: as the paragraph on agency above demonstrates, this does not apply to all trans diverse people, but is a very common experience):

- Lacking identity documentation aligned to their preferred gender, trans-diverse persons experience extreme discrimination at school, at church, and in other social settings at the hands of their peers who are ignorant of and uncomfortable with their gender identity;
- Facing active discrimination from family and church leaders – who are likely to sexually molest many trans diverse people – their experience finally drives trans diverse people out of school before completion of their studies, and also out of home (another key site of sexual abuse);
- Trans diverse people are at a permanent disadvantage against former peers in seeking work in that we are underage, underqualified, can't progress further in their studies, and cannot secure basic documents such as a driver's license (a significant minority of those few that manage to secure work are likely to experience sexual harassment at work,

or to lose their jobs as a result of their gender identity) so most of them wind up unemployed;

- Lack of education, employment, plus official and societal discrimination against the trans diverse usually means we cannot access housing and wind up on the street, which drives them into underground subsistence activities including petty criminality and especially sex-work in order to survive;

- That demi-monde existence in turn makes them even more vulnerable to abuse by members of the public and the police (including arbitrary assault, arrest, and detention), to substance abuse and self-harming behaviour including suicide attempts, and to disease including but not limited to STIs, HIV/Aids, TB and viral hepatitis; so

- Ill and in desperate need of medical attention and psychological assistance (not to mention hard-to-get hormones and almost unreachable transitional surgery), the trans diverse turn to the health-care system – but encounter yet more ignorance, prejudice and even abuse.

This cascade of horrors has its source in ignorance: the state's ignorance leads to a lack of progressive policies and the lack of gender-appropriate identification in order to access services, especially health-care; while societal ignorance leads to widespread discrimination, abuse and even hate crime.

So, as will be seen, there is an urgent need in all four countries to fill in the policy gap, starting with an extension of the Key Populations interventions to include trans diverse communities, and so by doing so enable the legal recognition and human rights protection of those communities, starting with enabling the trans diverse to apply to have their foundational identity documents altered to reflect their preferred gender, so that all other related documents such as drivers licenses and passports reflect the change.

This legislative reform needs to be allied with a pro-active educational campaign among health-care professionals, police and magistrates/judges, Church/religious leaders, and the broader society. Further policy reforms should involve enabling non-prejudicial access to health-care, psychological support, transitional hormones and surgery, and other elements necessary for the restoration of the communities to the mainstream of the population, albeit with specialised concerns.

The dismantling of official exclusion and invisibility and of unofficial prejudice and abuse should mark the start of the rehabilitation of the trans-diverse communities from the underworld of their societies to full, normal and active citizenship.

Section 2: The Purpose of the Research

Globally, stigma, discrimination and violence towards persons who are trans* diverse is very high.

The situation for trans diverse people is dire on an international scale but perhaps even more so in Africa where in recent years we have a backlash against improving rights for trans diverse people. The criminalisation, marginalisation and discrimination against trans diverse people extends beyond mere law making and extends to moral policing, restrictions of bodily autonomy and the abuse of basic human rights. These oppressions of trans diverse people and their allies, has also been aimed at broader society particularly civil society organisations (CSOs), health service providers and rights organisations who advocate for greater inclusivity and equality in society.

African society as a general rule still holds conservative views around gender and sexuality. Violence against women and children is a major issue on the continent which stems from deep gender inequalities and a patriarchal culture which control's (especially) women's sexuality and sexual and reproductive health and rights. Very strict gendered and sexual norms exist which are heavily policed by society. If these norms are transgressed, there are often severe consequences, particularly for same-sex practicing and gender variant people.

Scare tactics are often used in conjunction with untruths about sexual and gender diversity. This situation results in African society being held hostage to discriminating ideas, and keeps Africans in a state of fear of any person who is sexually or gender diverse. The following common arguments and untruths are used and spread through some churches, mosques through the media, religious leaders and political leaders. These arguments and untruths are common and deeply entrenched and drive violence, stigma, discrimination and the exclusion of same-sex orientation and gender variant people from African society. These arguments are used by African leaders as leverage as they collude with religious parties and the media to hold African society hostage and to not 'deviate'. It also legitimises stigmatising and discriminatory behaviour by Africans against sexually diverse Africans. These behaviours are not just exclusion but also include violence, sexual violence and murder. In this way a patriarchal society is maintained and protected.

Gender DynamiX engaged AAI to assist with a situation analysis on the barriers that trans diverse persons in Africa face in accessing health-care, with specific focus on the intersections between legal and policy frameworks that create and maintain these barriers, for 5 countries in Southern Africa, Botswana, Namibia, Swaziland, Zambia and Zimbabwe. The report aims to allow for comparisons between the countries while painting a sub-regional picture, using the AAI Scorecard format.

The objective of this report is to improve the ojective and subjective understanding of the trans diverse experience in Southern Africa, and to improve the long-term security, especially in terms of health, of the LGBT communities' resident there.

Section 3: Country Introductions

1. WHAT IS HAPPENING IN YOUR COUNTRY RIGHT NOW WITH REGARD TO HUMAN RIGHTS FOR TRANS DIVERSE PEOPLE? PLEASE SPEAK TO HEALTH RIGHTS, LEGAL RECOGNITION (INCLUDING CITIZENSHIP) FOR TRANS DIVERSE PEOPLE SPECIFICALLY.

Swaziland

It is a common but inaccurate belief in Swaziland that trans diverse people do not exist. This belief that "we don't have trans people here" has made it so that the abuses against the community are also unseen. This leads to stigma, discrimination, abuse, and violence, through all channels, both structurally and through individual acts. Although in theory, a trans diverse person has the same rights as every other citizen; it is in accessing those rights where there are daily abuses. Trans diverse people are often stigmatized and discriminated against in health care settings making it so that they fear or avoid seeking services in the first place. Inability to change gender markers on all identity documents makes it so trans diverse people are in a situation where they face harassment and mistreatment anywhere these have to be presented, including, but not limited to, school registration, filing police reports, seeking employment, and applying for housing. These human rights abuses usually go unreported, as it is not against the law to discriminate against someone based on gender identity, and overall there is the assumption that this is not an issue because "how can you abuse a population that does not exist?" Only recently, in the last few years, and continuing to build momentum today, have we begun to vocalize the needs of the trans diverse community, and take steps in documenting and fighting this struggle. We thank Gender DynamiX and AIDS Accountability International for the opportunity to advance this progress.

Botswana

At the moment, there is no policy that speaks to trans diverse people, more specifically be it in health, legally or any other form.

Zambia

There are no health or legal rights that necessarily speak to trans diverse people. In terms of access to health services, there are no services specifically tailored to meet the needs of trans diverse people. Access to hormones and an endocrinologist, specific medical procedures pertaining to SRHR and mental health services. In the legal context, trans diverse people are not recognised. There is no legal representation for trans diverse persons provided by the state. Zambians are aware of lesbian and gay people but when it comes to transgender or intersex issues, the public knows little. Health-care worker sensitisation with regards to trans health that includes and extends beyond HIV/AIDS, psychological support through various activities such as one-on-one counselling, group therapy as well as games and sports,

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legal support in cases where trans people have been arrested for simply being who they are. Transgender health-care provision has been included in the NAC strategic plan. There is a legal firm that is offering services in terms of legal aid representation in court. Trans persons continue to experience transphobic injustice in health and courts; it's happening.

Zimbabwe

Currently trans people are not recognised as a class of people in Zimbabwe. They are generically lumped together with other same sex minorities – the gays and lesbians, and as such subject to the same sex criminalisation laws. In as far as health and citizenship, these laws have not even been broached, as these are still new topics.

2. WHAT WAS THE CLIMATE FOR HUMAN RIGHTS FOR TRANS DIVERSE PEOPLE IN THE PAST?

Swaziland

The climate for addressing human rights for trans diverse people has shifted over the last few years in Swaziland. Only recently has there even been a platform to discuss issues that affect the transgender community, let alone human rights violations. Trans diverse people have always existed but in the last few years there has been an increase in people identifying as transgender. There hasn't always been knowledge of the vocabulary for trans diverse individuals to self-identify as such. Before then people would either be lumped in with gays or lesbians or simply state their identified gender such as "I am a man" regardless if they were born female or not. This still is not uncommon in our community. With this increase in visibility, and more funding for Key Populations and HIV, there have been more platforms to vocalize issues of stigma, discrimination, and human rights abuses. Even with these changes, it is still a common belief that transgender people do not exist in Swaziland, unfortunately making the human rights abuses invisible as well.

Botswana

When labour passed a law that no-one should be fired because of their identity or gender. There has been no recognition of any form – but the existence of trans persons has been there.

Zambia

Trans people in the past have been confused for being homosexual, so the sodomy laws generally applied to them as well. Simply put, human rights with regards to trans people were not recognised; it was a bad climate. In the past, trans persons reported less violence and arrests. In the past, the climate in Zambia for trans diverse persons was perceived as fair, fair in the sense that the population at large paid no mind to LGBTI persons in the country. The situation quickly change(d) after the visit made by UN secretary general Ban Ki-moon. This stemmed from a speech he made demanding that no person should be discriminated against on the basis of sexual orientation and or gender identity. There was an outcry from the public on the matter and since then, the vulnerabilities of trans diverse persons are more visible.

Zimbabwe

The climate for human rights for trans people is bleak as the laws in the country are not cognisant of them as a population.

3. WHAT DOES THE TRANS COMMUNITY HOPE WILL CHANGE IN THE NEXT YEAR OR TWO IN YOUR COUNTRY?

Swaziland

The trans* community hopes that through multi-sector sensitization, issues of stigma and discrimination will have less of a devastating impact on support structures and address barriers to access in systems such as (but not limited to) health care and legal services, as they have in the past.

Botswana

Issue of the gender mark is priority in Botswana.

Zambia

Increased awareness and acceptance in society with regards to trans issues. Equal and equitable access to health-care that is discriminatory-free, justice and access to appropriate identification. More sensitised health-care workers. Stronger legal teams to assist the community to work towards legal recognition. Increased funding locally and internationally for advocacy, yes.

The trans diverse community hopes in the next two years to have affordable and adequate health services that will cater to each of their needs. Employment / jobs are being sought by the trans diverse people, trans diverse hope the situation changes soon. Lastly, trans diverse persons dropped out of school and as such would like to return to school to complete their primary, secondary and tertiary education.

Zimbabwe

We hope to get discussion moving with key players and champions – parliamentarians, traditional leaders, medical sector and the media.

4. WHAT DOES THE TRANS COMMUNITY HOPE WILL CHANGE IN THE NEXT TEN YEARS IN YOUR COUNTRY?

Swaziland

The transgender community looks to a future where trans* specific health care needs, such as transition related health services, are made available, affordable, and seen as legitimate and necessary to meet the needs of the community. There is hope that there will then be a clear and affordable process to change gender markers on identity documents. The trans diverse community has also expressed the need for anti-discrimination legal protections and hate crime legislation.

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Botswana

The law, and recognition of the third [gender] mark, and visibility of trans issues. Access to health-care services specifically for trans diverse persons as well as legal recognition and inclusion into mainstream policies and strategies.

Zambia

The trans community hopes in the next 10 years, they will have access to surgery, mostly among the trans men, surgery is a top priority. Less hostile environments and laws that are inclusive of trans diverse people. The trans diverse people hope that laws that do not discriminate against trans diverse peope will be enacted and implemented at community level. Institutionalised transphobia reduction in depression, substance-abuse and sexual violations. An end to transphobia; a society that is just, for everyone.

Zimbabwe

That efforts put in during this period will see the introduction of trans specific favourable legislation and services.

5. WHAT ARE YOUR BIGGEST CHALLENGES?

Swaziland

The biggest challenges faced by the trans diverse community in Swaziland is the invisibility, erasure of needs, and dehumanization of trans individuals due to stigma, discrimination and misinformation. This environment makes it difficult to address the very pressing needs of the community with governing bodies in the country.

Botswana

The law, and health service. Legal recognition.

Zambia

Safe spaces to meet and share information; social safe spaces. Legal recognition. Affordable and specialised health-care services – hormones and safe routine check-ups, SRHR. The biggest challenges faced are insufficient funds to cater to the trans diverse population we work with. Another challenge is sensitizing health-care providers to be proactive in providing services to trans diverse people as they fear revocation of their practicing license. Lastly, the hostile environment we work in is a challenge as we rely on using a low profile to achieve goals. Lack of capacity in terms of skills, materials and finances. Resistance from influential segments of society.

Zimbabwe

Getting the population at large to recognise that being trans is a gender identity and expression issue and not a sexual orientation issue. This will change its perception, and thereby enable the introduction of trans specific legislation, using a human rights approach.

6. WHAT DO YOU NEED OTHERS TO DO TO HELP?

Swaziland

The trans* community is in need of vocal, sensitized, and well-informed advocates within multiple sectors of government, social services, and civil society organizations. We need these advocates to actively call out discrimination

The trans* community is in need of vocal, sensitized, and well-informed advocates within multiple sectors of government, social services, and civil society organizations. We need these advocates to actively call out discrimination and misinformation that harms the community and perpetuates stigma and discrimination as well as bring attention to the needs of the community and the challenges faced.

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Botswana

Advocacy and policy change.

Zambia

There is need for more collaborations among partners in order to share best practices, sharing contacts of like-minded partners within the region, capacity-building with young organisations is also useful. Meet the skills gap through providing training programmes in leadership and advocacy.

Assist to meet material and financial requirements. Donate or provide undergarments for FTMs and simple gadgets like medicine spoons. Financial support for safe spaces and reading material for our literacy classes,

DVDs for the video library. Provide platforms abroad for community members to engage with other peers to assist with self-actualisation and encourage activism.

Zimbabwe

Support in the form of a push for regional collective policy and legislative review that looks at standardising laws that affect trans persons favourably.

7. WHAT MUST OTHERS NOT DO, SO THAT THE SITUATION FOR TRANS DIVERSE PEOPLE IN-COUNTRY GETS BETTER?

Swaziland

Government and Civil Society Organizations should not develop interventions for the trans diverse community without first consulting with them on the specific needs and approach and making sure to include the community served throughout the process, from planning all the way through to implementation. Too often are trans diverse people excluded from contributing to programs that are meant to serve their community.

Botswana

Encourage transphobia and discrimination people have towards the trans community.

Zambia

With the presence of robust organisations such as TBZ that specifically looks into the welfare of trans persons in Zambia it would be unwise for any person or organisation to take actoon in any way or form, even with the view to help in advocacy or otherwise without in-depth CONSULTATION wth TBZ management. Do NOT make public statements about Zabian trans without consent or publish stories without asking the lead organisation about it. TBZ is working closely with NAC and is the only voice representing trans at the moment. Others should not be seen to champion an agenda that is viewed in Zambia as "un-African". Dialogue should be held between partners to strategise a plan of action for interventions and thereafter, implementation of an action plan.

Zimbabwe

They should not keep silent and remain impartial but take the stand with the trans people.

8. WHO ARE YOUR BIGGEST AND MOST INFLUENTIAL ALLIES? WHY?

Swaziland

The Ministry of Health is our biggest ally in the Government. Recent surveillance has shown HIV prevalence among Men having Sex with other Men (MSM), and Sex workers (SWs) to be well above general population estimates. The Behavioural Surveillance Study (BSS) Show that Men

Having Sex with Men: HIV prevalence among MSM aged 16-44 years is estimated at 17.7%, and increases with age, ranging 11% (20-24 years) to 60% (40-44 years) (BSS MARPS 2010). Through this data, HIV funding has been available for Key Populations. While the focus of these programs has been MSM, programs that focus on health care center sensitization has been moderately inclusive of others that fall within the LGBTI spectrum, including transgender individuals. These programs however fall short as they only address service provision when it comes to sexual and reproductive health and are exclusive of other transgender health needs such as transition services and psycho-social support.

Botswana

Politicians, because some are helping advocate for trans. Some religious leaders and cultural leaders: these are people who have the most influence in the communties.

Zambia

In my personal view, local civil society is of immense value in forging our work because of the influence they have in society at many levels and with many from different walks of life. NAC because they are a government institution and are advocating for the inclusion of trans programming into their NSP. Bilaterals, missions and embassies who speak at policy level with government on our behalf and also provide HRD support. UNAIDS who have been instrumental in pushing for the inclusion of trans in the global fund process. Local: Engender Rights Centre for Justice, Zanerela, Media Institute of Southern Africa, due to the manner in which they conduct their work around LGBTI issues and the support rendered to TBZ over the years.

Zimbabwe

In-country other civil society organisations like GALZ, Contact [family counselling centre], Zim Lawyers for Human Rights, Abammeli Human Rights Lawyers, Zimbabwe National Network of People Living Positively – these allies assist with pushing the agenda of the trans agenda. Regionally, Gender Dynamix, Iranti Org, SALC. They provide support in the form of capacity enhancement, information dissemination and legal assistance.

9. FROM WHOM DOES THE GREATEST OPPRESSION OR SUPPRESSION COME FROM?

It is difficult to name one source as the primary cause of oppression or suppression as it is a combination of many socio-political factors. Denial of existence from government is a serious form of oppression.

Swaziland

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Botswana

The Church leaders and traditional leaders. Some cultural and political laders and the evangelist faith in Botswana.

Zambia

From the church clergy, and some policy-makers who perpetuate discriminatory laws and policies. A percentage of the Zambian public and the evangelical church control politics; politicians use transphobia as a way of gaining popularity. Religious leaders.

Zimbabwe

The government and politicians.

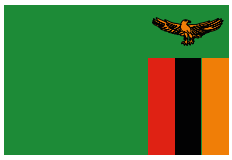
10. DESCRIBE THE WORK BEING DONE BY YOUR ORGANISATION IN ADVANCING HUMAN RIGHTS FOR TRANS DIVERSE PEOPLE.

Swaziland

The Rock of Hope has strong roots in advocacy, actively speaking out on human rights issues for trans diverse people in Swaziland. Programs such as health care centre sensitisations that aim to strengthen the knowledge of and access to trans* health services, as well as programs dedicated to legal outreach and documenting and reporting human rights violations are platforms where we are able to begin to address the health and legal needs of the community. The Rock of Hope is actively pushing for trans* leadership, amplified voices, and strong visibility within all levels of the organization.

Botswana

We lobby, we advocate and we provide contraception. Advocacy work in addressing issues of trans and intersex persons, workshops, dialogues with influential persons who can help advance our mandate.



Zambia

TBZ wishes to become a centre of excellence regarding trans services in health, legal and socio-economic matters. The work we do is to create avenues in which we can reduce poverty and dependency among community members, raise awareness among cis-persons about trans existence, give voice and visibility to community members and provide support systems for parents and guardians. We also provide in-house and group psychological support and provide emergency health care provision for any member of the community. We also provide legal aid where possible; we have a paralegal unit that is trained to monitor violations and compile cases for the legal team. TBZ provides a safe space for trans diverse people to freely express themselves. Support groups for persons living with and affected by HIV, psycho-social counselling, youth empowerment through sport, health referrals to friendly health-care workers, consultative dialogues with legal practitioners, sensitising trainings with stakeholders. TBZ provides a safe space for trans individuals to be fully true with who they are. Legal support in cases where trans people have been arbitrarily arrested and tried in court is offered.

Further advocacy programmes that intend to bring to light issues pertaining to trans people are carried out, human rights campaigns through drama or artistic expression are also done by community members, the right to discriminatory-free health-care is also advanced through sensitisation of health-care providers.

