Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Human Rights in Southern Africa

A Contemporary Literature Review

December 2014
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<td>Acquired Immune Deficiency Syndrome</td>
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<td>ARASA</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>CCM</td>
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<td>CSO</td>
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<td>DiDiRi</td>
<td>Diversity, Dignity and Rights</td>
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<td>GARPR</td>
<td>Global AIDS Response Progress Report</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>IBBS</td>
<td>Integrated Biological &amp; Behavioral Surveillance Survey</td>
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<td>ILGA</td>
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<td>LGBTI</td>
<td>Lesbian, Gay, Bisexual, Transgender and Intersex</td>
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<td>Men who have sex with men</td>
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<td>MSMGF</td>
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<td>National Strategic Framework on HIV/AIDS</td>
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Executive Summary

Same-sex acts remain outlawed in more than two-thirds of African countries (Dionne, Dulani & Chunga, 2014) and evidence suggests that Africans are among the least accepting of homosexuality in the world (Pew Research Center, 2013). As such, African people who do not fit into normative roles of identity and sexuality are rendered invisible and unintelligible to policy makers, health workers and communities (Livermon, 2013; Milani, 2014). In recent years, there is a context of increasing moral political salience of LGBTI in the region, as well as an unprecedented increase in the visibility of LGBTI people and organizations. This literature review focuses on the state of LGBTI human rights in 10 Southern African countries: Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. The purpose of this review is to contribute towards a strong evidence base and scientific foundation for informed programming in the region.

The legal environment for LGBTI people in Southern Africa varies greatly from country to country. South Africa is the only country in the region (and indeed, the continent) to afford people sexual orientation and gender identity (SOGI) rights. In all other countries in Southern Africa, homosexuality is illegal, either expressly indicated in the penal code, or according to common-law. However, LGBTI people are criminalized to varying degrees. In Angola and Mozambique, the punishment for homosexual acts is a short term of probation or physical labour. At the other end of the scale, in Malawi and Zambia those convicted can serve up to 14 years in prison.

One of the major recurring themes in much of the recent literature on LGBTI rights in Southern Africa is the relationship between religion, sexuality and homophobia (Epprecht, 2013c; Lee, 2013; Sandfort & Reddy, 2013; Tamale, 2014; Van Klinken & Gunda, 2012; Vincent & Howell, 2014). While it is often cited as a barrier and a challenge to LGBTI rights, it is also a potential context to foster acceptance and understanding. As a direct result of the hostile environments in which most LGBTI people in Southern Africa live, violence is a regular threat for many people in these communities. In some countries in the region, one in three lesbian women report experiences of rape, which some evidence shows is the most important risk factor for HIV infection (Sandfort et al., 2013).

Much of the violence and discrimination directed at LGBTI people – while never justified – likely stems from a lack of knowledge and understanding as well as a fear of the unknown. In many Southern African countries, gay men and other men who have sex with men (MSM) also have female partners (McNamara, 2014; Miller, 2014; Nala et al., 2014; Risher et al., 2013) and lesbian and other women who have sex with women (WSW) also have relationships with men (Matebeni et al., 2013; Poteat et al., 2014; Sandfort et al., 2013). In the African context in particular, it is important to understand sexual orientation, gender identity, and behavior as nuanced in the ways they align, or diverge, and how these may change over time to adapt to challenging contexts.

The criminalization of same-sex practices in the majority of countries in Southern Africa results in a lack of targeted health and social welfare programs (Jacques, 2014). Even in South Africa, where LGBTI people enjoy equal rights, service delivery for LGBTI people can be extremely poor. Delayed entry into care, (Cloete, Kalichman & Simbayi, 2013; Kennedy et al., 2013; Müller, 2014; Wirtz et al., 2014) and fear of disclosure to health workers (Poteat et al., 2014; Risher et al., 2013) hamper access to health for LGBTI people. Some suggest that a fore-fronted public health approach, with human rights language toned down, may help (Epprecht, 2012; Oberth, 2012).