Zimbabwe

Sexual Rights Centre is currently hosting Trans Research, Education, Advocacy & Training [TREAT] – which as on offshoot, is looking at addressing the human rights issues in the areas of health, socio-economic, justice and the law.

11. DESCRIBE THE SITUATION AND EXPERIENCES REGARDING HIV FOR TRANS DIVERSE PEOPLE IN YOUR COUNTRY.

Swaziland

Because of the stigma and discrimination in some health centres trans diverse people tend not to go for HTC because the treatment they receive from the staff there is not welcoming or friendly, it is different from any other person coming for HTC. They see them as abnormal human beings. In response to requests for sensitization, it is often brought up that members of the LGBTI community "self-stigmatize" and that is why they do not seek services. We would argue that this stigmatization and discrimination is not internalized but rather comes from years of lived experience that translates into a distrust of health care personnel. This unnecessarily blames them for their own oppression and ignores the very real issue of mistreatment of trans diverse people in health care facilities.

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Zambia

With regards to HIV/AIDS in Zambia from the HTS that have been conducted by the lay providers most Trans women are positive. And this has come from the stories that have been shared where a majority of the trans women are sex workers and mostly they never use protective barriers when having sexual intercourse.

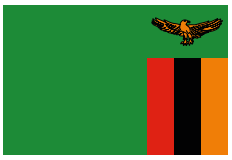
Zimbabwe Trans persons are subject to sexual assault in all sectors. Discrimination leads them to be chased away from home, drop out of school and enter into underground work for survival. These all make them vulnerable to contracting HIV. Coupled to this is a medical sector that discriminates them and treats them with stigma. Economic impoverishment makes it difficult for them to access proper medical care.

12. DESCRIBE THE SITUATION ON SEXUALLY TRANSMITTED INFECTIONS (STIS) (FOR EXAMPLE SYPHILIS, GONORRHOEA, CHLAMYDIAL INFECTION AND TRICHOMONIASIS) FOR TRANS DIVERSE PEOPLE IN YOUR COUNTRY.

Swaziland

The situation with STIs is similar to that of HIV when it comes to access to health care services. For example, we have been told of situations where the location of the STI (such as herpes on the anus) prompts uncomfortable questions.

Community members have told us of how their confidentiality was broken by bringing in other health care centre personnel to show off an individual so they could see what a transgender person looks like. This makes seeking any kind of medical treatment, especially in relation to SRH, an embarrassing task.



Zambia

STI for Trans women is very high especially when it comes to anal warts most of the trans women usually have anal warts and this has come from the community outreach reports that have been conducted.

Zimbabwe

These are pretty much as for the case of HIV above. They are a product mainly of discrimination and stigma experienced which have a ripple effect on their lives. Further compounding this fact are the cases of trans women who, not only do sex work, but also have "validative sex" – often to validate their femininity. More often than not this happens with men who do not want to use protection – or they are not in a position of power to negotiate safe sex.

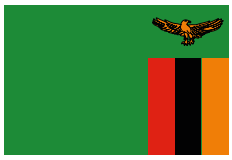
13. DESCRIBE THE SITUATION ON ACCESSING SEXUAL AND REPRODUCTIVE HEALTH COMMODITIES (FOR EXAMPLE CONTRACEPTIVES, AND DRUGS TO TREAT SEXUALLY TRANSMITTED INFECTIONS) FOR TRANS DIVERSE PEOPLE IN YOUR COUNTRY.

Swaziland

Condoms are made readily available through avenues such as clinics and civil society organizations. Other SRH commodities such as lubricants and female condoms are available but harder to find.

The availability of dental dams is inconsistent and trans diverse people mostly receive what they need from organisations working with the LGBTI community.

Some hospitals allow men to pick up contraceptives, which allow more freedom in access. The limitation is the unavailability of certain commodities due to either prices or lack of legal framework to have them in circulation in the country.



Zambia

Accessing of sexual reproductive health commodities is very difficult for trans diverse persons in Zambia. This comes from firstly trans diverse person been invisible they are not recognized and as such when it comes to health access it becomes a big challenge, when it comes to mental health.

Zimbabwe

These are accessible through private and medical facilities. Although trans diverse persons would rather seek private medical care to avoid the stigma and discrimination faced in public health facilities.

14. DESCRIBE THE SITUATION ON MENTAL HEALTH EDUCATION AND SERVICES FOR TRANS DIVERSE PEOPLE IN YOUR COUNTRY.

Swaziland

There is no mental health education or services directed to meet the needs of the trans diverse community. Unfortunately, this is a significant and urgent need that is not being addressed.

Even in cases where we have been assured a mental health professional is "sensitized" we then come to learn through trial and error that they are not familiar with nor truly know how to handle the mental health needs of the community.

This then can put the individual that is in need of help in a more life-threatening situation. The need for psycho-social support services for the trans diverse and entire LGBTI community is severe.

Zambia

Trans Bantu Association has psycho-social therapists that most trans diverse people go to visit when there have issues that they need to deal with and need someone to talk to.

Zimbabwe

These are basically non-existent.

15. DOES YOUR COUNTRY USED THE ICD[1] OR DSM[2] TO CATEGORISE TRANS DIVERSE AS A MENTAL HEALTH ISSUE? DISCUSS.

Swaziland

The information gathered from the MoH, SNAP office seemed not to be sure of this, even though the DSM was a familiar term with the officials; however, I was cautioned that of the governmental health documents made reference to the WHO code of conduct.

Botswana

Yes, the country uses both the DSM4 and ICD-10 to categorise transverse as mental health issue because of the World Health Org and international standards set. We are not sure whether Botswana authorities really understand implications of this.

Zimbabwe

No. Transgenderism is not discussed, therefore not given any medical attention as yet.

16. DESCRIBE THE SITUATION ON ACCESSING GENDER AFFIRMING HORMONAL THERAPY IN YOUR COUNTRY.

Swaziland

It is not uncommon for trans diverse individuals to access hormones through pharmacists who are willing to sell them without a prescription through back channels. There is no way to regulate or assure that what is being given is accurate dosage as this is done without doctor consultation.

It is also common for trans diverse people to travel to neighbouring South Africa to access gender affirming hormone therapy. There is nothing legitimizing or illegitimating hormonal therapy, but rather it becomes a situation of finding a doctor who will prescribe such, as well as an issue of economic means as these costs can be expensive and is thus only available to those that can afford it.

Botswana

It is difficult to access hormones due to the fact that there are no policies from the Ministry of Health.

[1] ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO). It contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.

[2] The Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, offers a common language and standard criteria for the classification of mental disorders.

Zambia

With access to hormones it's still on a very low and hidden scale as hormones are not easily accessible.

Zimbabwe

These are unavailable.

17. DESCRIBE THE SITUATION ON ACCESSING GENDER AFFIRMING SEX REASSIGNMENT SURGERY IN YOUR COUNTRY.

Swaziland

There is no access to any gender affirming surgery in Swaziland. The government does not recognize it as a necessity to offer within the health care system.

Botswana

Only when a person does it in a private hospital.

Zambia

With Zambia accessing gender affirming sex reassignment is close to none as this doesn't happen mostly people have to travel outside the country to have surgery which is very expensive and not affordable for an average Zambian person.

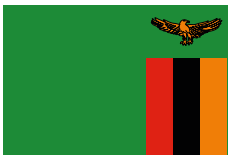
Zimbabwe

These are unavailable.

18. DESCRIBE THE SITUATION ON SAFE INJECTION EDUCATION AND NEEDLES RELATED TO HORMONAL THERAPY AND/OR INJECTION OF SILICONE AND OTHER SOFT TISSUE FILLERS FOR TRANS DIVERSE PEOPLE IN YOUR COUNTRY.

Swaziland

There is no safe injection education in relation to needles used for hormone therapy.



Zambia

Most Trans diverse persons are given information and education when it comes to safe injection. But some decided to self-medicate especially if they read up on information via the internet. But TBZ through its outreach officers tries to reach the community members that self-medicate and teach them about safe injection of hormonal therapy.

Zimbabwe

These are unavailable.

19. DESCRIBE THE SITUATION ON ACCESSING SUBSTANCE ABUSE AND HARM REDUCTION STRATEGIES FOR TRANS DIVERSE PEOPLE IN YOUR COUNTRY.

Swaziland

This is a very general concern for the MoH, however, there is no specification for the trans community. There are no substance use – harm reduction interventions for trans diverse people who inject drugs.

Zimbabwe

Substance abuse is rife in Zimbabwe, not only for the trans diverse population, due mainly to unemployment and an adverse economic climate. Strategies around harm reduction are mainly in the form of public service announcements – but targeted at the population at large and not trans specific.

There are no statistics regarding trans diverse persons. However, trans men have reported gross cases of stigma and discrimination on going for cervical cancer screenings. There is no data on tuberculosis or viral hep for trans diverse persons.

20. DESCRIBE THE SITUATION ON SELF-INFLICTED HARM AND SUICIDE AND NATIONAL STRATEGIES ON THESE ISSUES FOR THE TRANS DIVERSE COMMUNITY IN YOUR COUNTRY.

Swaziland

There is no mention of trans diverse persons in national strategies for self-inflicted harm and suicide in Swaziland. This is a serious issue as there is a severe need for these services. Many people in the LGBTI community as a whole have considered suicide when support structures fail and there is no psycho-social support to help cope. The government has a suicide watch department that works with the MoH and the Police department; however, this department is not known to be sensitized to the needs of the trans diverse community.

21. DESCRIBE THE SITUATION ON CANCER, VIRAL HEPATITIS[3] AND TUBERCULOSIS FOR TRANS DIVERSE PEOPLE IN YOUR COUNTRY.

Swaziland

The issue of cancer amongst the Key Population is still at a developmental stage, and thus now it is a general concern with MoH. Viral hep is an issue very particular,

[3] Viral hepatitis disproportionately affects trans diverse people globally. Some forms can cause liver cancer, some are vaccine preventable, but all require access to quality health care to diagnose and successfully treat.

especially with the KP as indicated by the MoH, they are noticing as the progress that it's affecting the KP more that the general population, this means it's not been distinguished between the LGBTI, as to which group is affected more.

Zimbabwe

There are no statistics regarding trans diverse persons. However, trans men have reported gross cases of stigma and discrimination on going for cervical cancer screenings. There is no data on tuberculosis or viral hep for trans diverse persons.

22. DESCRIBE THE SITUATION ON SEXUAL VIOLENCE AGAINST TRANS DIVERSE PEOPLE IN YOUR COUNTRY. INCLUDE INTIMATE PARTNER VIOLENCE AND ATTEMPTED AND COMPLETED RAPE AND OTHER SEXUAL VIOLENCE AND VIOLENCE.

Swaziland

Trans diverse people in Swaziland are more prone to abuse of all sorts. However, there is no hard data to support this claim, except for community member narratives that speak to many cases of sexual violence, usually at the hands of family members who are unaccepting of their gender identity.

Botswana

These are kept at organisational level unless the victims really want to take the matter further but judgement may never occur because law enforcers do not know how to handle such cases.

Zimbabwe

Sexual assault is rife. A recent study [base line survey] produced the following statistics on sexual assault: Workplace – 24%; Public accommodations – 34%; Jail/ prison – 4%; Faith leader – 74%

23. DESCRIBE THE SITUATION ON HATE CRIME (INCLUDING VERBAL ABUSE, ALL FORMS OF VIOLENCE ETC.) AGAINST TRANS DIVERSE PEOPLE IN YOUR COUNTRY.

Swaziland

Hate crimes against the trans diverse community are a very real but unreported issue. Through community member narratives we know that these take many forms including, but not limited to, verbal harassment at the bus rank, physical assault after being targeted in bar fights, property destruction, serious intimidation and threats of violence.

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Botswana

Most of the cases are not reported as hate crimes or are not reported at all. Hence no stats on issues involving hate crimes against trans people.

Zimbabwe

Hate crimes in Zimbabwe take on mainly the form of verbal abuse, and are experienced in all sectors. From homes to schools, retail stores, airports, public transport, etc.

24. WHAT OTHER COMMENTS OR INFO WOULD YOU LIKE TO ADD HERE?

Swaziland

The Rock of Hope is not only dedicated to advocacy and providing services to the trans* community but we emphasise the need for trans* leadership and voices from the initial idea throughout the planning and implementation stage. We believe that the most successful programs are those that run by the community served.

Botswana

There is still a huge misconception about issues involving sexual orientation and gender identity expression because in Botswana they are lumped into one thing and hence driving the work that the organisation does becomes very difficult.

Zambia

TBZ desperately needs support to purchase office space to help reduce the stress from fear of eviction.

Section 4: Country Performance Scorecard

COUNTRY/ELEMENT	SWAZILAND	BOTSWANA	ZAMBIA	ZIMBABWE
a. Legal and Policy Environment	E	E	D	E
	7%	10%	25%	0%
b. Quantitative Health Data	E	E	E	E
	0%	0%	0%	0%
c. Gender-Affirming Health-care	E	E	E	E
	0%	7%	10%	0%
d. Citizenship	E	B	E	E
	10%	70%	10%	0%
e. Law Enforcement	D	B	E	E
	40%	80%	20%	20%

SCORECARD GRADES

AAI places countries in five broad 'grades', from A to E as a means to indicate how they are performing. The grade is based on the percentage according to the following formula: A (81-100%); B (61-80%); C (41-60%); D (21-40%); E (0-20%) – from A (very good) to E (very poor). Every scorecard has it's own scope and paradigms and for the purposes of this scorecard, the ND, signifying no data, signifies that no response was provided by the country teams which completed the questionnaire. In the quantitative section this is especially significant as we know that it speaks not to the shortfall of knowledge of the trans* activists but the dearth of data on trans* people.

Responses from country trans civil society were graded according to their choices, with no changes. Then to determine the final grade for each element, a simple point system was allocated. 1 point for every A grade; half a point (O,5) for every C; and no points for an E.

ND is not included in calculations as the lack of data may be due to civil society ability and time to complete questionnaire, as well as the act that at country level there is no data.

SCORE	GRADE	
81-100 %	A	SIGNIFICANT PROGRESS
61-80 %	B	SLIGHTLY PROGRESSED
41-60 %	C	MAINTAINED
21-40 %	D	SLIGHT LOSSES
0-20 %	E	SIGNIFICANT LOSSES

a) Legal & Policy Environment

COUNTRY	CODE	PRO-TRANS ANSWERS	POSSIBLE PRO-TRANS ANSWERS (#QUESTIONS COMPLETED)	% (PRO-TRANS ANSWER/ 21*100)	GRADE
Swaziland	SWA	1,5	21	7%	E
Botswana	BOT	1	10	10%	E
Zambia	ZAM	3	12	25%	D
Zimbabwe	ZIM	0	2	0%	E

*O,5 for every C; 1 point for every A, no points for an E. ND not included in calculations as lack of data may be due to civil society ability and time to complete questionnaire.

Q1: Is Being trans diverse legal?		
Swaziland	E	*No, being trans diverse is neither legal nor illegal in the country. There is no law to use as a reference.*
Botswana	E	*State does not mention anything on trans diverse or gender identity / expression.*
Zambia	E	*The constitution of Zambia is silent on matters relating to trans diverse persons in the country. Further the country has no dress code so any individual is permitted legally to dress as they see and feel fit. But the country does have anti-sodomy laws that many times are used against transgender individuals. The Zambian constitution is quiet on specifically speaking to trans issues. But nevertheless, the anti-sodomy laws adopted from the colonial system is what is used against trans individuals, in particular trans women.*
Zimbabwe	E	*No comment*
Q2: Is there protective legislation for trans diverse people?		
Swaziland	E	*In accordance with Chapter 3, section 20 of the constitution. "(1) All persons are equal before and under the law in all spheres of political, economic, social and cultural life and in every other respect and shall enjoy equal protection of the law. (2) For the avoidance of any doubt, a person shall not be discriminated against on the grounds of gender, race, colour, ethnic origin, tribe, birth, creed or religion, or social or economic standing, political opinion, age or disability." There is no anti-discrimination protection for gender identity.*
Botswana	ND	*No data*

Zambia	C	*But the law in Zambia has anti-discriminatory laws that apply to everyone regardless of sexual orientation or gender identity. It is these laws that are used for various advocacy programmes in the country that involve trans persons. There are no particular laws that speak to the protection of trans diverse people. Nevertheless, the country does have laws to protect all citizens from discrimination and abuse as well as laws that speak to equality. Such laws are used by the trans movement to lobby and advocate.*
Zimbabwe	ND	*No data*
Q3: Is the death penalty not used as punishment for being trans diverse?		
Swaziland	A	*There is no death penalty punishment for trans diverse people in Swaziland.*
Botswana	ND	*No data*
Zambia	A	*As a matter of fact, the death penalty is rarely exercised even in cases where the law says it applies.*
Zimbabwe	ND	*No data*
Q4: Does the law separate diverse sexual orientation and gender identity issues into one?		
Swaziland	E	*Only the Common Law incriminates sodomy, in some cases trans diverse people will be accused of being gay.*
Botswana	A	*Yes*
Zambia	A	*According to society and the general interpretation of the law, the sodomy law applies to both trans and homosexual individuals. Many law and policy makers don't consider or are aware that gender and sexual orientation are fundamentally different. This is visible in the anti-sodomy laws being used against trans people. Further there is generally little knowledge in Zambian society on the difference between sexual orientation and gender identity. The two are treated the same.*
Zimbabwe	ND	*No data*
Q5: Is there prohibition of discrimination in employment based on gender identity/being trans diverse?		
Swaziland	E	*Section 20 of the constitution of the Kingdom of Swaziland speaks to employment discrimination. There are no constitutional protections for trans diverse individuals.*
Botswana	E	*Gender in reference to Botswana refers only to male or female.*
Zambia	E	*There is no law that prohibits discrimination in employment based on gender identity or being trans diverse. The issue is that many are simply stigmatised when seeking employment or after they are in fact employed. The law does mention that everyone in seeking employment should be treated equally regardless of status but in some instances trans people are discriminated against.*

Zimbabwe	ND	*No data*
Q6: Are trans diverse people able to access law enforcement services without discrimination or unfair treatment in your country?		
Swaziland	E	*Law enforcement personnel are not well versed or sensitized to trans* needs or the crimes often committed against the trans* community. Transgender individuals face stigma, discrimination, and harassment that often prevent them from seeking help from the police.*
Botswana	E	*It is still difficult to say because at government offices what is used is what is on the national identity card.*
Zambia	E	*Law enforcement officers tend to hold stereotypes relating to trans persons; this generally affects the service delivery. Moreover, there is a tendency by the officers to blame trans persons for the harm occasioned to them. This is so because many are judged based on their looks and expressions. Law enforcement often mocks and stigmatises them when services are sought.*
Zimbabwe	ND	*No data*
Q7: Are trans diverse people able to access legal and judicial remedy through the common-law system without discrimination or unfair treatment in your country?		
Swaziland	E	*While legal services are made available to trans* persons, those who work in this sector are not sensitized or informed on issues or barriers to access facing the community.*
Botswana	E	*Because there is no policy, it is difficult to access these, but with common law, discretion by officers may be used.*
Zambia	C	*Yes, but it must be noted that trans people will be very reluctant to do so owing to the repercussions that may follow. Security and protection of the law is not guaranteed. It is possible for trans diverse people to access legal and judicial remedy though the common-law system without discrimination. The issue here is that trans people are not interested in seeking legal and judicial remedy because of the negative implications that may come after. It also takes long and may be an overwhelming process that can be psychologically damaging.*
Zimbabwe	ND	*No data*
Q8: Are trans diverse people able to access legal and judicial remedy through the customary law system without discrimination or unfair treatment in your country?		
Swaziland	E	*There is no data to reflect this but stigma and discrimination throughout the legal sector is evident.*
Botswana	E	*Just like common law, discretion is used at most times.*

Zambia	E	*Culturally, all people are respected so judicial remedy through customary law is possible even when individuals express themselves as they are, but at no point should they disclose their gender identity. If they do matters can become complicated. Traditionally, everyone is respected regardless of how they choose to express themselves. But at the same time people revealing their gender identity to customary law is a risk that can actually lead to discriminatory behaviour.*
Zimbabwe	ND	*No data*
Q9: Is there constitutional prohibition of discrimination based on gender identity/being trans diverse?		
Swaziland	E	*Section 20 of the Constitution does not include legal protections for citizens based on gender identity.*
Botswana	ND	*No data*
Zambia	E	*There is no prohibition of discrimination based on one's gender identity. The law is silent on specific issues on trans but the country has itself anti-discrimination laws that apply to everyone in society.*
Zimbabwe	ND	*No data*
Q10: Does the law recognize trans diverse marriages?		
Swaziland	E	*No, the Marriage Act only speaks to Men and Women getting married.*
Botswana	ND	*No data*
Zambia	E	*It is not a matter even discussed either by society or even the trans movement.*
Zimbabwe	ND	*No data*
Q11: Is adoption by trans diverse people legal?		
Swaziland	E	*There have not been any cases of adoption, however a married couple is permitted to adopt in the country.*
Botswana	ND	*No data*
Zambia	E	*But anyone can apply to adopt a child but if they disclose their gender identity problems may arise.*
Zimbabwe	ND	*No data*

Q12: Are there policy provisions for trans diverse people in the National Health Policy (or the equivalent document in your country)?		
Swaziland	E	*No, there are only categorised under the Key Populations, specifically MSM: Trans diverse people are not included in the National Health Policy.*
Botswana	ND	*No data*
Zambia	ND	*No data*
Zimbabwe	ND	*No data*
Q13: Are there policy provisions for trans diverse people in the National Development Plan?		
Swaziland	E	*No, no developmental document addresses the trans diverse community.*
Botswana	ND	*No data*
Zambia	ND	*No data*
Zimbabwe	ND	*No data*
Q14: Are there policy provisions for trans diverse people in Common country assessment / UN Development assistance framework?		
Swaziland	C	*Yes, however these are international declarations that are subject to local interpretation. This means that certain aspects are deliberately excluded in the local policy frameworks.*
Botswana	E	*Botswana still stays silent on the matter.*
Zambia	ND	*No data*
Zimbabwe	ND	*No data*
Q15: Are there policy provisions for trans diverse people in National HIV Communication Plan?		
Swaziland	E	*No, there are no specifications.*
Botswana	E	*No there is not even an HIV prevalence for trans diverse people.*
Zambia	ND	*No data*
Zimbabwe	ND	*No data*
Q16: Are there policy provisions for trans diverse people in National STI Policy/policy guidelines?		
Swaziland	E	*No*
Botswana	ND	*No data*

Zambia	**ND**	*No data*
Zimbabwe	**ND**	*No data*
Q17: Are there policy provisions for trans diverse people in National Sexual and Reproductive Health and Rights policy or policy guidelines?		
Swaziland	**E**	*No*
Botswana	**ND**	*No data*
Zambia	**ND**	*No data*
Zimbabwe	**ND**	*No data*
Q18: Are there policy provisions for trans diverse people in National HIV/AIDS Strategic Plans/Response plans?		
Swaziland	**E**	*No, they are still categorised as the Key Populations and often grouped together with MSM.*
Botswana	**ND**	*No data*
Zambia	**ND**	*No data*
Zimbabwe	**ND**	*No data*
Q19: Are there policy provisions for trans diverse people in the National Composite Policy Index (NCPI)? The MCPI is part of every country's submission to UNAIDS on their HIV progress reports.		
Swaziland	**E**	*No, the country does not recognize any other gender identities other than cis-men and cis-women, within the legal framework.*
Botswana	**ND**	*No data*
Zambia	**ND**	*No data*
Zimbabwe	**ND**	*No data*
Q20: Are there policy provisions for trans diverse people in National Gender and Development Policy?		
Swaziland	**E**	*No, there are no provisions in the National Gender and Development Policy.*
Botswana	**ND**	*No data*
Zambia	**ND**	*No data*
Zimbabwe	**ND**	*No data*

Q21: Financial accountability: Are any funds allocated for trans diverse people in the national budgets, whether in HIV programming, gender affirming health care or other? Please provide as much detail as possible.		
Swaziland	E	*There are not enough funds being directed to cater for the Trans Diverse, and neither are there any to address issues affecting the LGBTI. It is only a myth that the government is doing something for the LGBTI community, this is only left to the Civic Community, and through the aid of EU, US aid, Global Fund and many others, something is done. Government, because it lacks the political will to have such issues addressed only allows the Civic Community to address the issues, living them to the denialism to the existence of LGBTI persons in the country. Sources: Human Rights Lawyer; Gender Department, DPM's Office*
Botswana	E	*No, because the Ministry of Health policy does not recognise trans diverse persons, there is no financial accountability and in challenging these it would also be difficult because the "right to health" in Botswana is not constitutionalised.*
Zambia	E	*In national budgets, no, but in HIV programming currently the National Aids Council is incorporating trans diverse HIV programming because of the global fund money they are to receive or have received. And various other NGOs also receive such funding and are trying to implement HIV programming with trans people in mind.*
Zimbabwe	E	*None whatsoever. Trans diverse persons are not mentioned at all in any of the country's plans, documents or laws.*

ANALYSIS

The environments relating to the trans diverse communities in the four countries are quite different in their legal versus their policy aspects: while there are some legal sanctions applied against trans diverse people (and none in favour), there is a total vacuum when it comes to government policy. So it appears from this that the community is at most treated as a minor law enforcement problem, relating to a projected criminality, and is not at all located within Key Population development, health or other considerations tied into either national policy objectives or international commitments.

The sole exception here is Swaziland where the respondents note that there were policy provisions for trans diverse people in the Common country assessment / UN Development assistance framework – but only under Swaziland's international commitments, and these are deliberately not integrated into national policy frameworks.

The root of the problem is an apparent bureaucratic/ governmental refusal to recognise gender identities beyond the cis-binary of male and female. This means automatically that all identity documents are cis-

binary as are all policies – although some governments begrudgingly recognise LGB sexuality identities. The result is a total disappearance of the entire trans diverse community and all of its issues as deserving of policy or progressive interventions. The only exceptions are where the trans diverse community appears on government's radar because they intersect in some instances with policies for LGB and MSM Key Populations so qualify for interventions. This lack of recognition, it will become apparent in this report, is a key grudge of the trans-community and a key area of desired rectification.

The total policy gap has the direct result of there being no state budget line-items that relate to progressive interventions on behalf of the communities – although Swaziland notes that NGOs are able to access trans-focused funds directly from international donor organisations.

Regarding the legal status of the community, even where it is targeted for criminalisation, this is fortunately not very severe, there are no specifically anti-trans laws, and in no instances do sanctions involve the death penalty. It is worth stressing that there are no laws protective of the community except for broad equality clauses in national constitutions – which do offer an opportunity for defense; hopefully in future, such legal defences will be proactive in establishing pro-trans equality rather than merely responding to abuses of trans people's equal status by local authorities or individuals.

The most important laws deployed against the trans diverse community are anti-sodomy laws; naturally this only relates to a section of the trans diverse community such as trans women. There is an advocacy opportunity

> There is a total vacuum when it comes to government policy. So it appears from this that the community is at most treated as a minor law enforcement problem, relating to a projected criminality, and is not at all located within Key Population development, health or other considerations tied into either national policy objectives or international commitments.

relating to the sodomy laws, as they were inherited lock, stock and barrel from the colonial era, and as decolonisation becomes an issue in some countries in the region, these laws could be challenged as de facto un-African (however, the reactionary cultural counter-argument has also been made that sodomy is un-African).

It is worth highlighting that Zambia reports that trans diverse people are able to access customary and even common law remedies without prejudice, so long as they do not disclose their gender identity: we take this to mean that trans diverse persons whose appearance does not disrupt the cis-gender binary, will be treated as the gender they are perceived as.

b) Quantitative Health Data

COUNTRY	CODE	PRO-TRANS ANSWERS	NO DATA ANSWERS	POSSIBLE PRO-TRANS ANSWERS	GRADE
Swaziland	SWA	0	31	32	E
Botswana	BOT	0	32	32	E
Zambia	ZAM	0	30	32	E
Zimbabwe	ZIM	0	30	32	E

This research asked 32 standard quantitative questions on trans health that would have been answerable for the general population. However, it yielded only five pieces of information.

1. Zimbabwe reported 25% HIV prevalence among trans diverse people (%).
2. Zimbabwe reported 20+ % of trans diverse people that have received an HIV test in the last twelve months and who know their results.
3. Swaziland reported one clinics and hospitals doing behavioural interventions including education and risk-reduction counselling through outreach and peer education. (MoH lists Family Life Association Swaziland (FLAS) as the only Clinic involved in the behavioural intervention.)
4. Zambia reported three clinics and hospitals doing behavioural interventions including education and risk-reduction counselling through outreach and peer education.
5. Zambia reported one clinics and hospitals offering substitution therapy (OST) for people dependent on injecting drugs.

None of the above responses can be considered pro-trans. The percentage of HIV prevalence is very high and thus merits an E grade for Zimbabwe. Similarly, the fact that only 20+% of trans* people have received HIV tests and know their results is way below the desired levels. Swaziland and Zambia's outreach and and OST cannot be graded as anything other than significantly inadequate with an E. Obviously the lack of data provided at country level could be said to be the lack of knowledge of local activists, but if we examine their comments below we can clearly see that this is not the case.

The questions for which our governments, health centres and United Nations colleagues do not have information for trans* people at all are:

1. HIV prevalence among trans diverse people (%)
2. Percentage of trans diverse people who report having an STI in the past 12 months
3. Percentage of trans diverse people reached with HIV prevention programmes
4. Percentage of trans diverse people that have received an HIV test in their lifetime
5. Percentage of trans diverse people that have received an HIV test in the last 12 months and who know their results
6. Percentage of trans diverse people reporting the use of a condom the last time they had sex with a partner
7. Trans diverse people reporting ever using lubricant

8. Trans diverse people reporting ever using fingerdoms, dental dams, sex toys (Please write all separately)
9. Number of clinics and hospitals doing behavioural interventions including education and risk-reduction counselling through outreach and peer education.
10. Number of clinics and hospitals offering mental health education and services targeted at trans diverse people.
11. Number of clinics and hospitals offering gender affirming hormonal therapy
12. Number of clinics and hospitals offering gender affirming sex reassignment surgery
13. Number of clinics and hospitals offering trans-targeted substance use-related harm reduction interventions
14. Number of clinics and hospitals offering substance use-related harm reduction interventions for trans diverse people who inject drugs
15. Number of clinics and hospitals offering substitution therapy for people dependent on injecting drugs
16. Number of clinics and hospitals offering sterile needle exchange or provision
17. Number of clinics and hospitals offering safe injection education and needles related to hormonal therapy and/or injection of silicone and other soft tissue fillers
18. Number of clinics and hospitals offering trans-targeted prevention and treatment of tuberculosis (TB)
19. Number of clinics and hospitals offering trans-targeted Prevention and treatment of viral hepatitis.
20. Percentage of trans diverse people reporting physical violence in the last 12 months
21. Percentage of trans diverse people reporting physical violence ever in their lifetime
22. Percentage of trans diverse people reporting sexual violence including attempted or completed rape in the last 12 months
23. Percentage of trans diverse people reporting sexual violence including attempted or completed rape ever in their lifetime
24. Percentage of trans diverse people reporting attempted or completed rape by an intimate partner (intimate partner violence) in the last 12 months
25. Percentage of trans diverse people reporting attempted or completed rape by an intimate partner (intimate partner violence) ever in their lifetime
26. Percentage of trans diverse people reporting hate crime being committed against them in the last 12 months

The paucity of quantitative health data in just about all aspects in all four countries interlocks with the lack of governmental health policies that firstly recognise the trans diverse community as a distinct population group mostly separate from the LGB and MSM populations,

27. Percentage of trans diverse people reporting hate crime being committed against them ever in their lifetime
28. Percentage of trans diverse people reporting experiencing stigma in the last 12 months
29. Percentage of trans diverse people reporting experiencing stigma ever in their lifetime
30. Percentage of trans diverse people reporting

experiencing stigma at public clinics and hospitals in the last 12 months

31. Percentage of trans diverse people reporting experiencing stigma at public clinics and hospitals ever in their lifetime
32. The percentage of trans diverse people who have experienced sub-optimal/sub-standard/ unsatisfactory service access as a result of stigma and discrimination

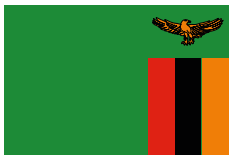
Comments by the country activists are revealing and pivotal to understanding the difficulties this lack of data and information poses:

Swaziland

This is a problem with data collection and it is therefore hard to determine the exact numbers or data in general. This is not just an issue of the Trans Diverse society; it is across the LGBTI community as a whole. The predicament is that the government, through the MoH, recognises the LGBTI under one term, MSM (Men having sex with other Men) which is an extension of the Key Populations. This has created a language barrier for the health sector. This has meant that the data collected is not necessarily a true reflection of the society. This means that any pilot studies and surveys being conducted are not recorded properly, because the legal framework being incongruent. Source: MoH. SNAP Official (Swaziland National AIDS Programme).

Botswana

It is difficult to get such above statistics because of the challenges that we have, especially with our own trans diverse community, it is difficult for them to open up about their personal information for statistical purposes for the mere fact of the discrimination they faced externally and internally. The other challenge is that because at government sector the national identity card is the one that is used, our community tends to disregard going to government offices. Ministry of Health also does not seek to establish or recognise trans diverse persons due to the fact that the country itself (Botswana) does not have anything that speaks to gender identity / expression be it in health, employment, etc.



Zambia

The above questionnaire statistics will be derived from the personal information that individuals were giving from the research, as most times reports are not done and percentages are hard to derive.

ANALYSIS

The paucity of quantitative health data in just about all aspects in all four countries interlocks with the lack of governmental health policies that firstly recognise the trans diverse community as a distinct population group mostly separate from the LGB and MSM populations, and secondly recognises the need to extend health and other services to trans* people as a specifically targeted group. This data and policy gap appears to derive in part on the one hand from a basic lack of understanding of the specificity of trans diverse people and their needs, and on the other hand from a lazy extension of LGB and MSM Key Population policy responses to the trans

diverse sector without adequate differentiation (though cultural and religious prejudices also play their role in influencing a reluctance to recognise the population and devise policy for them, as we shall see).

Even where one might expect the trans diverse organisations themselves – or at the very least, the broader LGBTI advocacy organisations – to conduct surveys of their communities in order to fill in the gap left by a lack of NGO or governmental surveys, they appear to lack the capacity to do so. This most probably stems from the marginalised status of the trans diverse community and its representative organisations, in particular their poor economic status.

But there are other drivers, such as that noted by Botswana which responded in essence that their members are so afraid of exposing themselves that they are on the one hand shy of even sharing data with their own organisations for anonymous data-gathering purposes, and on the other hand eschew approaching government for many regular services out of fear of experiencing prejudice.

The data-gathering gap on the part of trans diverse organisations themselves when it comes to trans diverse experiences of hate crimes, prejudice, exclusion and a lack of satisfactory service-delivery, may reflect that the responding organisations erred on the side of caution in not including anecdotal experiences in this, essentially empirical, section. If this is so, then their experiences are better explored regarding those questions in the Qualitative Health Data section below. Notable exceptions include Zimbabwe where, despite the country's desperate economic conditions, the respondents know the percentage of their community that is HIV+, and Zambia where the community knows its STI and HIV status. The sole bright light in this section is that clinics in Swaziland and Zambia do offer behavioural interventions – though this appears to be directed at general population and so embrace the trans diverse community by accident.

It seems logical that the four governments in question would only survey the trans diverse community and establish a statistical basis for progressive interventions once they have recognised the imperative of establishing policy for this population – probably under international donor / multilateral organisation pressure – so it emerges as an important focus of future advocacy to convince governments of the need for recognising, surveying and devising interventions regarding the trans diverse community that align with, but are discrete from, LGBT and MSM Key Population engagements.

The data-gathering gap on the part of trans diverse organisations themselves when it comes to trans diverse experiences of hate crimes, prejudice, exclusion and a lack of satisfactory service-delivery, may reflect that the responding organisations erred on the side of caution in not including anecdotal experiences in this, essentially empirical, section.

c) Gender-Affirming Healthcare

COUNTRY	CODE	PRO-TRANS ANSWERS	POSSIBLE PRO-TRANS ANSWERS	% (pro-trans answer /15*100)	GRADE
Swaziland	SWA	0	15	0%	E
Botswana	BOT	1	15	7%	E
Zambia	ZAM	1,5	15	10%	E
Zimbabwe	ZIM	0	15	0%	E

*O,5 for every C; 1 point for every A, no points for an E. ND not included in calculations as lack of data may be due to civil society ability and time to complete questionnaire.