Chief among those health challenges faced by LGBTI people is the exacerbated vulnerability to HIV. Not one national HIV policy in the region targets WSW, despite evidence which shows that approximately one in ten WSW in the region self-reports living with HIV (Sandfort et al., 2013). Further, evidence shows that MSM in the region have higher burdens of HIV than their heterosexual male peers, and the epidemic among MSM is getting worse while it is improving for the general population (Risher et al., 2013; Wolf et al., 2013).

If real progress is to be made, programs must adapt and change to disrupt the widespread perception that human rights discourse is a not-so-subtle form of Western donor “queer imperialism”. There must also be sustainable funding for local LGBTI organizations. Lastly, programs must continuously seek improved knowledge and evidence-base for more effective interventions, so that all people may enjoy equal rights in Southern Africa.
Introduction

To date, same-sex acts remain outlawed in more than two-thirds of African countries (Dionne, Dulani & Chunga, 2014) and evidence suggests that Africans are among the least accepting of homosexuality in the world (Pew Research Center, 2013). However, despite common Western tropes about Africa and homosexuality, many countries in Africa do seem to have a de facto culture of tolerance (or indifference) to homosexuality, bisexuality and transgender identities that amounts to freedom from discrimination in some cases (notwithstanding the often harsh laws and political homophobic rhetoric) (Epprecht, 2012). A disjuncture sometimes exists between the loud expressions of homophobia, on the one hand, and popular cultures that prefer to turn a blind eye to private matters around sexuality on the other (Epprecht, 2012). According to Makofane (2013), homosexuality is held by people, but silenced by taboo; it is a known, yet unspoken history. This is not to minimize the dangerous realities that many LGBTI people face on a daily basis in the region, but rather to appropriately contextualize the struggle for LGBTI human rights in the region as one with both setbacks and successes.

However, the “blind eye” and the “unspoken” is also a form of erasure, which has dangerous implications for rights, health and security of LGBTI people. Milani (2014) highlights the macro-discourses in Africa which perpetuate the view that people who are not-cisgender or heterosexual are “un-African”. As such, Africans (and particularly Black Africans) who do not fit into these normative roles of identity and sexuality are rendered invisible and unintelligible to policy makers, health workers, and communities (Livermon, 2013; Milani, 2014).

Background and Context

The idea that homosexuality is “un-African” and that it should be criminalized is widely regarded as a myth concocted by British imperialists during the colonial era (Gaudio, 2014; Han & O’Mahoney; 2014; Human Rights Watch, 2013). However, Gaudio (2014) argues that this may be true for primarily Christian and Anglophone countries, but not for non-British ex-colonies where other contributing histories which may have played a role in constructing the myth of “heterosexual Africa”. Within the scope of this literature review, which includes Angola and Mozambique, it is useful to broaden the debate beyond the discussion of British colonial legacy.

Gaudio (2014) offers three additional explanations for the opposition to LGBTI human rights in Southern Africa which are worth considering: First, Gaudio (2014) suggests that the trans-Saharan slave trade gave rise to different sexual tropes with local variations, on both sides of the Sahara. Second, others have argued that state-sponsored homophobia (particularly from Presidents Robert Mugabe of Zimbabwe and Sam Nujoma of Namibia) reflected the political anxieties of formerly ‘Frontline’ leaders who felt threatened by the end of Apartheid and South Africa’s rise as a regional hegemon (Gaudio, 2014). Third, it has been posited that opposition to homosexuality was motivated more by the competitive threat of Islam than by anticolonial fervor or other concerns (Gaudio, 2014). If religious leaders appeared to condone homosexuality, their followers may flee to other Christian churches, or leave the faith altogether in favour of Islam.

Han and O’Mahoney (2014) find that there is no difference between British and non-British ex-colonies in terms of the amount of time it takes to decriminalize homosexuality, which indicates that the “Alien Legacy” argument (Human Rights Watch, 2008; Human Rights Watch, 2013) - while useful in understanding some histories - may not be as helpful in shaping human rights advocacy going forward.