Q1: Is quality health care available to the trans diverse community?		
Swaziland	E	*No. It doesn't address the specific needs of the Trans Diverse*
Botswana	C	*Yes. Available, but on the ground it is different.*
Zambia	E	*No.*
Zimbabwe	E	*No.*
Q2: Is trans-specific health care included in training manuals/curriculum for health care workers		
Swaziland	E	*No.*
Botswana	E	*No.*
Zambia	E	*No.*
Zimbabwe	E	*No.*
Q3: Is trans-specific mental health and psychological support available?		
Swaziland	E	*No.*
Botswana	E	*No.This is only available if we have practitioners who are willing to assist or work with us.*
Zambia	E	*No. Yes and No. Yes as there is one counsellor from TBZ. No, as this would be seen as a mental problem when one goes to a psychologist who is not an ally or who isn't sensitized about trans diverse issues.*
Zimbabwe	E	*No.*

Q4: Is hormone treatment available to trans diverse people on the public health system?		
Swaziland	E	*No. No policies in place or legislation to allow it. Trans diverse community members are resourceful in their procurement of gender affirming hormones and have been able to obtain them without a prescription through back channels or by paying a pharmacist the right price to turn a blind eye. Some trans diverse individuals have also travelled to neighbouring South Africa for hormone treatment.*
Botswana	E	*No. Technically, it's available, but the Ministry of Health would rather give the opposite of hormones one is lacking. There is no gender policy regarding trans health care hence the hospitals give out oestrogen to transmen and testosterone to transwomen. Others access these privately or on the black market.*
Zambia	E	*Yes and No. Yes, though TBZ, its allies, and health care providers trained by TBZ. No, though hormones are available to the public system but not to trans diverse people the hormones are available to cis men that are either impotent or for weight lifters.*
Zimbabwe	E	*No.*
Q5: Are gender-affirming surgeries available?		
Swaziland	E	*No. There are no laws allowing such surgeries in the public health system, so they use pharmacies or go to South Africa.*
Botswana	E	*No. Not In public health, only in private hospitals (government hospitals refer to them as "cosmetics")*
Zambia	E	*No, there is a private clinic which can conduct top surgery but it's very expensive. Zambia does carry out top surgeries at the University Teaching hospital but it's mainly for those with breast cancer and the surgery isn't done well.*
Zimbabwe	E	*No.*
Q6: Generally, are trans diverse persons able to be treated in accordance with their gender expression in cases where their ID is incongruent to that expression when seeking medical attention?		
Swaziland	E	*No. In health care centres, particularly hospitals, trans diverse persons will always be directed to the ward of their sex assigned at birth.*
Botswana	E	*No.*
Zambia	C	*Yes. Not really but if you are in an area where people know you then you can access service with incongruent documents without any problem.*
Zimbabwe	E	*No.*

Q7: Is trans-specific health care covered by public health costs or do trans diverse people have to fund it themselves?		
Swaziland	E	*No.*
Botswana	E	*No.*
Zambia	E	*No. Trans people have to fund it because trans divers issues are very silent.*
Zimbabwe	E	*No.*
Q8: Percentage of government budget allocation for health activities which focus on trans diverse people		
Swaziland	E	*No, not even for the key populations. The only way the SNAP office helps the Key Populations, is through outsourcing from NGOS and other funders, not limited to EU, USA, Netherlands and other funding Organisations, like the Global Fund.*
Botswana	E	*No.*
Zambia	E	*No, as firstly its seen as un-Christian so it can't even be put on the budget.*
Zimbabwe	E	*No. Zero*
Q9: Number of sites and locations offering trans-specific health care		
Swaziland	E	*None.*
Botswana	E	*No.*
Zambia	C	*Yes. Two sites, but they are not themselves trans specific. Both in urban areas.*
Zimbabwe	E	*No. Zero*
Q10: Does religion in your country affect the trans diverse community's ability to access gender affirming health care? How so?		
Swaziland	E	*Yes and No, while religion isn't specifically cited as a reason for the inability to access gender affirming health care, it is a contributing factor in the societal erasure of the trans diverse community and their health care needs, including transition related health services.*
Botswana	A	*No.*
Zambia	E	*Yes, Christianity is dominant here and trans is masked under LGB which is seen as a sin.*
Zimbabwe	E	*Yes. Religion – particularly the charismatic churches are very vocal of LGBT issues [negatively]. And these churches make up the majority of religion in Zimbabwe.*
Q11: Do culture/cultural norms in your country affect the trans diverse community's ability to access gender affirming health care? How so?		
Swaziland	E	*Yes and No, for the same reasons as religion.*
Botswana	E	*No.*

Zambia	E	*Yes, a person born a female or male needs to remain that way and carry out their expected roles of being masculine or feminine in the cis sense.*
Zimbabwe	E	*Cultural practices do not acknowledge transgender therefore this affects their ability to access health care. Trans women are still forced to undergo ritual male circumcision.*
Q12: Does the economic status of your country affect the trans diverse community's ability to access gender affirming health care? How so?		
Swaziland	E	*Yes, gender affirming health services are seen as cosmetic and therefore not a priority*
Botswana	E	*A lot of trans diverse persons are unemployed and accessing health care is difficult and there is no financial accountability from the state in giving this service.*
Zambia	E	*Yes, as the cost of living in Zambia is high and most of the community members are illiterate hence they have no income.*
Zimbabwe	E	*Zimbabwe is facing an adverse economic climate. The study recently completed by TREAT showed that close to half the trans diverse persons earned less than US$ 100 per month.*
Q13: Does the income/economic status of individuals affect the trans diverse person's ability to access gender affirming health care? How so?		
Swaziland	E	*Yes, most people generally depend on the government-subsidised health care at public hospitals and clinics. This is not limited to the trans diverse community, which does not receive the trans specific health care from these public health care units, thus making it expensive and impossible for many to access.*
Botswana	E	*It is expensive to get gender-affirming health care.*
Zambia	E	*Yes, hormones are expensive and not every individual can afford them as they are mostly illiterate or unable to secure jobs.*
Zimbabwe	E	*As for question above.*
Q14: Does the judiciary affect the trans diverse community's ability to access gender affirming health care? How so?		
Swaziland	E	*Yes, the judiciary and legislative bodies create legal and bureaucratic barriers to accessing gender affirming health services*
Botswana	E	*Because so far there are no policies that speak to gender identity / expression issues hence no legal recognition.*
Zambia	E	*There is uncertainty on this, but the judiciary is mostly silent on issues of trans diverse people.*
Zimbabwe	E	*There are no laws in favour of it.*

Q15: Does the healthcare system affect the trans diverse community's ability to access gender affirming health care? How so?		
Swaziland	E	*Yes, it is very generic and mainstream in service delivery. There are no instruments put in place to enable the accessibility of the needed services for the trans diverse community.*
Botswana	E	*Ministry of Health does not have policies that specifically speak to trans diverse persons.*
Zambia	E	*Yes because most nurses or doctors are not trained on issues of trans diverse people, and trans issues are not recognised.*
Zimbabwe	E	*Their inability to provide the healthcare due to being uninformed, and the discriminatory manner in which they treat the trans diverse persons.*
Q16: What other barriers exist for either personal, structural and/or societal reasons in attaining gender-affirming health care in your country? Explain:		
Swaziland		*There is the incorrect assumption that no one in Swaziland wants gender-affirming health services and therefore there is no need to provide this care.*
Botswana		*Cultural, Religion, Community, Law. A lot of Batswana are driven by culture, religion and law and if these three influential aspects of the country still do not accept and recognise trans diverse persons it will be difficult to attain gender affirming health care.*

ANALYSIS

Access to general healthcare not involving hospitalisation is indeed possible in the four countries surveyed, so general health check-ups at a doctor or clinic, or access to medicine for various ailments from a pharmacy is largely unrestricted – but this exists as a basic service for all population groups, and none of this access is officially trans-specific.

Hospitalisation presents the trans diverse person with a significant dilemma in that hospital wards are organised on a cis-normative binary, so it appears that in the view of admitting nurses/doctors, accommodation for the trans diverse person presents an accommodation problem. This is likely to be even more problematic regarding trauma admissions where the trans diverse patient is not in a condition to mediate in the admissions process.

It is clear that the trans diverse community has developed significant innovation when it comes to accessing trans-specific services (usually through sympathetic individual health care providers, or in localities where the trans diverse person is known personally), and hormones (usually through sympathetic allies, the black market, by in essence bribing pharmacists to provide them under the counter, or in Botswana's case simply because they

care handed out indiscriminately at hospitals – one of the few advantages of a lack of policy).

Trans-specific healthcare, including for mental health, is generally not available – and yet in several countries, private clinics / hospitals do provide gender-affirming surgery, though it must be noted that this is expensive, has no government subsidy (in fact, there are no trans-specific government budgets that fall outside the Key Populations, including LGB, boundaries). The generally low economic status of the countries studied and the exclusion from much of the job market of the trans diverse communities make access to private gender-affirming health-care very difficult.

Meanwhile, the four countries' dominant conservative religious and cultural practices tend to create a societal environment that either erases or condemns the trans diverse communities. This broader societal exclusion is exacerbated by institutional exclusion by the judicial and health-care system: the judiciaries either by failing to provide protections to, or by totally ignoring the communities; the health-care systems by failing to provide trans-specific training to their staff, and so by perpetuating prejudice through ignorance.

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d) Citizenship

COUNTRY	CODE	PRO-TRANS ANSWERS	POSSIBLE PRO-TRANS ANSWERS	% (pro-trans answer /15*100)	GRADE
Swaziland	SWA	0,5	5	10%	E
Botswana	BOT	3,5	5	70%	B
Zambia	ZAM	0,5	5	10%	E
Zimbabwe	ZIM	0	5	0%	E

*O,5 for every C; 1 point for every A, no points for an E. ND not included in calculations as lack of data may be due to civil society ability and time to complete questionnaire.

Q1: Are trans people able to change gender/sex markers on their national identity documents in your country?		
Swaziland	E	*No. There have not been any reports to this regard; however, there is not any legislation to allow this to happen either. Most of the issues remain openly denied and there are no proper documentations, if any case does exists. The biggest obstacle is the legal stand on them. There is not a single document or legal framework within the government that allows a person to change their gender, and neither is there one to stop it. Sources: Gender Department, DPM's Office and an Officer at The MoH, Immigrations Department.*
Botswana	A	*Yes. After one has gone through all the procedures and has "fully" transitioned.*
Zambia	C	*No. Not really but one can try and change their ID. They can do this by presenting that there was probably a mistake with the first document, though it's very hard.*
Zimbabwe	E	*No.*
Q2: Are trans people able to change gender/sex markers on their birth certificate in your country?documents in your country?		
Swaziland	E	*No. This is the duty of the medical practitioners at birth, and therefore lacks the legality to change on a later date.*
Botswana	E	*No.*
Zambia	E	*No, it's challenging to change.*
Zimbabwe	E	*No.*

Q3: Are trans people able to change gender/sex markers on their passports in your country?		
Swaziland	**E**	*No. This document is always congruent to the birth certificate.*
Botswana	**A**	*Yes. As above, the national identity card determines every document that one changes.*
Zambia	**E**	*No.*
Zimbabwe	**E**	*No*
Q4: Are trans people able to change gender/sex markers on their national health documentation in your country? (National health documentation may be a clinic card or patient identifier number and info for example.)		
Swaziland	**E**	*No. There has not been any formal request, and now, the National Identity is the reference to compiling this document.*
Botswana	**A**	*Yes, but first any change of document is determined by the change in the national identity card.*
Zambia	**E**	*No. Not really but a clinic card can easily be changed*
Zimbabwe	**E**	*No.*
Q5: Are trans people able to change their names on national ID documents in this country?		
Swaziland	**C**	*Yes, and there are certain protocols involved, which becomes a matter of bureaucracy.*
Botswana	**C**	*They can only add names but not remove any.*
Zambia	**E**	*No*
Zimbabwe	**E**	*No. Just surnames – not first names. Section 18, subsection 3 of the Births & Deaths Registration Act.*

ANALYSIS

The lack of official documentation (ID card, birth certificate, driver's license, passport etc.) that reflect a gender congruent with the trans person's desired gender is one of the most serious problems affecting the trans community as it has a direct negative impact on their ability to exercise their full citizenship, and so automatically excludes them from accessing not only state services such as health, but also their physical mobility on the roads or airways, and even their ability to secure employment, or engage in sports.

The lack of gender-aligned documentation automatically puts the trans diverse person – with the sole exception of those who have fully transitioned in Botswana – into a second-class citizen, or even invisible category. But even

> The lack of gender-aligned documentation automatically puts the trans diverse person – with the sole exception of those who have fully transitioned in Botswana – into a second-class citizen, or even invisible category.

in Botswana, this assumes that the trans diverse person in fact does want to fully transition to the apparently opposite gender via the required surgery; in other words, there is no recognition at all of the nuances within the spectrum of gender and sexuality identities within the trans diverse experience. Trans diverse persons who do not wish to undergo gender reassignment surgery, which is of its nature drastic and invasive, are left in a legal and thus human rights limbo.

Of interest is the suggestion in the country introduction by Botswana that the trans diverse community desires legal recognition of a third gender mark on the national identity cards, in other words a trans option in addition to the cis-binary of male and female. This desire was not expressed by the other communities polled and may result from the apparent fact that Botswana is more advanced than the other four countries in terms of the existence of transitional surgery.

Several questions on sexual reassignment surgery, and the related bureaucratic necessities, was removed from the scorecard calculations due to the lack of useful data that came through. However, what did become apparent is that the countries have absolutely no legislation regarding this issue, and that reassignment surgery is simply just not done. Botswana has made progress, but in so doing has put a foot wrong in bureaucratically demanding that surgery be done in order for gender reassignment to be legally documented.

There are some differences between countries but in all cases, one document is taken to be determinant of the rest: in Swaziland, the birth certificate is the determinant document, while in Botswana, it is the national ID card which determines the gender reflected on all other documentation. In some cases, (Swaziland), it is nearly impossible to retroactively alter a birth certificate as a doctor signed off on the gender at birth, but in other cases (Zambia) it is difficult but possible by arguing that there was an error in the birth certificate.

There is a little more leeway regarding the renaming of oneself on certain documents, but this generally relates only to surnames, in other words, is tied to cis-normative marriages, and not at all to matters of gender identity.

The lack of an adequate legal mechanism for changing documentary identity is grounded in the lack of a progressive legal position on the existence and reality of trans diversity, and as a result, there are no legal precedents on which trans activists and the courts can rely to get documents to reflect the desired gender.

e) Law Enforcement

COUNTRY	CODE	PRO-TRANS ANSWERS	POSSIBLE PRO-TRANS ANSWERS	% (pro-trans answer /15*100)	GRADE
Swaziland	SWA	2	5	40%	D
Botswana	BOT	4	5	80%	B
Zambia	ZAM	1	5	20%	E
Zimbabwe	ZIM	1	5	20%	E

Q1: Is there a history of police harassing trans diverse people in your country?		
Swaziland	E	*Yes, this has been told through community member narrative.*
Botswana	A	*No.*
Zambia	E	*Yes.*
Zimbabwe	E	*Yes.*
Q2: Do the police ever stop and search or arrest self-identifying or perceived trans people in public areas?		
Swaziland	E	*Yes, this has been told through community member narratives.*
Botswana	A	*No*
Zambia	E	*Yes, especially if its been initiated by the members of the public around that particular area.*
Zimbabwe	E	*Yes.*
Q3: Do the police ever perform house raids in search of self-identifying or perceived trans persons?		
Swaziland	A	*No. Not that we know of.*
Botswana	A	*No.*
Zambia	E	*Yes, mostly if they have received information about sexual acts of that particular person.*
Zimbabwe	A	*No.*
Q4: Are trans diverse people detained (prior to conviction) in cells according to their identified gender as opposed to their assigned sex?		
Swaziland	C	*No .Trans diverse individuals will always be detained according to assigned sex. The power to allocate a prisoner residence rests with the warrant, signed by the magistrate or judge. This can mean one or two things for sure.*

Swaziland	C	*If the culprit is a trans diverse person, they can either ask the judge to allow them to be imprisoned in a cell that is congruent to their identified gender, other than their assigned sex, or present themselves to the judge as the identified gender. However, the question on both instances lies on whether there is enough legal ground to recognise a person's gender identity as incongruent to the assigned sex.*
Botswana	C	*No. Because of the issue of the gender mark.*
Zambia	E	*No.*
Zimbabwe	E	*No.*
Q5: Are trans diverse people imprisoned (after being convicted) in cells according to their identified gender as opposed to their assigned sex?		
Swaziland	C	*Yes and No. Note the above mentioned issue of gender mark.*
Botswana	C	*No, most times they are let go after the detention and just charged for public nuisance or impersonation.*
Zambia	E	*Yes.*
Zimbabwe	E	*Yes.*

ANALYSIS

It is not surprising that, because of traditional machismo, the police emerge – alongside the earlier identified bigoted Christian and opportunistic political leaders – as a source of prejudice, especially when they are required to enforce antiquated laws such as the anti-sodomy laws. But this does not automatically explain the tendency by police to harass, question and search trans or apparently trans people in public, clearly acts designed to shame them in the eyes of onlookers. A welcome exception here is the experience in Botswana.

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The (fortunately) unique Zambian experience of house searches by police at the instigation of members of the (cis) community is of particular concern as this is an even greater violation of the trans community's privacy, and must certainly create a climate of great uncertainty and fear and may even encourage a tendency for cis people to inform on their trans neighbours, undermining social harmony and human solidarity. The laws that are most commonly used to fine/arrest/detain trans

diverse people were said to be the common law in Zambia and then mostly [the crime of] impersonating [another gender]; and in Zimbabwe respondents said the Criminal Nuisance Act; Criminal Codification Act [sodomy]was used.

In both jails and prisons, the lack of choice may be due to overcrowding and the lack of an alternative such as solitary detention/imprisonment. Botswana is the exception – but only if the detainee / convict's identity card has been altered (and as we have seen in the previous section, that is only allowed to occur after gender reassignment surgery). It is likely that even sympathetic magistrates and police officers have their hands tied by a lack of accommodation options or the constraints of the law – but as indicated by Swaziland, there are opportunities for officials to use their discretion.

The general inability of trans diverse people to convince arresting officers to detain them in jail cells reserved for the gender they identify as is problematic as it may easily expose the trans detainee to violence and sexual abuse at the hands of other detainees. This threat is only exacerbated with the longer terms implied regarding post-conviction imprisonment.

One of the aspects not covered in this survey but likely to produce some interesting results is whether or not law enforcement agencies themselves employ trans diverse people – despite the open hostility reported by such agencies towards the community. A similar question could be asked of health services, as both police and health services often unofficially at least accept – by turning a blind eye – the recruitment of LGB members.

The Rock of Hope is thankful for the platform and opportunity to document the barriers to accessing human rights within the trans diverse community. This data will help us to develop a framework to address these needs and continue our work moving toward and advocating for a more just and equitable environment for our trans diverse community members.

- Rock of Hope Respondents

Section 5: User-Friendly Services Priority Setting

Q1: Please check what you believe are the five most important policy priorities affecting Trans Diverse/Gender non-conforming people in your country. Mark 5 only.	
4	Better policies on gender and identity documents and other records
3	HIV prevention, education and treatment, including PEP (Pre Exposure Prophylaxis) for trans diverse people
3	Access to trans diverse-sensitive health care and providing gender affirming treatment and surgeries
2	Protecting trans/gender non-conforming people from discrimination in hiring and at work
2	Passing laws that address hate crimes against trans diverse/gender non-conforming people
2	Training health care workers at clinic level on trans specific health care
1	Passing a law that protects and provides equal rights for trans diverse people
1	Educating, sensitising and training police on trans diverse issues
1	Better policies on trans diverse/gender non-conforming prisoner's rights
0	Ensuring trans diverse access to justice at court
0	The right to equal recognition of marriages involving trans diverse partners
0	The right of trans diverse/gender non-conforming people to parent, including adoption
0	Cancer, tuberculosis, hepatitis and STIs prevention, treatment and education for trans diverse people
0	Protecting trans diverse/gender non-conforming people from discrimination in housing

ANALYSIS

The three top-most pressing priorities for the trans diverse communities in all four countries are:

1. Better policies on gender and identity documents and other records;
2. Inclusion of trans specific health issues into mainstream public health; and
3. Provision of gender affirming hormone treatments and surgeries.

So, the legal and policy vacuum is viewed as the fundamental problem that needs to be rectified in order for the community to access congruent gendered identity documents which then need to be aligned with all their other official documentation. The mainstreaming of trans-specific health issues indicates a desire to be treated as a part of Key Populations with no differentiation other than in aspects such as hormones and transitional surgery that are trans-

Q2: Please check what you believe are the five most important policy priorities affecting user-friendly services for Trans diverse/gender non-conforming people in your country. Mark 5 only.	
4	Inclusion of trans specific health issues into mainstream public health
4	Provision of gender affirming hormone treatments and surgeries
3	Change in law for psychiatric evaluation and diagnosis in order to change sex.
3	Training of general health care workers on trans-specific health
2	Creation of health sites that deal only with trans-specific health
1	Provision of sexual and reproductive health commodities (condoms, contraceptives etc.)
1	Provision of trans specific mental health care
1	Provision of trans specific substance replacement therapies and counselling
1	Provision of education, screening and treatment for cancers for trans diverse community
0	Screening and treatment for HIV and other STIs
0	Provision of trans specific substance and alcohol abuse counselling
0	Provision of education, screening and treatment for tuberculosis for trans diverse community
0	Provision of trans specific substance and alcohol abuse counselling
0	Change in logistical issues at clinic level (for example pink forms for females and blue forms for males)
0	Provision of vaccinations for hepatitis for trans diverse community

specific – themselves of top priority. In sum, the trans diverse communities in the surveyed countries view the following as secondary, but nonetheless vital priorities:

4. HIV prevention, education and treatment, including PEP (Pre-Exposure Prophylaxis) for trans diverse people;
5. Access to trans diverse-sensitive health care and providing gender affirming treatment and surgeries;
6. Training of general health care workers on trans-specific health; and
7. Change in law for psychiatric evaluation and diagnosis in order to change sex.

So, given the known (or suspected) high HIV prevalence, it is no surprise that HIV prevention, education and treatment is viewed as important – but this is linked directly to the proper training of trans-sensitive health-care workers (remember that prejudice here is a significant driver of exclusion), and consequently, the ability to trans diverse-sensitive healthcare including gender-affirming treatment and transitional surgery. Also, this needs to be buttressed by improvements in trans-sensitive mental health care, particularly as an aid to gender realignment.

Lesser priorities (perhaps counter-intuitively) include the outlawing of hate crimes against the trans diverse, and the passing of progressive protective equal rights legislation, including where they are jailed.

The detail provided by the individualised responses from Botswana demonstrate that some priorities are shaped by an individual respondent's factors such as age and partner status, for example, those who marked the desire for parenting and adoption rights.

Section 6: The Trans* Experience Survey

THE RESPONDENTS

The survey received 336 responses in total. The regional analysis of the data is skewed towards Namibia, Botswana and Zimbabwe as we received more responses from these three countries than the other 2 countries (Namibia forms 34% (n=114) of the respondent population; Botswana 26% (n=92); Zimbabwe 21% (n=63), and Swaziland just 13% (n=44); Zambia only 5% (n=17); 6 did not state current country or were from other countries. The median age of the respondents was 26.8 years, with the youngest at 17 years and the oldest at 50 years.

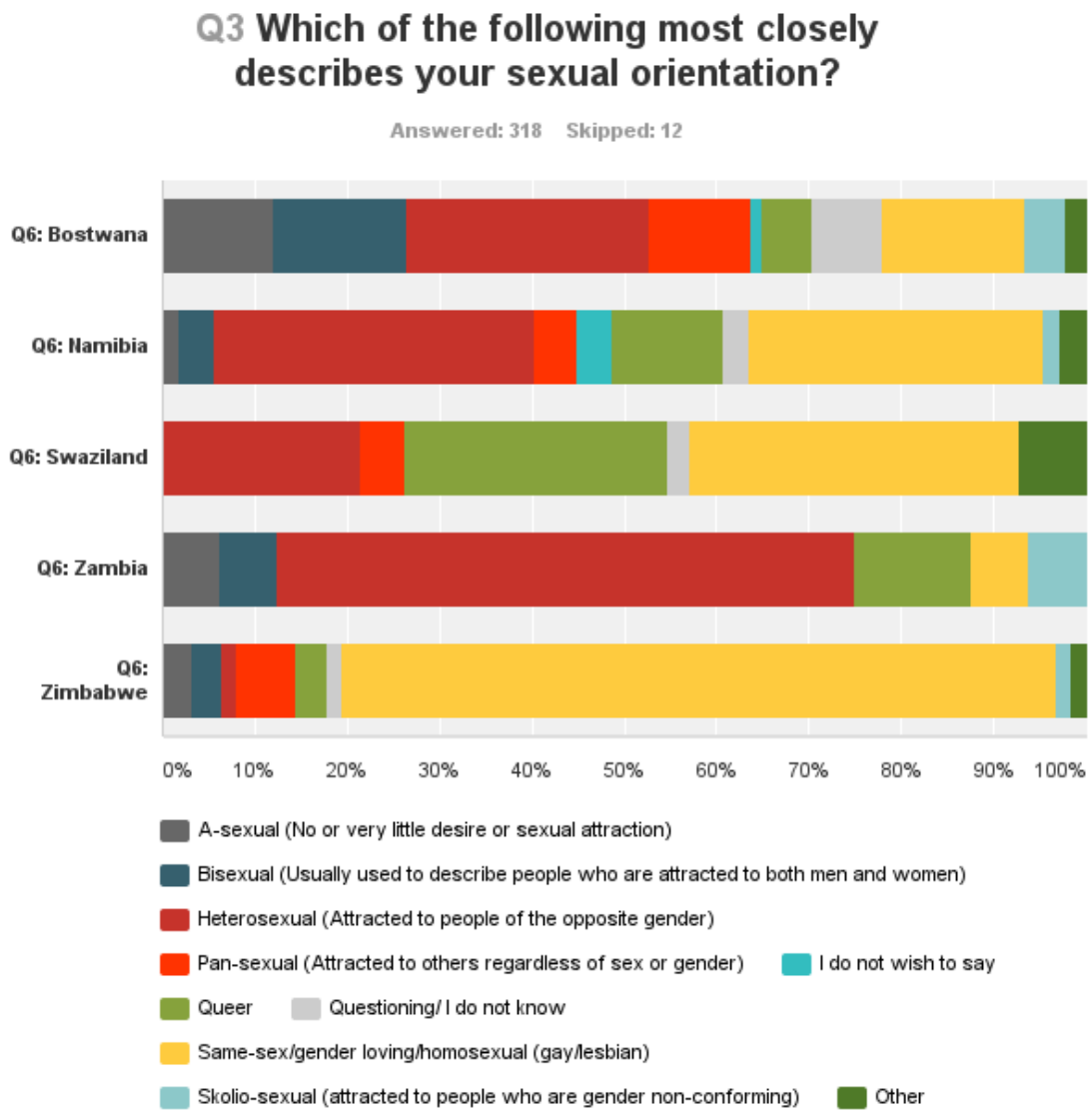
Only 10 of the 336 respondents (3%) from the four countries were assigned intersex at birth, whereas 43% marked female (n=145) and 54% (n=181) marked that they were assigned male sex at birth. The largest number identified as transwomen currently at 39% (n=130), and then 32% identified as GNC (n=107) Only 12% (n=40) identified as Transmen and then 5% (n=17) as gender-questioning. Small percentages of the other groups were: 4% woman (n=13); 3% as part time one gender and part time another gender (n=10); 2% man (n=7); 1% two-spirited (n=3); 1% ciswoman (n=3); 1% other (n=3); and 0% agender.

GENDER IDENTITY AND SEXUAL ORIENTATION

Although the research is about gender identity, the DT decided it would be interesting to interrogate the question of sexual orientation, and indeed the results are interesting. In a regional analysis, we can see that: 35% (n=112) of respondents marked same-sex/gender loving (academic estimates in the general public globally place this at between 10 and 20% usually, so this represents a high figure); 25% (n=81) heterosexual (lower than would be expected); 10% queer; 7% bisexual; and 7% pansexual. Other interesting data is 5% asexual; 4% questioning; 3% other; and 2% skolio-sexual, with another 2% wishing to not state. (n=34; n=20; n=16; n=12; n=9; n=8 respectively). This selection is naturally somewhat inflected by the individual respondent's exposure to, and level of comfort with, such terminology.

Interestingly, the percentage of self-defined heterosexual to homosexual respondents varied greatly across countries, as you can see in the chart below, where the homosexual respondents from Zimbabwe represent the overwhelmingly dominant sexual orientation, as compared to Zambia where heterosexual respondents represent the dominant orientation.

However, responses shifted again in Namibia with roughly similar sized groups of heterosexuals and homosexuals, again in Swaziland where a queer orientation was a close second to homosexual, pushing heterosexual into third place, and again in Botswana where the number of bisexual respondents was second to heterosexual, but roughly equal to homosexual – with a notably strong showing by pan-sexual and a-sexual minorities, making the country the most orientation-diverse of the five studied. This demonstration of orientation diversity by Botswana is likely linked to the more favourable position of the trans* community there as shown by the country studies.



WHAT IS LIFE LIKE FOR TRANS DIVERSE PERSONS IN SOUTHERN AFRICA?

Globally homelessness and rough living is closely associated with trans diverse people. Lack of acceptance and discrimination result in trans diverse people often being chased out of family homes, out of work and unable to pay rent, and otherwise at risk of being unstably housed. The survey showed that 5% (n=16) of respondents were homeless, although AAI would expect that this number might be lower than in reality as homeless transgender people are the least accessed by services, and least able to get support, even from the transgender CSOs that conducted this research. Added to the 5% is that 28% (n=90) responded that they are unstably housed and at risk of losing their housing (this could be because they live with a partner who might kick them out, their landlord may evict them if they discover they are transgender etc.)

Respondents stated that only 41% (n=172) were employed, well below any of the national averages: Zimbabwe 82%; Zambia 68.7%; Botswana 62.8%; Namibia 48.4%; and Swaziland 44.8%.

Respondents stated that only 41% (n=172) were employed, well below any of the national averages: Zimbabwe 82%; Zambia 68.7%; Botswana 62.8%; Namibia 48.4%; and Swaziland 44.8%.[4] 38% (n=107) of respondents stated that they had dependent children (definition 18 years or younger and reliant on respondent for basic needs). Given that only 41% are employed this poses difficulties for those who are unemployed yet being looked to for support for children. The number of children in the care of the respondents ranged between 1 and 4.

18% (n=59) of respondents had completed tertiary education, representing a statistic better than the national average in three of the five countries surveyed: Zimbabwe 13,6%; Swaziland 2,5%; and Namibia 2,4%[5]. The vast majority had completed some or all of their secondary formal education, and 25% (n=82) some tertiary formal education, and only 8% (n=27) primary school; 1% had no formal education whatsoever.

The respondents were largely single (54%; n=175), or co-habiting (20%; n=64). Only 1% were currently married, 2% divorced and 6% separated. 17% (n=55) marked other which could represent having multiple relationships, a serious relationship but not co-habiting or various other options.

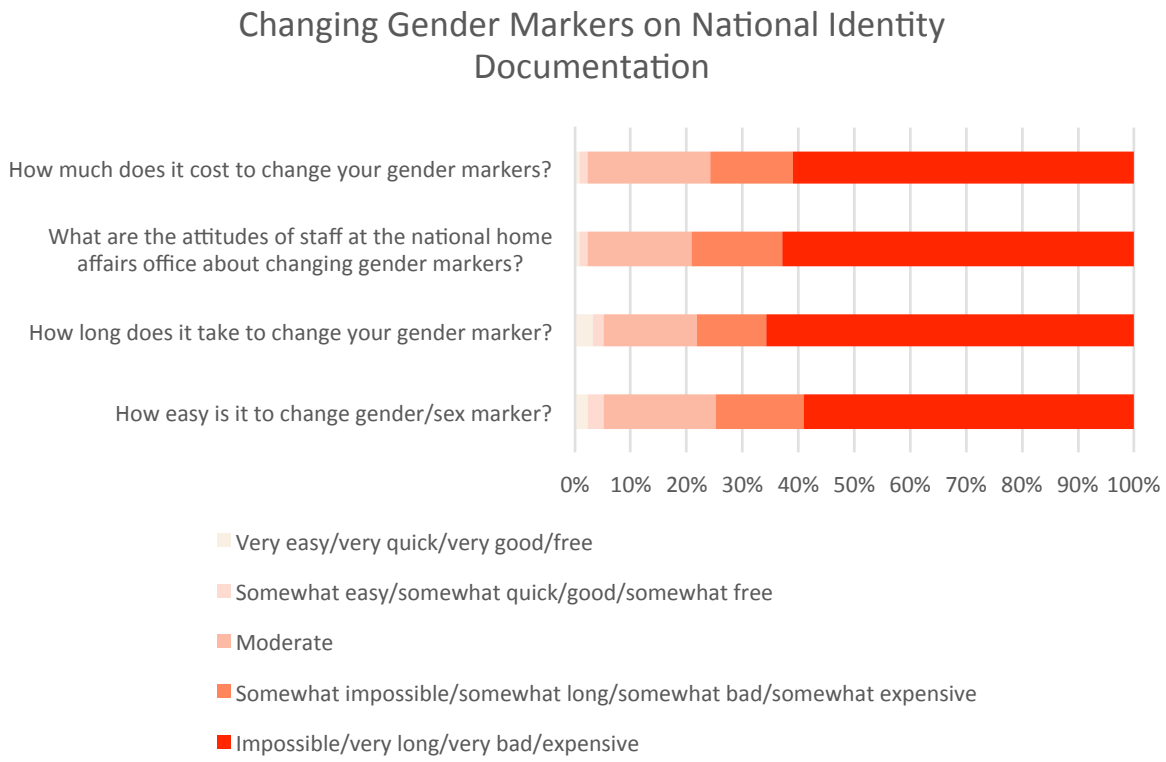
CHANGING GENDER MARKERS ON NATIONAL IDENTITY DOCUMENTS

There was no significant difference between the five countries with regard to this question. They all showed the same trends, as shown in Figure 2 below. On aggregate, 59% reported that it was impossible to change their gender or sex markers on their national identity documents, with 16% reporting it was a somewhat impossible task, 20% reporting a moderate ease, and only 3% reporting it was somewhat easy and quick, and 2% reporting it was very easy and quick. 66% reported it took very long to change such markers, 12% somewhat very long, 17% moderately long, and only 2% somewhat quick, and 3% very quick.

It appeared that a hostile attitude of national home affairs office staff was possibly one of the reasons behind this poor service experience, with 63% reporting encountering a very bad attitude, 16% a somewhat very bad attitude, 19% a moderate attitude, and only 1% reporting a somewhat good, and another 1% a very good attitude. The costs involved in changing gender markers – where possible – and including legal fees, are overwhelmingly prohibitive, with 61% reporting they were very expensive, 15% somewhat expensive, 22% moderately expensive, and only 1% somewhat free, and another 1% free.

[4] Source: Employment to Population Ratio, Africa Survey 2015-2016, Good Governance Africa. The figures are all for 2014.

[5] Source: Tertiary Graduates 1990-2013, Africa Survey 2015-2016, Good Governance Africa. The figures for Zimbabwe and Swaziland are for 2013, while the latest for Namibia are 2005; the report has no data for Botswana and Zambia.



AREAS OF LIFE MOST AFFECTED BY GENDER-INCONGRUENT IDENTITY DOCUMENTS

Figure 3 below clearly demonstrates that the area of life most affected by incongruent documentation is health (63%), closely followed by marriage (56%), education (50%), employment (40%), banking (35%), police (32%), cultural and traditional practices (31%), housing (28%), driver's license (26%), justice and the courts (24%), and foreign travel (24%).

We will examine health and police experiences in greater detail below, but regarding marriage, Swaziland reported a 71% impact, followed by Zimbabwe at 62%, Botswana 60%, Zambia 53%, and Namibia 43%. It is worth noting here the impact on divorce: Zambia (24%), followed by Swaziland (7%), Zimbabwe (5%), and Namibia (4%) – with Botswana reporting 0%, perhaps because marriages of trans diverse people are already very rare. Regarding education, Zambia reported the highest impact at 76%, followed by Botswana at 58%, Swaziland at 56%, Zimbabwe at 52%, and lastly Namibia at 38%. Regarding employment, Zambia reported the highest impact at 53%, followed by Zimbabwe and Swaziland tied at 44%, Namibia at 39% and Botswana at 38%. Regarding banking, Zambia reported a 53% impact, followed by Botswana at 42%, Namibia at 39%, Zimbabwe at 30%, and lastly Swaziland at 15%.

Clearly demonstrates that the area of life most affected by incongruent documentation is health (63%), closely followed by marriage (56%), education (50%), employment (40%).

Regarding cultural and traditional practices, the highest impact was experienced in Botswana, reporting 49%, followed by Swaziland at 46%, Zambia at 29%, Zimbabwe at 21%, and Namibia at 18%.

Regarding housing, the greatest impact was experienced by Namibia at 39%, followed by Zambia and Zimbabwe at 35% each, then Swaziland at 24%, and Botswana at 9%. Accessing a driver's license was most difficult in Zambia at 59%, then Botswana at 40%, Swaziland at 22%, Namibia at 20%, and Zimbabwe at 16%. Regarding justice and the courts, the heaviest impact was reported from Zambia at 65%, then Zimbabwe at 30%, Namibia at 23%, Swaziland at 17%, and Botswana at 16%. The impact experienced on the ability to travel internationally was felt heaviest in Zambia at 65%, Zimbabwe at 40%, Botswana at 17%, and lastly Namibia and Swaziland at 15% each.

Moderate areas of impact were experienced in accessing public benefits, life or unemployment insurance, and professional registration (all at 19%), bank card or credit card payments (18%), then national travel, child support, family planning, and public transport (all at 14%).

Regarding accessing public benefits, the greatest impact was reported in Zambia at 59%, then Zimbabwe at 22%, Botswana at 20%, Namibia at 15%, and Swaziland at 7%. When it comes to life or unemployment insurance, Zambia was most affected at 47%, then Botswana at 22%, Namibia and Zimbabwe at 16% each, and Swaziland at 15%. On professional registration, Zambia again experienced the worst scenario at 47%, Swaziland at 20%, Botswana at 19%, Zimbabwe at 16%, and Namibia at 13%. Regarding bank or credit card access, Zambia again was most problematic at 47%, then Botswana at 36%, Zimbabwe at 21%, Namibia at 5%, and Swaziland at 2%. National travel was most difficult for Zambians, at 65%, then Botswana at 19%, trailed by Zimbabwe at 2%, and Namibia and Swaziland at only 1%. Child support impact was felt most strongly in Zambia (29%), followed by Zimbabwe (17%), Botswana and Namibia (14%), and Swaziland (2%). It was felt that family planning was influenced most strongly in Namibia (22%), then Botswana (13%), Zambia (12%), Zimbabwe (10%), and Swaziland (7%). Public transport, it was experienced, was affected most strongly in Zambia (41%), then Zimbabwe (27%), Swaziland (15%), Namibia (8%), and Botswana (5%).

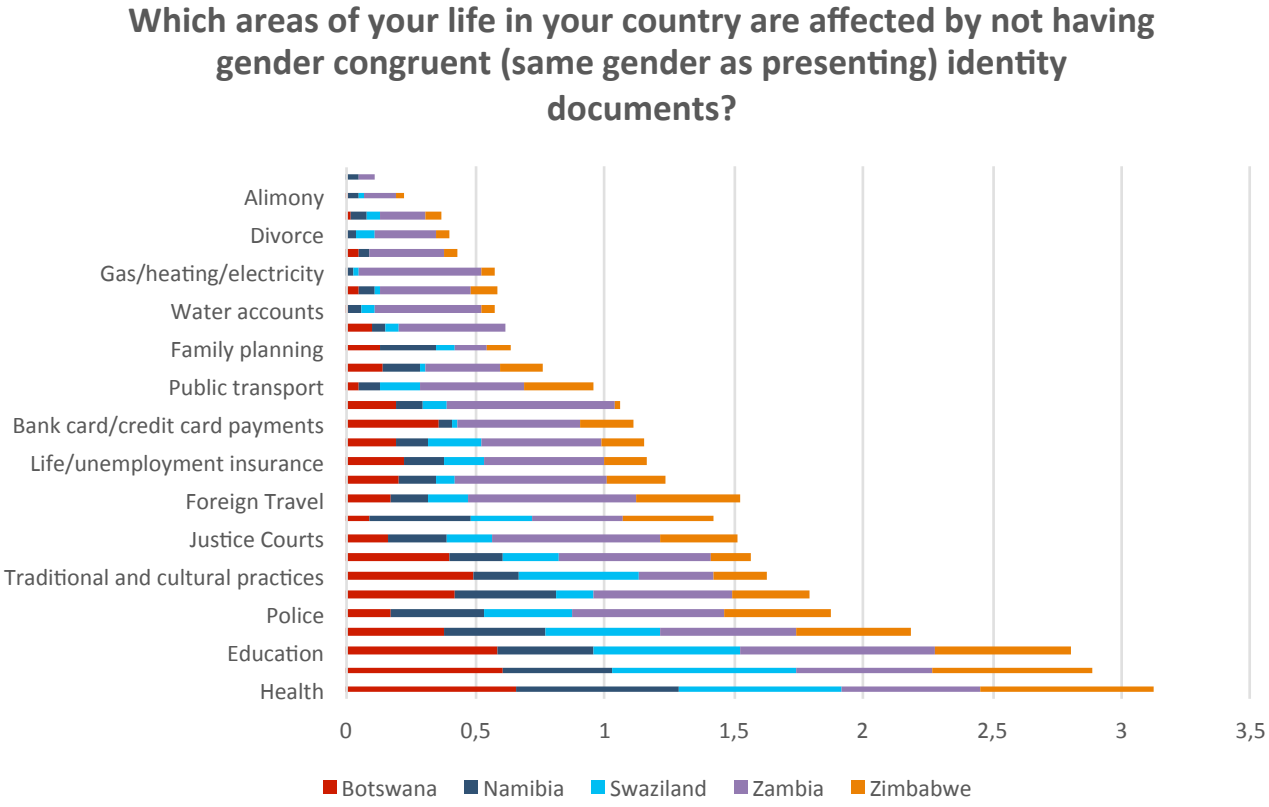
Marginal areas of impact were experienced in credit access, and vehicle ownership (both at 7%), water accounts (6%), then divorce, parcel delivery, gas or heating or electricity, and telephone or mobile phone (all at 5%), and finally alimony (3%) and internet access (2%).