Another theme in the literature is a focus on examples of homosexual relationship and their acceptance in pre-colonial African histories (Eppechrt, 2012; Eppechrt, 2013a). These contextual debates also have their supporters and their opponents. Marc Eppechrt is one of the leading scholars on the subject of homosexual African histories. He consistently points to examples in language, such as nkotshana, hungochani, bukhontxana, which are words in Southern African languages that were invented by migrant mine workers in the late 1800s to describe brief male–male ‘marriages’ (Eppechrt, 2012). Makofane (2013) problematizes Eppechrt’s approach, cautioning that invoking this history might reinforce the perception that male homosexuality is only something that happens in places where women are not available, and that it is an aberration which is inferior to heterosexuality.
This literature review is written within the context of increasing moral and political salience of LGBTI issues in the Southern African region. In addition, this is also written in the context of an unprecedented increase in the visibility of LGBTI people in the region over the last several years (Makofane, 2013). Based on a media analysis, Grossman (2013) argues that the importance of LGBTI issues on the public agenda has increased more than threefold over the past ten years. Grossman argues that this increase in LGBTI salience in Africa is due to two main factors: i) the rapid growth of Pentecostal, Evangelical and related renewalist churches and (ii) heightened political competition as a result of democratization.

**Figure 1: News Articles Featuring LGBTI Issues**

Grossman (2013) measure salience of LGBTI issues by assessing content of newspapers in the region. His analysis shows that LGBTI issues are reported much more frequently in Lesotho, South Africa, Swaziland, Zambia and Zimbabwe than they are in other countries in the region. Malawi and Mozambique have the least news coverage of LGBTI subjects. This may also be an indication of varying levels of press freedoms in the different countries in the region. Further, Grossman finds that that only 16% of these newspaper articles have a positive tone, with the majority having a clear negative one. Mabvurira et al. (2012) present a slew of negative LGBTI headlines from Zimbabwean newspapers from 2010 to 2012.

**Source:** Grossman (2013)

**Approach and Methodology**

The importance of information gathering and data monitoring cannot be overstated. Data must be full, relevant, correct, accurate, unbiased and methodologically sound. It needs to be periodically collected and collectively discussed and reported as well as transparent about its failings and limitations. This is a vital starting point for any discussion on developing a response to health challenges (AIDS Accountability International, 2014). Particularly in the context of marginalized groups living in the challenging social, legal and political environments of Southern Africa, reliable data and accurate information – if disseminated effectively and used judiciously - makes it much more difficult for the denial of human rights to go unnoticed.

**Scope of the Review**

This literature review focuses on the state of LGBTI human rights in 10 Southern African countries: Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. It draws on multiple sources of information, including both published and unpublished reports, peer-reviewed academic journals and books. Data and statistics were also drawn from recognized international organizations, such as the Joint United Nations Programme on HIV/AIDS (UNAIDS), The International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA), Human Rights Watch, The Global Forum on MSM & HIV (MSMGF), AIDS Accountability International (AAI), AIDS Rights Alliance of Southern Africa (ARASA), among others. Wherever possible, information has been sourced from African publications, organizations and authors. Since this literature review builds on preceding documents of a similar nature, sources from 2012, 2013 and 2014 have been heavily prioritized. As such, this should be regarded as a contemporary literature review.

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1 In Angola, South Africa, Zambia and Zimbabwe, pentecostals represent more than 20% of the population (Grossman, 2013).

2 Incumbents such as Robert Mugabe (Zimbabwe), the late Binguwa Mutharika (Malawi), and Rupiah Banda (Zambia) all accused their opponents of being supportive of the homosexual agenda when their leadership was threatened (Grossman, 2013).
First-hand perspectives from LGBTI organizations and individuals in the region were also prioritized as a primary source of data, and feature throughout this literature review to emphasize the importance of voice and participation from LGBTI people themselves in demanding and claiming their human rights. Further, this literature review does not limit itself to government legal and policy frameworks, but also attempts to take into account societal attitudes wherever possible.

**Analytical Framework**

The purpose of this review is to contribute towards a strong evidence base and scientific foundation for informed programming in the region. It provides empirical examples, challenges and progress related to LGBTI human rights in Southern Africa, which should inform as well as bolster future rights-based activities and advocacy. In order to allow for both national-level and regional analysis, this literature review features “Country Profiles” for each of the ten countries, as well as regional syntheses of topics presented with a lens of comparative analysis.

As much as possible, this literature review focuses on presenting evidence for previously identified gaps in knowledge in older versions of this literature review. In many cases, recent research findings from 2013 and 2014 respond to earlier questions. For instance, developing a better understanding of religion and civil society were previously identified as knowledge gaps, for which this review offers thematic sections with recent discussions and debates in the literature.