Access to credit was more influenced in Zambia (41%), then Botswana (10%), and then Namibia and Swaziland together (5%) – with Zimbabwe reporting 0% (possibly because there is perhaps no access to credit there for trans diverse persons). Access to water was felt to be more influenced in Zambia (41%), then Namibia, Swaziland and Zimbabwe together (5%), trailed by Botswana (1%), while access to vehicle ownership was again more sorely affected in Zambia (35%), then Zimbabwe (10%), Namibia (6%), Botswana (5%), and Swaziland (2%). This pattern was repeated regarding access to gas, heating, and electricity: a 47% impact was reported in Zambia, trailed distantly by 5% in Zimbabwe, 3% in Namibia, and 2% in Swaziland.

Telephone and mobile phone services were most affected, again, in Zambia (29%), followed distantly by Zimbabwe and Botswana both at 5%, then Namibia at 4% - with Swaziland reporting 0% interference. 18% was reported for interference with parcel deliveries in Zambia, dropping to 6% for Zimbabwe and Namibia, 5% for Swaziland, and 2% for Botswana. Internet access showed the lowest interference, with Zambia at 6%, Namibia at 5% - and the other three countries registering no interference at all.

Outside of the critical areas of access to health, education, and employment, Botswana appears from the results to be the easiest country for the trans diverse community to live in, with Zambia being the most difficult.

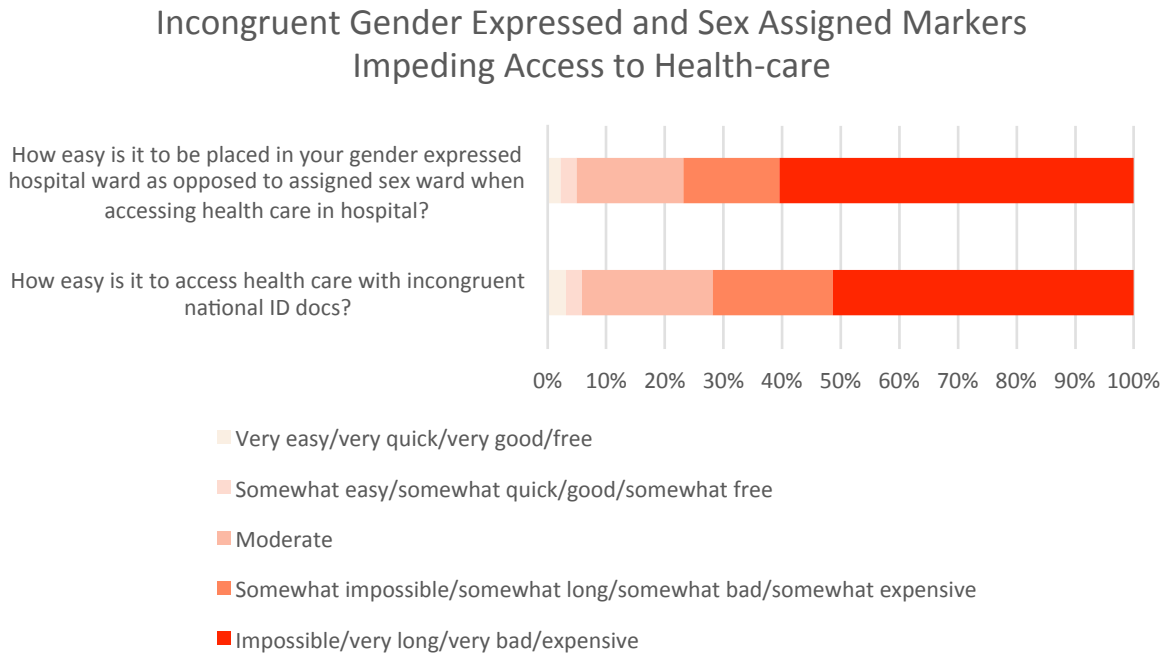
It appears from this that in general, national state and capital competencies and societal practices have the greatest impact on the trans-diverse community, while local state and capital competencies and societal practices have a lower impact. Outside of the critical areas of access to health, education, and employment, Botswana appears from the results to be the easiest country for the trans diverse community to live in, with Zambia being the most difficult.



ACCESSING HEALTH-CARE

Regarding the most affected area, access to health-care, Zimbabwe polled 67%, Botswana 66%, Namibia and Swaziland 63% each, and Zambia 53%, for the average of 62,4%. Of the total, 51% of respondents said it was impossible to access health-care if one possessed incongruent national identity documents, with 20% saying it was somewhat impossible, 22% moderately difficult, and only 3% saying it was somewhat easy, and another 3% saying it was very easy.

This had a direct impact on whether it was possible to be placed in a ward that matched one's gender expression as opposed to one's gender assignation when hospitalised: 60% said it was impossible to be accommodated in an expression-congruent ward, 16% said it was somewhat impossible, 18% said it was moderately difficult, and only 3% said it was somewhat easy, with another 2% saying it was very easy.



EXPERIENCE OF THE POLICE

Incongruent national identity documents had the strongest impact on the trans diverse community accessing policing services in Zambia (59%), followed by Zimbabwe (41%), then Namibia (36%), Swaziland (34%), and Botswana (17%). 61% (n=189) of respondents stated that police officers had not generally treated them with

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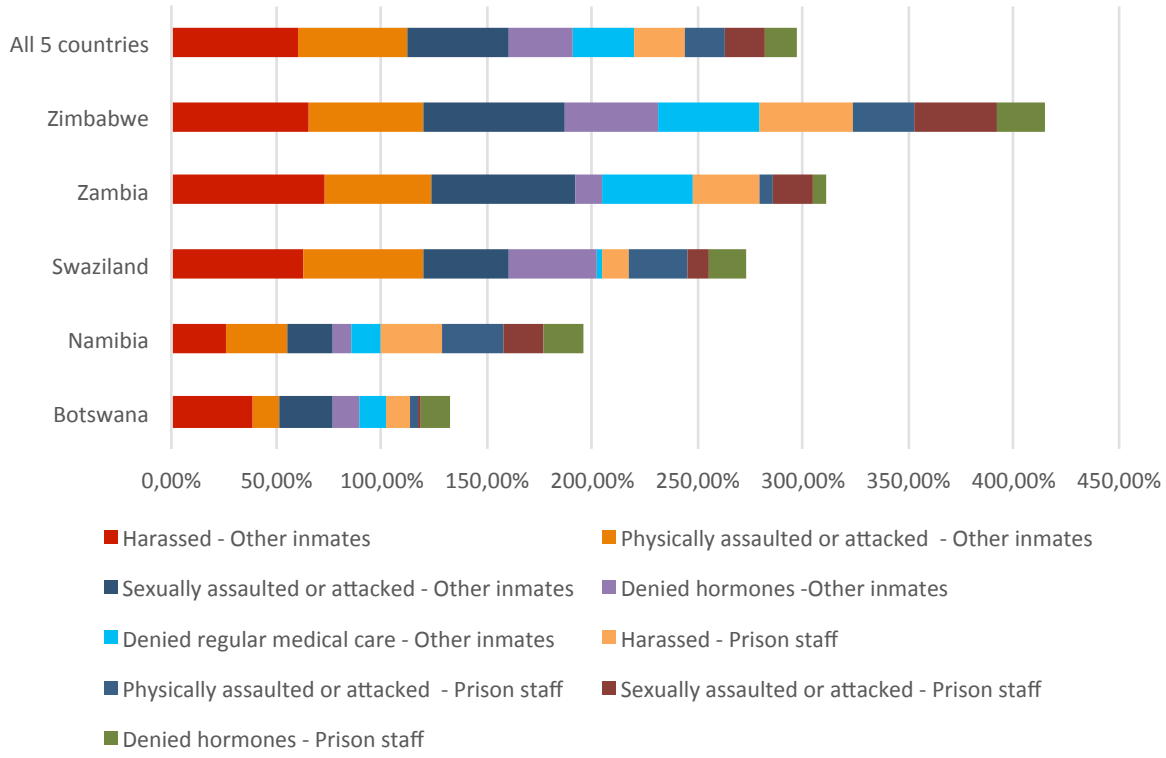
respect. 49% (n=156) stated that police officers have harassed them, and sadly 31% reported that they had been physically assaulted by police officers (n=90). Worse still is that 17% or 56 people reported being sexually assaulted by police officers. 23% or 76 people report being held in a police cell because of their being trans diverse or GNC.

Worse still is that 17% or 56 people reported being sexually assaulted by police officers. 23% or 76 people report being held in a police cell because of their being trans diverse or GNC.

31% (n=95) have been denied law enforcement services on the basis on being trans diverse or GNC. Appallingly not only are the police responsible for not protecting trans diverse people, but assaulting and sexually assaulting trans diverse people, and also denying them medical attention when necessary (20%; n=60) and the necessary documentation to access medical attention (17%; n=49). Clearly, the third most important place to begin with any improvement in rights for trans diverse people is to begin to work with the police.

Which have occured in your interactions with the police because you are trans diverse/gender non conforming?



Not surprisingly, as a result, 51% or 161 of the respondent's report refusing going to the police when necessary due to the fact of being trans diverse/GNC. 7% (n=20) reported feeling very comfortable seeking help from the police, and 6% (n=20) somewhat comfortable, versus 33% (n= 105) neutral, 21% somewhat uncomfortable (n=64) and 33% very uncomfortable seeking help from the police (n=109).

EXPERIENCES OF VIOLENCE, PREJUDICE, AND DENIAL OF CARE

Of those trans diverse respondents who had experienced jail or prison – 79 respondents answered while 263 skipped the question – 66% reported being harassed by warders and 56% by fellow inmates, 54% reported being physically assaulted by warders and 52% from fellow inmates, 64% reported being sexually assaulted or attacked by inmates and 44% by warders, 19% reported being denied hormones by inmates and 18% by warders, while 34% reported being denied regular medical care by warders and 25% by inmates.

53% of respondents reported experiencing physical violence in the past 12 months because of being trans diverse/ GNC. Yet only 24% reported it to the authorities, and only 30% received the necessary medical care. 34% of respondents reported experiencing sexual violence, including attempted or completed rape, in the last 12 months; 16% of respondents reported it to the authorities and a mere 19% received medical attention. 22% of respondents reported having experienced attempted or completed rape by an intimate partner, yet only 14% reported it to the authorities and only 17% received medical attention.

Within broader society – 320 respondents answered while only 22 skipped the question – 53% of respondents reported experiencing physical violence in the past 12 months because of being trans diverse/ GNC. Yet only 24% reported it to the authorities, and only 30% received the necessary medical care. 34% of respondents reported experiencing sexual violence, including attempted or completed rape, in the last 12 months; 16% of respondents reported it to the authorities and a mere 19% received medical attention. 22% of respondents reported having experienced attempted or completed rape by an intimate partner, yet only 14% reported it to the authorities and only 17% received medical attention.

The figures were significantly higher in terms of the respondent's lifetime experience of violence: 66% of respondents reported experiencing physical violence over the course of their lives because of being trans diverse/GNC. Yet only 29% reported it to the authorities, and only 38% received the necessary medical care. 43% of respondents reported experiencing sexual violence, including attempted or completed rape, in their lives; 22% of respondents reported it to the authorities and 22% received medical attention. 21% of respondents reported having experienced attempted or completed rape by an intimate partner, yet only 11% reported it to the authorities and only 17% received medical attention (this latter reporting at levels below the 12-month experience may mean respondents excluded the last 12 months from their lifetime experiences).

In terms of the experience of hate crimes, 33% of respondents reported having been the target of hate crimes over the past 12 months (and 40% over their lifetimes), with 24% reporting this to the authorities (and

20% over their lifetimes), and 25% receiving medical attention (and 24% over their lifetimes). Again, the under-reporting on the lifetime responses indicates that respondents excluded the last 12 months.

The general experience of stigma – prejudice, negative attitudes and abuse from others – over the past 12 months was 74% (75% over their lifetimes), with only 16% reporting it to the authorities (15% over their lifetimes): here the variance in under / over-reporting is within a single percentile error and so can be discounted. The specific experience of stigma at public clinics and / or hospitals over the past 12 months was reported by 38% of respondents (and 33% over their lifetimes), with only 19% reporting this to the authorities (and 17% over their lifetimes), and 32% receiving the proper medical attention (and 27% over their lifetimes). Again, the under-reporting pattern appears to apply. Most respondents appeared reluctant to comment on their questions, but one of the respondents maintained a defiant tone despite this, writing: "The reality is that we are part of the community and they have to live with us whether they like it or not."

45% of all respondents said they had had to teach their health-care provider about trans diverse issues when accessing health-care (338 people answered and only four skipped this and the following question). 53% respondents said and that they had at one point or another postponed or refused to get medical assistance when they were injured or sick when they needed it because of stigma and discrimination from health-care providers. 49% said they had one time or another postponed or refused to get check-ups or other preventative health-care when they needed it because of stigma and discrimination from health-care providers. 27% reported that a doctor or other healthcare provider had at some point refused to treat them because they were trans diverse / gender non-conforming.

EXPERIENCES OF RELIGION, CULTURE, THE ECONOMY, THE JUDICIARY AND HEALTH-CARE

Regarding their broader experiences, 53% of respondents reported that religion affected their ability as a trans diverse person to access gender affirming health-care, 56% reported that culture or cultural norms had the same impact, 57% reported that economic status did likewise, 55% reported that the judiciary did so, and finally 56% reported that the heath care system itself was an impediment to accessing gender affirming health-care.

There were no comments by respondents explaining these responses, but a question on other barriers to access to equality attracted a flood of responses, which can be roughly grouped into responses relating to:

a. The legal and policy environment: "The policing of LGBTI issues," "The harsh Zimbabwean laws," "Minority groups are denied their rights," "The law affects us the most," "Political and cultural barriers," "Laws and policies that do not adequately address transwoman issues," "The king and the government always utter hate speech against LGBTI," "The right to get married or adopt children and to have my own family," "Legal marriage, legal guardian[ship] of my kids, changing my gender on legal documents," "Our country is not equal," "Our

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government is ignorant," "Our law," "Adoption," "Not getting married to another female," "Our law," "I cannot get married and have to get medical prescriptions for medication," "None except the law," "No policies / strategies from government to address GIE issue," "GOVERNMENT," "OUR LAW DOES NOT RECOGNISE US," "It is illegal to be transgender in Zambia," "Policing and strategy to trans specific issues," "The law," "Our law," "No third mark in Botswana," and "THE LAW THAT DOESN'T COVER ISSUES CONCERNING TRANSGENDER PEOPLE" (bold quotes in the original responses).

b. The institutional environment: "Prisons, hospitals, police stations," "Police stations and hospitals," "That I can't get hormones and change my ID," "Police. Faith," "When you are trans you are even denied land or housing and have no word on community problems," "In places like hospitals, police stations and shops, people are discriminating against us," "The judiciary," "Justice system," "Clinical Services," "LAW ENFORCEMENT," "Treatment," "Medical," "Education: tertiary level especially from lecturers. They really make one's life hard."

c. The social environment: "Society's beliefs," "Scared to present ourselves as trans and others believe we are born a curse," "Our youth can't go out in public without being ashamed of our sexual orientation and gender identity," "Gender-based violence (verbal abuse)," "Adoption of children because we are regarded as less cultured," "Social ignorance about the transgender identity," "Social ignorance and lack of understanding," "Faith," "Because it's a Christian nation," Probably Zambia is a Christian nation," "Dress code, faith, police," "Lack of recognition and acceptance from the society we live in," "Zambia is the Christian nation," My expression and identity impedes on the standard expectations of society," "Law and faith," "Religion. Everyone makes it their point to impose their beliefs, thus overstepping and being judgemental," "Everything," "Family," "Society's perception of my being," "Religion, culture, lack of information," "Community members find it hard to tolerate," "Only faith," "Faith and dressing," "Family," "Dress code, family, public health places," "A lot," "My feminine looks," "They don't accept me," "Tradition," "Appearances: I am judged by my looks," "Look down on trans people and say names / label them," "Religious, lack of sensitisation," "Culture is strongly believed that man and women are made for each other; they view transgender as a curse," and "Zambia is a Christian nation."

d. Poverty and the economy: "No-one wants to employ a transgender person in Zimbabwe," "Socio-economic problems," "Family stress and employment."

EXPERIENCES OF SUBSTANCE ABUSE, DEPRESSION, AND DISEASE

Regarding substance abuse, 45% of respondents admitted to now or ever having misused or abused drugs or alcohol to cope with the mistreatment they experienced as a result of being trans diverse / NGC (323 answered the question and only 19 skipped it). Fortunately, fully 88% reported they had not used a needle to inject drugs in the past 12 months, with only 8% reporting that they had done so (and 4% declining to answer out of 223 responses, only 10 skipping the question); meanwhile, 90% of those did not share needles or drug injection equipment, with a worrying 5% reporting that they had. The lifetime use of a needle to inject drugs was relatively low, at 10%, with 87% saying they had never done so, 3% declining to answer, and 1% unsure.

A shocking 38% of trans diverse respondents reported having attempted suicide out of 326 responses (only 16 skipped the question).

32% of respondents (263 answered with 79 abstaining) reported their experience of seeking help from government or public health clinics and hospitals was either not good at all, 22% reported it was somewhat not good at all, 32% moderately bad, with only 6% saying it was somewhat very good, and 8% very good.

Asked whether they had been reached by HIV prevention programmes, 60% said they had, 33% said they had not, 4% declined to answer, and 3% were unsure. Asked whether messaging about HIV prevention and care addressed the respondents as trans diverse people, 38% responded not at all, 14% somewhat not at all, 24% not really, 8% somewhat, and 17% yes. Asked how comfortable they were in seeking help from public health clinics and hospitals (263 answered the question and 79 abstained), 32% responded not good at all, 22% somewhat not good at all, 32% moderately good, 6% somewhat very good, and 8% very good.