**Limitations**

Literature reviews can never be exhaustive assessments of all the research which has been conducted on the subject matter, and hence there will always be some gaps in any analysis. For this literature review, historical context may be seen as a limitation, as its scope is especially intended to be a very contemporary assessment (2012 onwards). If information is needed on research with a wider timeframe, previous versions of the literature review may be able to provide some more historical depth.

Secondly, another limitation which bears mentioning is the lack of data on many of the themes discussed here. Primary data on the health, security, livelihoods and behaviour of LGBTI communities in Southern Africa are often scarce, incomplete or – in many cases – completely nonexistent. Within this context of a lack of information, LGBTI individuals are often rendered invisible to policymakers, service providers and other public officials who are supposed to represent their needs as citizens (Oberth & Tucker, 2013).

Lastly, it is important to be transparent about the lens through which the literature is analyzed here. It should be noted that this review takes its point of departure in a position rooted in upholding human rights, equality, and freedom – particularly in support for the rights of LGBTI people and communities. Its intention is to analyze the current science through a frame which combines these principles, with respect and admiration for the strength and resilience of many Southern African people facing a daily struggle (Kerrigan, 2013).

**Country Profiles**

The following section presents 10 countries profiles, which briefly outline the legal environment, civil society landscape and HIV/AIDS policy and progress for LGBTI populations at the national level. These profiles are not intended to be a comprehensive context of the country, but are instead aimed at providing a snap-shot overview of each national context before delving into thematic regional analyses.
Angola

Legal Environment

Section 191 Articles 70 and 71(4) of the Angolan Penal Code (16 September 1886, as amended in 1954) provide for the imposition of security measures on people who “habitually practice acts against nature” (Itaborahy & Zhu, 2014). The Penal Code was inherited from the Portuguese colonial era. The list of security measures is detailed in Article 70, including: confinement in an insane asylum; confinement in a workhouse or agricultural colony; probation; pledge of good conduct; and disqualification from the practice of a profession (Global Legal Research Center, 2014). However, there are no records of any convictions under this statute (Human Rights Campaign & Human Rights First, 2014).

Civil Society, Perceptions, Obstacles and Support

Next to South Africa, survey data shows that Angola is the second most accepting population of homosexuality in the region, albeit still at a very low acceptance rate of 34% (Dionne, Dulani & Chunga, 2014). Despite a relatively accepting social climate, the government of Angola limits the existence of non-governmental organizations in Angola, particularly ones for LGBTI people (DiDiRi Collective, 2013). According to the DiDiRi Collective (2013), Angola is the only country in the region that does not have an LGBTI support group or civil society organization working to support LGBTI rights.

Without a vibrant civil society, support for LGBTI Angolans is a challenge, however, data is emerging which may help galvanize organizations towards this cause. A recent study (Kendall et al., 2014) conducted a size estimate of MSM in Luanda, estimating a population size of 6236 MSM in the city. Further, Kendall et al. (2014) also found that MSM who experienced homophobic episodes were significantly more likely to be HIV positive, which is strong rationale for the need for programs which combat discrimination and promote human rights in the country.

HIV/AIDS

At the time of writing, Angola’s National Strategic Plan (NSP) for the period 2015-2018 is still being finalized. In the country’s current strategy – the National Strategic Plan for Response to STI, HIV and AIDS (2011-2014) - MSM are included in the list of populations at increased risk of infection (along with sex workers, migrant populations and prison populations). The NSP notes that there are available seroprevalence studies for MSM in the country, indicating that MSM account for 2.1% of new HIV infections. The NSP outlines education in schools and universities as a key strategy, committing to conducting further research on at-risk populations – including MSM – and to disseminate the findings to relevant government ministries, civil society organizations and media outlets. Lastly, the NSP includes priorities around skills development among at-risk populations, peer education among prison populations (including MSM). WSW, lesbian women, transgender and intersex people are not included in the country’s current policy (Government of Angola, 2010).

In May 2014, the government reported data on all four UNGASS indicators for MSM\(^3\) (Government of Angola, 2014). According to the government’s 2014 Global AIDS Response Progress Report (GARPR), the HIV prevalence among MSM in Angola is 8.2%. The proportion of MSM reached with prevention programs is 80.1%. The percentage of MSM who used a condom the last time they had anal sex with a male partner is 33%. Lastly, the government reported that 91.2% of MSM in the country received an HIV test in the past year and know their results. While it is commendable that the government is reporting data for these populations (many countries do not), these numbers should be interpreted with a certain degree of circumspection. The same source is cited for this data in Angola’s 2012 GARPR, yet the numbers are different. For instance, in 2012 Angola reported 29.6% of MSM had received an HIV test in the past year, making the 2014 performance of 91.2% look like a marked improvement. However, given the sources of

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\(^3\) (1) % of MSM reached with HIV prevention programmes, (2) % of MSM reporting the use of a condom the last time they had anal sex with a male partner, (3) % of MSM that have received an HIV test in the past 12 months and know their results, (4) % of MSM who are living with HIV.
data are the same for both years (a 2011 MSM study conducted in Luanda) the validity of this data should be called into question.

Botswana

Legal Environment

Section 164 of the Botswana Penal Code, on “Unnatural offences” provides that any person who has carnal knowledge of any person against the order of nature, or permits any other person to have carnal knowledge of him or her against the order of nature, is guilty of an offence and is liable to imprisonment for a term not exceeding seven years (Itaborahy & Zhu, 2014). Further, Section 167 has provisions around committing or procuring acts of “gross indecency”. Attempt is also an offense, and punishable on conviction with up to five years in prison. However, according to the Global Legal Resource Center (2014), in order for carnal knowledge to be against the order of nature there must be anal penetration by a sex organ. As such, while sodomy is an offense under this provision, homosexual acts that do not involve anal penetration with a sex organ may be legal.

It is worth noting here that Botswana’s recent Employment Amendment Act of 2010 protects LGBTI people from wrongful dismissal if based on their sexual orientation or gender identity. Botswana is one of the only countries in the region to protect this right.

Civil Society, Perceptions, Obstacles and Support

While there were reports of a surge of anti-LGBT sentiment from religious and political leaders in the country in 2013 (Kol-Kes, 2014, March 4), in 2014 Botswana supported a call from the African Union’s human rights body to protect LGBTI people and uphold their human rights (Potts, 2014, June 17). Perceptions from the LGBTI community suggest that the people of Botswana are relatively tolerant, it is only the laws and policies which discriminate: “We like to say that Batswana are not homophobic, that the country itself is homophobic” (Oberth, 2012, p. 12). Recently, a civil society organization called Lesbians, Gays and Bisexuals of Botswana (LeGaBiBo) won a court case which will permit them to register as an officially recognized organization in the country (Mguni, 2014, November 21). LeGaBiBo, in partnership with BONELA and Schorer/COC Netherlands, is currently working on a qualitative needs assessment related to challenges experienced by sexual minorities in Botswana (Jacques, 2014).

HIV/AIDS

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

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

Legal Environment

There is uncertain and conflicting evidence on Lesotho’s legal environment. ILGA’s 2013 State-sponsored Homophobia Report places Lesotho on the list of countries where homosexuality is legal, stating that “It seems that homosexual acts in Lesotho are legal, probably since the entry into force of the Penal Code Act on 9 March 2012. The Sexual Offences Act of 2003 did not explicitly repeal the common law offence of sodomy (see its article 37)” (Itaborahy & Zhu, 2013, p. 50). However, in ILGA’s 2014 edition of the report, Lesotho is back on the list of countries where homosexuality is illegal (without explanation) and there is no mention of the March 2012 Penal Code Act.

Two other 2014 sources (Global Legal Research Center, 2014; Itaborahy & Zhu, 2014) maintain that sodomy is a common-law offence in Lesotho as per Section 185 (5) of the Penal Code.