Fully 86% of 336 respondents (only 7 abstained) reported having had an HIV test in their lifetimes, with 7% reporting they had not, 6% declining to answer, and 1% stating they did not know. 64% said they had had an HIV test in the past 12 months and knew their results, with a worrying 26% reporting they had not, 7% declining to answer, and 2% reporting they did not know. Fully 75% said they knew their HIV status, 13% did not, 8% declined to answer, and 4% were unsure; and of those who knew their status (n=309), 53% reported they were HIV-negative, 13% reported they were HIV-positive, 23% declined to answer, and 11% said they did not know.

Fully 65% of respondents (304 answered, with 38 abstaining), said they had not been diagnosed with an STI in the past 12 months, 23% said they had been diagnosed with an STI, 11% did not wish to answer, and 2% were unsure.

Condom usage the last time the respondents had sex with a partner was reported at 58%, with 29% saying they had not (bearing in mind that condoms are limited to the relevant biology, which might also explain why 20 respondents skipped the question), 11% declining to answer, and 2% saying they did not know. Condom usage over the respondent's entire sexual life was significantly higher, however, at 70% versus 18% who reported they had not (the gender limitation naturally still applies; 17 skipped the question), 10% who declined

to answer, and 2% reported they did not know – the latter being a persistently small but worrying percentage in the answers to this theme. There were no responses to the question of what respondents used if condoms weren't available.

Regarding the use of lubricants during sex, 67% reported that they had, 24% that they did not use lubricants, 8% declined to answer, and 1% was unsure. If lubricants were unavailable, two respondents said they used: "Lotion;" and "Saliva, sometimes." The use of fingerdoms was a lot rarer, with 64% saying they had never used them, 25% saying they had, and 10% declining to answer, and 1% being unsure. The use of dental dams was also rare, with 62% saying they had never used them, 27% saying they had, 9% declining to answer, and 2% saying they were unsure. Sex toys were also not used abundantly, with 60% reporting they had never used one, 30% that they had, 9% declining to answer, and 1% being unsure. In the absence of sex toys, one respondent reported that they resorted to masturbation.

EXPERIENCES OF COMMUNITIES OF FAITH

Regarding their experiences with communities of faith, 58% of 337 respondents (only 5 abstaining) reported they grew up in a faith tradition, while 34% did not grow up within a faith, 3% declined to respond, and 4% were unsure. Trans diverse person's often negative experience of prejudice from the faith community had surprisingly little impact on their own expression of faith, however, with 57% of 334 respondents (7 abstaining) declaring themselves to be persons of faith today,

Of great concern because of the deep betrayal of trust involved is the 18% who reported having been physically abused by a faith leader (75% had not, and 6% declined to answer), and 11% who had been sexually abused by a faith leader (84% had not, and 4% declined to answer).

to answer and 3% unsure. The response to experiences with communities of faith (334 responses, with only 8 abstaining, and a minority "don't know" response rate of between 1% and 6%) included 29% who had been expelled from such a community (57% had not, but 9% declined to answer), 42% who had been excluded from the religious activities of that faith (48% had not, while 6% declined to answer), 53% who had had their gender identity denied in that environment (36% had not, and 6% declined to answer), and 44% who had been harassed by persons of faith (49% had not, with 6% declining to answer).

Of great concern because of the deep betrayal of trust involved is the 18% who reported having been physically abused by a faith leader (75% had not, and 6% declined to answer), and 11% who had been sexually abused by a faith leader (84% had not, and 4% declined to answer). This is worth comparing to Zimbabwe's baseline study showing that 74% of its trans diverse community has experienced sexual abuse at the hands of religious leaders. Trans* individuals further reported that fully 44% had been forced to undergo a "spiritual cleansing" or exorcism (48% had not), while 42% reported that their

families had been harassed by their faith community (48% had not).

On the positive side, 25% reported that their faith community had affirmed their gender identity and had given spiritual support (63% said they had not received such affirmation), 32% reporting that the faith community had supported their families through a process of acceptance (55% hand not received such support) and a significant 21% whose faith community had gone further and offered them political support and advocacy (69% had not).

TRANS DIVERSE PEOPLE'S TOP PRIORITIES

Asked about the five most important priorities affecting trans diverse / NGC people in their countries, the 334 respondents (8 abstaining) highlighted:

a. Protecting trans/gender non-conforming people from discrimination in hiring and at work (52%); closely followed by
b. Better policies on gender and identity documents and other records (51%); then
c. Access to trans diverse-sensitive health care and providing gender affirming treatment and surgeries (46%); then
d. HIV prevention, education and treatment for trans diverse people (42%), and passing laws that address hate crimes against trans diverse / gender non-conforming people (42%); then
e. Training health care workers at clinic level on trans specific health care (37%).

The respondents' next most important priorities in descending order were: the right to equal recognition of marriages involving trans diverse partners (35%); cancer, tuberculosis, hepatitis and STIs prevention, treatment and education for trans diverse people (34%); passing a law that protects and provides equal rights for trans diverse people (34%); educating, sensitising and training police on trans diverse issues (32%); better policies on trans diverse/gender non-conforming prisoner's rights (30%); the right of trans diverse/gender non-conforming people to parent, including adoption (29%); protecting trans diverse/gender non-conforming people from discrimination in housing (22%); and ensuring trans diverse access to justice at court (12%).

Asked what they believed were the five most important policy priorities affecting user-friendly services for trans diverse / gender non-conforming people in their countries, the top results were:

f. Training of general health care workers on trans-specific health (56%); then
g. Provision of sexual and reproductive health commodities (condoms, contraceptives etc.) (53%), then
h. Provision of trans specific mental health care (43%); then
i. Provision of gender affirming hormone treatments and surgeries (41%), then
j. Screening and treatment for HIV and other STIs (40%), and change in logistical issues at clinic level (for example pink forms for females and blue forms for males) (40%).[6]

[6] Data note: A technical error in aligning the issues to numbers in the two questionnaires may explain the low vote for the inclusion of trans specific health issues into mainstream public health – quite at odds with its high vote in the country surveys.

The respondents' next most important priorities in descending order were: Provision of vaccinations for hepatitis for trans diverse community (38%); creation of health sites that deal only with trans-specific health (33%); provision of education, screening and treatment for cancers for trans diverse community (28%); provision of trans specific substance replacement therapies and counselling (25%); change in law for psychiatric evaluation and diagnosis in order to change sex (24%); provision of trans specific substance and alcohol abuse counselling (21%); provision of education, screening and treatment for tuberculosis for trans diverse community (16%); and inclusion of trans specific health issues into mainstream public health (2%).

What is interestesting is the alignment between trans* individuals' priorities and trans* organisational priorities. For instance, comparing the top five priorities for trans* individuals to those of trans* advocacy organisations: **a)** protecting trans/gender non-conforming people from discrimination in hiring and at work was the top trans* individual priority – but was not mentioned by the organisations; **b)** better policies on gender and identity documents and other records was the second-most important priority for trans* individuals – and the first-most for their representative organisations (this represents a case in which the two groups are aligned); **c)** access to trans diverse-sensitive health care and providing gender affirming treatment and surgeries was the third-most important priority for trans* individuals – but rated fifth for their organisations; **d)** HIV prevention, education and treatment for trans diverse people was their fourth-most important priority – and also rated fourth for their organisations; on par with this, passing laws that address hate crimes against trans diverse / gender non-conforming people was also the fourth priority of the trans diverse – but didn't rate a mention by their organisations; then **e)** Training health care workers at clinic level on trans specific health care was the fifth priority for trans* individuals – but was not rated by their organisations.

Even in terms of policy priorities, there were only two points of agreement: Training of general health care workers on trans-specific health was top policy priority for the trans diverse – but sixth for their organisations; and the provision of gender affirming hormone treatments and surgeries was the fourth policy priority for trans diverse individuals – but rated third for the organisations.

Top individual policy concerns such as the provision of sexual and reproductive health commodities, the provision of trans* specific mental health care, screening and treatment for HIV and other STIs, and changes in logistical issues at clinic level were not seen as important by trans* advocacy organisations, whereas top organisational policy concerns such as the inclusion of trans* specific health issues into mainstream public health, and the changes in law for psychiatric evaluation and diagnosis in order to change sex, did not appear on the radar of individual trans persons.

Section 7: Key findings

A) LEGAL & POLICY VACUUM:

There is much commonality among the experiences of trans diverse people in the four countries studied. In particular, the almost universal inflexibility of the bureaucracies in recognising the very existence of the trans diverse community has deleterious effects such as preventing changes to gender markers in state identity and other official documentation to a gender-affirming status, which presents perhaps the most significant barrier to trans diverse people accessing state services, healthcare and education in particular, but also non-state aspects of life such as housing, sports and employment. The theoretical constitutional equality of all citizens falls far short in reality for the trans diverse. The five communities are very clear in their desire to gain policy inclusion in order to mainstream their access to health, legal and other services, and legal documentary recognition of their gender alignment, which has direct implications for their dignity, not to mention their access to proper employment, leisure, and resources.

B) INVISIBILITY & ABUSE:

The general invisibility and lack of understanding of the trans diverse as a distinct community separate to the LGB and MSM communities means that all five governments and societies have large "blind spots" when it comes to the trans diverse, which ignorance in turn enables anti-trans discrimination, and abuses including life-threatening hate crimes to proliferate and go unnoticed. Specifically, the unclear legal status of the trans diverse often leads to its persecution under outdated colonial-era sodomy laws, but also more generally allows its persecution by institutions and individuals because the abuses are not recognised, reported or tracked and so the perpetrators have impunity.

C) PERPETRATORS OF PREJUDICE:

It is of concern especially that of the social institutions expected to uphold ethical standards, the Christian church – especially its charismatic / evangelical denominations – is at the forefront of driving prejudice against the trans diverse communities, a position with no sound psychological, biological or theological understanding. It is very telling that the empirical data from Zimbabwe's baseline study shows that 74% of its trans diverse community has experienced sexual abuse at the hands of these self-same religious leaders. The misuse of this chauvinistic (and hypocritical, not to mention un-Christian) religious sentiment by politicians to score electoral points needs to be made politically unviable as an assault on the humanity of members of the collective community. For Swaziland, although no empirical data was presented, sexual abuse appears to occur most often at the hands of family members.

Abuse at the hands of police is perhaps unsurprisingly widespread (with the welcome exception of Botswana) – but it must be noted that some of this is driven by complaints raised by the cis-normative community and that the police are often required to enforce outmoded laws. An ameliorating fact is that sympathetic police and judicial officers are able to exercise a degree of discretion when dealing with trans diverse accused. Lastly, the ignorance of non-sensitised health-care workers has made them one of the most damaging drivers of prejudice and abuses – which is in direct contradiction to the ethics of the profession and of the Hippocratic Oath. This latter source of abuse is of particular concern because of the intimate and potentially intrusive environment within which health-care workers operate, so the psychological impact of abuses here is likely very grave.

D) SELF-ACTUALISATION:

One of the reasons for this almost total lack of positive experience at the hands of the state and society is that the trans diverse communities themselves have only very recently started organising, making their voices heard, and advocating for progressive changes to laws and policies affecting them. The newness of this experience of building platforms appears to extend as far as the trans community struggling to find an adequate lexicon for their own self-descriptions, and self-actualisation, and is strongly underscored by the impoverished position of both trans diverse individuals and their advocacy organisations.

E) TRANS MAINSTREAMING:

The trans diverse advocacy organisations in the four countries concretely desire the mainstreaming of their legal, policy and health concerns, into national dialogues and reforms within a universal human rights framework (and especially as an extension of the Key Populations interventions), that yet recognises their specific nature regarding the need for safe social spaces and protective legislation, as well as transitional hormone therapy, psychological support and realignment surgery. Regarding this specificity at clinics and hospitals, the desire is for the sensitisation of health-care workers, and for the provision of affordable and accessible services – but in some cases also a desire for trans-exclusive health services/clinics.

F) MISALIGNMENT OF INDIVIDUAL AND ORGANISATIONAL PRIORITIES:

On reflection, this result is perhaps not surprising in that trans* individuals expressed more immediate concerns such as protections in terms of access to employment and against hate crimes, or trans* sensitive training and logistical issues at clinic level, whereas their advocacy organisations naturally focused on broader environmental issues such as trans* mainstreaming. But it is still of concern, that even at policy level, there is a disconnection between the trans* individuals and their advocacy organisations – with the outstanding exception of gender-congruent identity documentation, the lack of which this research identified as the key concern of both groups, and access to health care, and egalitarian treatment by the police, judiciary, traditional authorities, banks, and civil servants as the foremost issues affected by one's trans* status.

G) PUBLIC AWARENESS & CONSULTATION:

Awareness alone can prove a double-edged sword as the experience of Zambia in the wake of Ban Ki-moon's visit demonstrates, because it might merely expose a previously secretive community to unwanted and hostile public scrutiny. This ties directly in to the trans diverse demand that any and all interventions be done only within a framework of detailed prior consultation with the affected communities.

H) SELF-RELIANCE:

While the necessary resort to innovation in accessing hormones, heath care and other services is an indicator of the marginality of the communities, it should also be looked on as a strength, a sign of resolve in terms of desiring to manage their own health care. In fact, the general quasi-criminalisation of the community has created a demi-monde that, however fragile and open to abuse (especially those engaged in sex-work), has had to develop a high degree of self-reliance and survival skills, which should not be underestimated. That said, the communities desperately need powerful allies in the legal, NGO and other sectors.

Section 8: Recommendations

1. TRANS* COMMUNITY FOREGROUNDING:

The entire field of proposed interventions in favour of the trans diverse communities must be understood not just in terms of the marginalisation and exclusion of the trans diverse, but also in terms of the pressures on the community of a steep learning curve regarding their new-found visibility and the vulnerability associated with that. The community must be recognised as one that has often deliberately been driven by society and the state into a twilit semi-criminal, or littoral, existence that undermines their equality, dignity and human rights, all of which need urgently to be restored. But the community must not be seen as solely victims of external forces; their own agency must be foregrounded – especially regarding consultations on all matters affecting them. Their specificity in relation to the LGB and cis-normative communities must be recognised in a non-prejudicial manner, as must identity and desired outcome differentiations within their community.

2. DATA COLLECTION:

Better quality data needs to be collected on trans* people's access to health, education, employment, issues of stigma and violence amongst many other issues. "Know your problem, to know your response" is the perfect phrase here. Programming without data could be wasteful of the ridiculously resources available to the trans* movement at this time. Bodies such as the United Nations and the African Union Commission need to lead on collecting data and making it an imperative at all levels and in all spaces.

3. POLICY REFORMS:

Given that the policy vacuum lies at the root of the bulk of the problems the trans diverse communities experience at the hands of officialdom, there is a pressing need to use multilateral organisations such as the United Nations and its instruments, and the international donor community and their programmes to urge the five governments to implement law and policy reforms. The most obvious starting point would seem to be to focus on ensuring the extension of Key Populations interventions beyond the LGB sector to include the trans diverse (and of course intersex) communities so that they constitute a full LGBTI suite, albeit differentiated where specific needs of the communities' demand such as gender realignment surgery. This would then necessitate clearly earmarked central government budget line-items for the trans diverse communities as a normal part of Key Populations development.

4. LEGAL REFORMS:

Given that numerous abuses of trans diverse persons' rights arise from the lack of both protective legislation, and of accessible gender-affirming identity document alteration processes, the UN and other multilateral organisations and donor organisations should urge the five governments to table an extension of their constitutional/equality legislation to cover the entire LGBTI spectrum, as well as to table legislation that outlaws discrimination and hate crimes against these communities – these latter two are of critical concern to trans* individuals in ameliorating their daily experiences of prejudice. In particular, pressure must be exerted to strike from the books the colonial-era sodomy laws; and it is suggested that stressing the non-African origin of

these laws may assist in undermining the supposedly African traditionalist stance of those who support their retention.

Most importantly, however, the trans diverse community must be legally enabled to with ease alter their gender on their foundational (birth or ID) documents, and all interlocking document sets downstream in order to ensure their treatment by officialdom as their oriented gender. It is unlikely that any country will consider introducing a third (trans/intersex) gender category, however, and this might in fact expose people so classified to targeted abuses; but this lack of option beyond a binary should in no legal sense enforce cis-normativity.

5. HEALTH-CARE EDUCATION & CAPACITATION:

Given that so many abuses occur within the supposedly protective and rights-based environment of health-care, there is an urgent need to run educational programmes for health-care workers, from porters and cleaning staff up to and including doctors and specialists, so that proper scientific understanding becomes widespread; these educational programmes need to be solidly grounded in national equality legislation, and professional ethics codes (especially the Hippocratic Oath).

Negotiations need to take place between government, trans advocates, and the health sector regarding all aspects of access to care, medicine and SRH items, and gender-aligned accommodation during hospitalisation. As part of Key Populations extension, hormonal and transitional surgery, trans-sensitive psychological care, and anti-substance abuse and anti-harm initiatives must be tailored for provision to the trans diverse communities.

6. POLICING & JUDICIAL REFORMS:

Once the preferred gender status of trans diverse persons is legitimised by policy, it should be bulwarked by an amendment to police standing orders to prevent police from harassing trans diverse persons in public – or at any time invading their homes purely on the pretext of their gender status. Negotiations need to take place between government, trans advocates, and the policing and judicial sectors regarding all aspects of trans diversity and the law, in particular regarding upholding the human rights of the communities, and regarding gender-aligned accommodation during jailing/imprisonment.

7. TRANS* COMMUNITY & ORGANISATIONAL ALIGNMENT:

Clearly further in-depth consultation needs to be undertaken between trans* advocacy organisations and the communities they serve to better align their desires in terms of policy reforms in particular, but also regarding other interventions. Poor capacity among the advocacy organisations is likely the most pressing cause of this dissonance, so donor organisations would do well to pay heed.

Particular note needs to be taken by trans* advocacy organisations of the expressed concerns of their constituents regarding protections from discrimination in the job market, and against hate crimes, and for the provision of practical support, training, and logistical

reform at clinic level – issues that scored low on their organisation's expressions of priority. Narrower trans* individual concerns that revolve around specific "domestic" issues such as the expressed need to raise families should not be eclipsed by advocacy officers in their focus on broader "societal" issues such as the need for gender-congruent documentation.

8. PUBLIC CAMPAIGNS:

There is a need to broaden the support for the communities especially among progressive NGO, legal and social circles – so as to defeat via public campaigns the chauvinistic notion that to be trans diverse is "un-African." In particular, there clearly needs to be an initiation of national dialogues between government, the trans diverse communities and their legal and other allies, and national religious leadership bodies to bring an end to the prejudiced and persecuting stance of the churches towards the trans diverse by educating communities of faith on the natural origins of trans diversity. Accepting church (and other faith) leaders should then be co-opted to drive anti-discriminatory campaigns among their peers, their congregations, and the broader public.

There would also appear to be a need for trans-sensitive training for families raising trans diverse children. A caveat arises however from the wave of prejudice generated in Zambia after Ban Ki Moon's well-intentioned but ill-informed pro-trans* statement: public campaigns need to be very carefully researched in advance, and properly grounded in reinforcing anti-prejudicial aspects of both traditional and modern culture in specific countries, regions, settlements, and even communities within them.

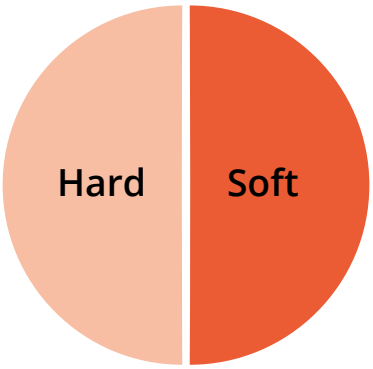
9. FUNDING REQUIRED:

Lastly, the trans diverse communities in the four countries require a significant injection of funding for their organisations and for all of their programmes such as the necessary public human rights awareness campaigns and health-access advocacy, as well as for anti-discriminatory law reform campaigns, for self-actualisation support, and for bridging programmes to enable the trans diverse to complete their education and access decent and secure regular employment.