Civil Society, Perceptions, Obstacles and Support

According to the DiDiRi Collective (2013) there are two civil society organizations which support LGBTI human rights in Lesotho, one of which is specifically an HIV/AIDS organization. Matrix Support Group is one of the leading groups advocating for LGBTI rights in Lesotho. Miller (2014) highlights how the first LGBTI pride march - which Matrix organized in May 2013 to commemorate International Anti-Homophobia and Transphobia Day - was a landmark moment for the LGBTI community in the country. Miller (2014) even notes that this event “seems to be having an impact on the MSM community and how it deals with stigma and discrimination” (Miller, 2014, p. 45).

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

HIV/AIDS

Although Lesotho has one of the highest HIV infection rates in the world, LGBT patients are often excluded from treatment (Hall, 2013, May 31). Lesotho’s current NSP – The National HIV Prevention Strategy for a Multi-Sectoral Response to the HIV Epidemic in Lesotho (2011/12-2015-16) - identifies MSM as an underserved at-risk population, indicating that this group likely contributes roughly 3-4% of new HIV infections in the country (Government of Lesotho, 2010). The strategy sets targets to increase the percentage of districts providing minimum packages of prevention services for MSM, aiming for 50% of districts by 2013 and 100% by 2015. The strategy also sets targets for increasing the percentage of MSM accessing HIV prevention services with a minimum package of services, aiming to reach 10% of MSM by 2013 and 30% by 2015. Under key strategies and activities, the government commits to conducting formative research, doing population size estimates, developing and implementing comprehensive HIV prevention programmes and training facilities to deliver friendly services to MSM. The country’s current National HIV Strategy does not address the needs of WSW, lesbian women, transgender or intersex individuals.

Lesotho is the only country in the region which has reported HIV prevalence data for WSW (Government of Lesotho, 2012). According to the most recent GARPR (2012), the prevalence of HIV among WSW in Lesotho is 7.1%, as compared to 11.6% for MSM and 22.9% for the general population. It should be noted that these prevalence data were generated from a study with a relatively small sample size of 190 MSM and 208 WSW. Among MSM in Lesotho, 48.2% reporting using a condom the last time they had anal sex with a male partner and 54.5% received an HIV test in the last year. Lesotho did not report data on the proportion of MSM reached with HIV prevention programmes. Progress mentioned in the 2012 GARPR includes the registration of networks of MSM by the registrar of societies and associations. Lesotho does not address transgender or intersex individuals in its reporting.
Malawi

Legal Environment

Section 153 of Malawi’s Penal Code on “Unnatural Offenses” criminalizes having carnal knowledge – or permitting a man to have carnal knowledge - of any person against the order of nature. This is punishable by a fourteen-year prison term. Section 154 criminalizes attempting to commit an “unnatural offence,” which is punishable by up to seven years in prison. Further, Section 156 criminalizes “indecent practices”, which warrants five years in prison for acts of gross indecency (Global Legal Research Center, 2014). In December 2010, Malawi’s Parliament passed a bill which amended the Penal Code of Malawi to include Section 137A on “Indecent practices between females”. The bill was signed into law in January 2011, making it illegal for any female person to commit acts of gross indecency with another female, punishable by a prison term of five years (Itaborahy & Zhu, 2014).

Civil Society, Perceptions, Obstacles and Support

Afrobarometer-Malawi data shows that 94% of Malawians disagreed that people practicing same-sex relationships should have the right to do so (Dionne, Dulani & Chunga, 2014). However, though attitudes were uniformly negative toward same-sex relationships, less than 1% of the Afrobarometer survey participants identified same-sex issues when asked about the most important problems facing Malawi that government should address (the most common answers were food shortage, economy, and water supply).

One study (McNamara, 2014) presents qualitative data featuring some Malawians who feel that homosexuality should be legal. Three were people currently in sexually active homosexual relationships and the others were a tour operator and a non-governmental organization (NGO) worker. The tour operator mentioned that legalizing homosexuality would improve business. The NGO worker noted that criminalizing an identity was futile. One of the homosexual men said it should be legal because same-sex prostitution is the way he is able to feed his family.

One of the leading organizations for LGBTI human rights in Malawi is the Centre for the Development of People (CEDEP). The Executive Director of the organization, Gift Trapence, has published widely on MSM issues in Malawi and in the region (see Baral et al., 2009; Fay et al. 2011; Baral et al., 2013; Breyer et al., 2013; Wirtz et al., 2014) and is now a member of Malawi’s Country Coordinating Mechanism (CCM) as of 2014.