Section 9: Methodology

MULTI-PRONGED RESEARCH

Due to the dearth of data on trans diverse people and their situation regarding rights and heath access in East and Southern Africa, the situational analysis required two questionnaires in order to gather the data required. One questionnaire was completed by country trans organisations, and the second was completed by trans diverse individuals in each country. The rationale behind this was to gather two types of information: info which is readily available and is factual or objective and frequently quantitative or "hard", and the second form of information which is subjective, experiential or personal or "soft".



The Elements of the Research	CSO Questionnaire	Individual Questionnaire
Element 1: legal & policy environment		
Element 2: Quantitative Health Data	Hard	
Element 3: Qualitative Health Data	Hard	
Element 4: Gender Affirming Healthcare	Hard	
Element 5: Citizenship	Hard	
Element 6: Law Enforcement	Hard	
Element 7: User Friendly Services/Priority rating	Hard	
Element 8: Trans* Experience Survey		SOFT

BEYOND THE AMBIT OF THIS WORK

- Size estimations (hoped to be in a second phase of this work).
- This research focusses solely on trans-identified people and intentionally does not include Intersex people or people who perform traditionally gender-fluid roles who do not identify as trans*, because the scope of work, length of questionnaire etc. would be significantly bigger and thus affect the ability of this project to be efficient with time, resources and coverage.

IMPLEMENTATION GUIDE AND QUESTIONNAIRE

The Implementation Guide was developed by AAI to help understand the rationale behind each indicator, as well as what each indicator measures and the data limitations. The questionnaire was developed at the same time for use for quality data collection.

The questionnaire was developed with a Development Team comprised of country level constituencies. Some questions have been sourced from the 2014 UNAIDS Guidance Note on Services for Transgender People, the US Trans Survey, the AAI AMSHeR African MSM Health Scorecard and the Zimbabwe Trans Women Survey.

DEVELOPMENT TEAM

AAI almost always uses Development Teams on our scorecards. The Development Team (DT) is asked to assist AAI in developing a rating. The DT on AAI scorecards are usually top experts in their field of work. The DT is central in developing the rating and the DT members will be asked to comment on drafts as the work progresses. DT members will receive acknowledgements for their work on the research project, in the reports and related materials, in print and on the website.

Selection process, criteria and composition is based on an invitation only basis to members that head up the trans diverse civil society organisations in the region only.

The Chatham House Rule applies throughout our discussions: information gained can be used, but neither the identity nor the affiliation of the source may be revealed. DT members will not receive any financial compensation for their engagement.

Members of the AAI GDX Development Team

- Zimbabwe - Ricky Nathanson: Sexual Rights Centre
- Zambia - Daniel Kakoma: Trans Bantu Zambia
- Zambia - Foster Chibwe: Friends of Rainka
- Botswana - Sputla Refilwe Mogorosi: Rainbow Identity Association
- Botswana - Mpho Tekanyo: HER (Health Empowerment Rights)
- Namibia - Deyoncé /Naris: Outright Namibia
- Lesotho - Lieketso Dk Kokome: Peoples Matrix
- Swaziland - Melusi Simelane and Veli Madau: Rock of Hope
- South Africa - Immaculate Mugo, Tshepo Kgositau, and Tahila Pimentel: GenderDynamiX

PARTICIPATORY ACTION RESEARCH WORKSHOP FOR DT

Participatory action research (PAR) aims to use the target community as co-researchers and in so doing not only builds the capacity of the community, but allows for better quality data and analysis. PAR is focussed on 3 major areas of integration: Participation, Action and Research. This means that self-investigation is at the core of the process, revealing analyses that would otherwise not be apparent. By its very nature it creates knowledge generation through self-reflection on oneself and one's experiences, rather than knowledge collection by outsiders.

Research in the Southern African region is increasingly being done by LGBT solidarity organisations, and can be done in a best practice, inclusive, participatory and capacity building model (Participatory Action Research) or it can be done in an "othering" model that sees the LGBT research subjects as items for inspection and interpreting.

This latter attitude, approach and behaviour further ingrains stigma, discrimination and feelings of hostility between LGBT and non-LGBT individuals, civil society organisations and academic institutions. It also, very importantly, leads to research findings that are flawed as the methodology is in and of itself erroneous.

This project uses a PAR approach, and as part of that the Questionnaire and the Report will be co-developed with the trans diverse advocacy organisations from the 10 African countries being studied, and who are also in turn the Development team members. A workshop was held on 8 October 2015, in Cape Town so that the constituencies could feed into the research project, and at the same time learn about how to conduct research.

The Questionnaires were completed at country level by national trans diverse organisations and trans diverse people. This step is very important and fits very closely with AAI's use of the PAR model as well as the AAI Framework Step 2: Dialogue. The impact of collaborative and collective input creates significantly better buy-in and ownership, and thereafter use of the scorecard as an advocacy tool.

The fact that the national trans diverse civil society organised the completion of the questionnaires also ensures that concerns around safety and security are managed by the local experts and not interlopers from outside. Country level teams who hosted, facilitated and led on completion of questionnaires at country level are very valuable and make the reach of the scorecards much greater.

AAI then used the data collected to analyse and produce the scorecard. AAI cleans and often has to validate and verify some of the data. When the data is considered satisfactory, AAI then does the analysis and produces the draft scorecard. This draft was then sent back to country level for feedback, before the final version was completed.

IN-COUNTRY RESEARCH LOGISTICS

As a result of the PAR Workshop with the Development Team the following commitments and decisions were made with regard to methodology and in country research logistics.

Questionnaire 1 CSO Questionnaire would be completed by national trans diverse civil society organisations, either in one meeting or by passing the document in a round robin to experts in country.

Questionnaire 2 Personal Experience Questionnaire would be completed in a number of ways:

1. Paper Self-administered: to offer the confidentiality that many respondents may require.
2. Online Self-administered: to offer even more anonymity to respondents.
3. Paper Face to face completed: to ensure that sufficient questionnaires have quality data (data quality compromise is the first concern with self-completed questionnaires).

The project aimed to have between 50 and 100 completed quality questionnaires from each country by 31 January 2016. This process took longer than expected and fewer total questionnaires were submitted with the survey receiving 336 responses in total: Namibia with 114, Botswana 92, Zimbabwe 63, Swaziland 44, and Zambia only 17; 6 did not state current country or were from other countries.

Respondents in country who did paper questionnaires were paid the equivalent of 50 ZAR for participating in order to cover sundry expenses incurred.

DATA LIMITATIONS

As part of the analysis AAI interrogates the limitations of the data, examining how it was collected, by whom, where, and when for example. All this info and other available information guides the analysis of the data and conclusions of the scorecard. The data included is often either United Nations or national survey data. We often examine policy and legal environments, budgets and financing expended, service provision/programming being done, and implementation and impact.

The regional analysis of the data is skewed towards Namibia, Botswana and Zimbabwe as we received more responses from these three countries than the other 3 countries (Namibia forms 34% of the respondent population; Botswana 26%; Zimbabwe 21%, and Swaziland just 13%; Zambia only 5% and 1% South African (the last may be an error made during interviewing).

SCORECARD GRADES

AAI places countries in five broad 'grades', from A to E as a means to indicate how they are performing in response to human rights needs. The grade is based on the percentage reported by the country according to the following formula: A (81-100%); B (61-80%); C (41-60%); D (21-40%); E (0-20%) – from A (very good) to E (very poor). With regard to government-reported data: If a country has not reported on a particular data point then the score will be marked as ND for No Data and because the value of knowing what the circumstance of your situation is, is paramount to informing and constructing your response, these indicators are given a numerical value of 0.

81-100 %	A
61-80 %	B
41-60%	C
21-40%	D
0-20 %	E
No data submitted = 0%	ND

Conversely though sometimes the lower the percentage, the better the health response is. For example, this kind of situation happens for example when we examine HIV prevalence. We want lower percentages.

0-5 %	A
6-10 %	B
11-15%	C
16-20%	D
>20%	E
No data submitted = 0%	ND

Section 10: Acknowledgements

We would like to thank all our regional trans partners that contributed to this initiative; it goes without saying that many of the partners invested their own resources beyond the ambit of this grant to ensure the successful completion of this initiative.

We thank the Rock of Hope in Swaziland, Health Empowerment Right and Rainbow Identity Association both in Botswana, Trans Bantu Zambia, Out-Right Namibia, the People's Matrix in the mountain kingdom of Lesotho, Sexual Rights Centre in Zimbabwe for the tireless effort you have invested in seeing the fruition of this initiative.

This exercise would not have been possible without the great support from The Arcus Foundation who continue to invest in trans organising, advocacy and programming in the region. Lucinda van der Heever and Phillipa Tucker you were amazing to have worked with and we are deeply grateful for all the tireless efforts you and the AIDS Accountability International team are the true definition of what a partner is and we look forward to all our future collaborative work in enhancing research and evidence generation for and within the trans diverse and gender diverse community. Credit for data cleaning, analysis and report writing goes to Michael Schmidt and Phillipa Tucker.

This initiative would not have been successful without the coordination team at Gender DynamiX; Busisiwe Deyi and Immaculate Mugo you were a great support team on the formulation of this exercise and your contributions were absolutely useful. We would like to send our deepest gratitude to Tshepo Ricki Kgositau who was the lead coordinator for this exercise; Ricki your work has not gone unnoticed and the trans diverse community will continue to benefit from the results of this exercise for generations to come.

This exercise kicked off with a literature review to assess what information was already available on the public domain regarding trans diverse persons in the region. Tahila Pimentel you did an amazing job at putting together this literature review and we can never thank you enough for it; you rock.

We had the honour of having an Advisory Committee that sacrificed hours going through the various drafts of this literature review from inception to completion. Dr.Mzikazi Nduna, Marie Ricardo, Dr.Jane Bennet, Rouzeh Eghtessadi, Dr.Arnaud de Villiers, Sis.Fikile Vilakazi, Nthabiseng Mokoena, Chris McLachlan you all were a back bone to this monumental work and we wish to strengthen our relationship with you all as your support enables us to reach for higher ground in all the work we do.

Finally we wish to thank one of the most incredible resources we have as an organization and a movement; Dr.Zethu Matebeni at the University of Cape Town who provided free consultancy and strategic guidance through the design process and implementation of this whole exercise. Zethu we would not have reached this far had it not been for all the hours we sat with you in your office and the extended hours spent on phone calls seeking your guidance; you are imbokodo yethu and we look forward to more work with you in the future.

And to the trans diverse and gender diverse persons in all the 6 countries where this exercise was piloted

in Botswana, Namibia, Lesotho, Swaziland, Zambia and Zimbabwe who opened up their lives to this exercise; we will ensure that the findings of this exercise go a long way in improving the state of all our lives to actualize all our human rights and access various services in all or respective countries. Without all your input this exercise would not have been the success it is, this report is a great step in us changing laws and policies around our region to ensure that all gender and trans diverse persons live dignified and fulfilling lives in future.

Section 11: Creative Commons

AIDS Accountability International follows the recommendations provided by Creative Commons (creativecommons.org) to stimulate and facilitate the dissemination of the ratings and other tools we develop. Therefore, AIDS Accountability International under this license gives you the right to remix, tweak, and build upon our work non-commercially; as long as you credit us and that you license your new creations under the identical terms. Others can download and redistribute this work just like the by-nc-nd license, but they can also translate, make remixes, and produce new stories based on our work. All new work based on ours will carry the same license, so any derivatives will also be non-commercial in nature.

Section 12: Feedback

Michael Schmidt, activist, journalist and researcher, provided the principal data analysis in this report. Phillipa Tucker, Co-Founder and Research and Communications Director at AIDS Accountability International supported with strategy, analysis and editing. Partner trans organisations provided input throughout the project, principally in designing the questionnaire content, and performing the field research, but also in providing feedback into the final draft of this report.

Every attempt has been made to ensure the accuracy of this report but any errors or omissions are our own. The author and AAI welcome any feedback, comments, and/or corrections on the content.

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Section 13: Definitions

Gender and sex

The term 'sex' refers to biologically determined differences, whereas 'gender' refers to differences in social roles and relations. Gender roles are learned through socialization and vary widely within and between cultures. Gender roles are also affected by age, class, race, ethnicity, and religion, as well as by geographical, economic, and political environments.

Biological Sex

Is defined by primary and secondary sex characteristics identified at birth. 'Sex' refers to the biological and physiological characteristics that define men and women.

Gender

Refers to the socially constructed roles, behaviours, activities and attributes that a given society considers appropriate for men and women. To put it in another way – male and female are sex categories, while masculine and feminine are gender categories.

Gender Identity

Refers to an individual's innate sense of being male or female, man or woman, both or neither. It usually, but not always, matches the gender expected of the person's sex assigned at birth. However, in the case of trans diverse people, their innate gender identity often does not match the expected gender of the sex assigned to them at birth.

Gender expression

Gender expression Is how one demonstrates and showcases their gender of identity through the ways they dress, behave, carry themselves and interact socially.

Gender diversity

The range of different gender expressions that spans across the historically imposed male-female binary. Referring to "gender diversity" is generally preferred to "gender variance" as "variance" implies an investment in a norm from which some individuals deviate, thereby reinforcing a pathologising treatment of differences among individuals.

Gender non-conforming (GNC)

Refers to a gender identity and expression by an individual which does not match typical masculine or feminine gender norms.

Sexual Orientation

A person's lasting emotional, romantic, sexual or affectional attraction to others (heterosexual, homosexual, pansexual, bisexual or asexual. This project has nothing to do with sexual orientations such as being gay, lesbian or bisexual but deals instead with gender identity and expression.

Trans*

Trans* is an umbrella term that includes all the various identities within the transgender spectrum: transgender,

agender, transsexual, genderfluid, crossdressers, third gender, genderqueer, non-binary, genderfuck, genderless, non-gendered, two-spirited, bigender, and transman and transwoman.

Trans diverse

This term is also an umbrella term for people who have a gender identity, and often a gender expression, that is different to the expected gender of the sex they were assigned at birth by default of their primary sexual characteristics. It is also used to refer to people who challenge society's view of gender as fixed, unmoving, dichotomous, and inextricably linked to one's biological sex. Gender is more accurately viewed as a spectrum, rather than a polarised, dichotomous construct. The broad term also encompasses crossdressers, transgender people, gender benders, transsexuals, genderqueers, people who are androgynous, gender fluid and those who defy what society tells them is appropriate for their gender.

Trans diverse people can be heterosexual, homosexual, bisexual or asexual. The word "trans diverse" has increasingly gained momentum as an alternative to "trans *" to indicate rejection of the hegemony of the global North in dictating the language used to describe the identities and experiences of trans diverse people. The terms trans* and trans diverse are used interchangeably in this report to demonstrate an inclusive attitude, but without also diminishing the fact that rights, circumstances, needs and priorities differ amongst people.

Transgender man / Transman

A person who was assigned 'female' at birth, but identifies as male. Such a person is also referred to as "female-to-male" (FtM) trans person. Male pronouns should always be used in reference.

Transgender woman / Transwoman

A person who was assigned "male" at birth, but identifies as female. Such a person is referred to as a "male-to-female" (MtF) trans person. Female pronouns should always be used in reference.

Transphobia

This terms refer to the fear of, rejection of, or aversion to anybody on the basis of them being or perceived to be trans diverse. These phobias are often expressed as stigmatizing attitudes or discriminatory behaviour

Transsexual

A trans diverse person in the process of seeking or undergoing some form of medical or surgical treatment to bring their body (sex characteristics) and gender identity into closer alignment. Not all trans diverse people wish to or undergo sex/gender reassignment procedures.

OTHER USEFUL TERMS

Cisgender / Cismen / Ciswomen

People whose gender identity matches their sex at birth. This has a more positive connotation than 'normal' or 'non-trans diverse'.

Intersex

A term referring to a variety of conditions (genetic, physiological or anatomical) in which a person's sexual and/or reproductive features and organs do not conform to dominant and typical definitions of "female" or "male". Such diversity in sex characteristics is also referred to as biological "variance" a term which risks reinforcing pathologising treatment of differences among individuals.

Hate Crime

Any incident, which may or may not constitute a criminal offence, perceived as being motivated by prejudice and hate. The perpetrators seek to demean and dehumanise their victims, whom they consider different from themselves based on their actual or perceived race, ethnicity, gender, age, sexual orientation, disability, health status, nationality, social origin, religious convictions, culture, language or other characteristics.

LGBTI

An abbreviation referring to lesbian, gay, bisexual, trans diverse and intersex persons. LGB are sexual orientations, while the "T" is a gender identity and "I" is a biological variant. They are clustered together in one abbreviation due to similarities in experiences of marginalisation, exclusion, discrimination and victimisation in a heteronormative and heterosexist society, in an effort to ensure equality before the law and equal protection by the law. It is important to recognise that LGBTI persons are not a homogenous group and that their issues, experiences and needs may differ significantly in several respects.

Section 14: About AIDS Accountability International

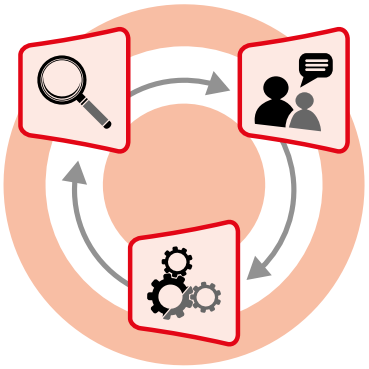
We are an independent research and advocacy think tank holding leaders accountable for the commitments they have made to respond to health needs. AAI uses research to develop various tools for stakeholders for them to use in their campaigns to advocate for better health. We conduct only needs-driven, evidence-based research and advocacy that measures performance against the commitments that have been made by governments. We also conduct our own advocacy, capacity building and monitoring and evaluation interventions to encourage those who are delivering on their commitments, identify and put pressure on those who are under-performing and stimulate constructive debate about what can be learned from different approaches and how best practices should be shared. AAI focuses on inclusion of the most marginalized in much of our work, with a focus on women, girls and lesbian, gay, bisexual, and transgender people. We have a global reach with an African focus.

AAI'S ACCOUNTABILITY FRAMEWORK

AAI use our 3 step Accountability Framework as a lens on all of our work. The framework suggests a way to ensure that the principle of accountability is translated from rhetoric into action.

Increasing accountability

AAI believes that strong and accountable leadership is necessary to ensure effective responses to health needs. We do this by increasing transparency, promoting dialogue and supporting action to improve the response.



TRANSPARENCY

Data, full, relevant, correct, accurate and unbiased data that is methodologically sound, periodically collected and collectively reported, discussed and reported as well as transparent about its failings and limitations is a vital starting point for any discussion on developing a response to health problems.

DIALOGUE

Dialogue should mean all relevant stakeholders can meaningfully and freely participate, without fear, in the discussions and debates on the delivery and performance of health by public servants, especially in relation to the commitments that they as governments and leaders have made.

ACTION

Action is necessary for public servants to improve their delivery of health, share their successes and learn from their failures making for quality, improved, sustainable and human rights based health access for all a reality. All leaders, not just governments, need to act to ensure transparency and dialogue are part of the health development process.

Notes:

Southern African Trans Forum

Hosted by Gender Dynamix with Trans Research, Education, Advocacy and Training (TREAT) as secretariat

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