HIV/AIDS

Malawi’s current HIV strategy – the Malawi National HIV and AIDS Strategic Plan (2011-2016) - indicates that there is a gap for MSM, noting that this group is not targeted with comprehensive combination prevention interventions (Government of Malawi, 2011). The policy commits to the following strategic actions for MSM: Develop procedures, guidelines, and minimum packages for interventions to reach MSM; identify the locations and numbers of MSM to reach and identify their health needs; scale up a comprehensive risk reduction package of combination prevention interventions in high prevalence geographic areas; strengthen linkages to HIV prevention and treatment, and HTC services; create an enabling environment for the implementation of an effective strategy. The government also prioritizes conducting population size estimation and biological and behavioural surveillance among MSM. However, while the strategy sets 2015/2016 targets for bringing down the HIV prevalence of other key populations, such as sex workers, fishermen and police, there are no targets set for MSM (stated “TBD”). The current strategy does not address WSW, lesbian women, transgender or intersex individuals.

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

The laws against homosexuality are the same in Mozambique as they are in Angola (as they are inherited from Portuguese colonial law). Article 71(4) of the Mozambican Penal Code (16 September 1886, and amended in 1954) determines that security measures are applicable to people who habitually practice “acts against nature.” The security measures are listed in Article 70 of the Penal Code, which include confinement in an insane asylum, internment in a workhouse or agricultural colony (from 6 months to 3 years), being put on probation for a certain period, pledge of good conduct, and/or disqualification from the practice of a profession (Global Legal Research Center, 2014; Itaborahy & Zhu, 2014).

Notably, in 2011, the Mozambican Justice Minister told the UN Human Rights Commission (UNHRC) that homosexuality is not illegal in Mozambique (Human Rights Campaign & Human Rights First, 2014; Mkhosi, 2011, March 3).

Civil Society, Perceptions, Obstacles and Support

According to Grossman’s (2013) analysis, Mozambique is one of the more tolerant countries in the region when it comes to public perceptions of homosexuality. He finds that Mozambicans are a more tolerant society than Botswana, South Africa and Zambia, as they are less likely to indicate that they view homosexuality to be morally wrong.

However, this tolerance can have a downside; a human rights activist in the country indicates that one of his biggest challenges has been to explain to people that they need to fight for their rights (DiDiRi Collective, 2013). Further, even in the least homophobic countries, LGBTI people are persecuted, if not by law, then by public opinion (DiDiRi Collective, 2013).

Mozambique Association for the Defence of Sexual Minorities (LAMBDA) is a leading organization supporting LGBTI human rights in Mozambique, though the organization has not been able to secure official recognition as an association (DiDiRi Collective, 2013).

HIV/AIDS

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

MSM are also mentioned as a priority for the government insofar as the next behavioral surveillance survey will provide data on the prevalence of HIV and behavior of MSM (along with female sex workers, truck drivers, and miners working in South African mines). The current policy acknowledges MSM, indicating that 5% of new HIV infections in the country are occurring among MSM. Aside from MSM, the current policy does not address other groups within the LGBTI spectrum.

Mozambique’s most recent GARPR does not report any data for MSM, WSW or transgender individuals. However, it does highlight the need for greater involvement and role played by high risk groups like MSM (Government of Mozambique, 2014).
Namibia

Legal Environment

Sodomy is a crime in Namibia according to the Roman-Dutch common-law (initially imposed by the South Africans), but there is no codified sodomy provision in the country (Itaborahy & Zhu, 2014). Further, no information on penalties imposed for this crime exist (Global Legal Research Center, 2014).

Civil Society, Perceptions, Obstacles and Support

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

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

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

HIV/AIDS

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

The prevalence of HIV among MSM in Namibia was reported to be 12.6% in their 2014 GARPR (Government of Namibia, 2014). This is compared to a prevalence of 14.3% in the general population. No data was reported for the indicators of condom use or testing for MSM, but targets for the 2015/2016 NSF are stated (increase by 50% of baseline and 80%, respectively) which does indicate a certain level of political will and commitment to HIV prevention among this group. The report also states that there is an Integrated Bio-Behavioural Survey (IBBS) ongoing in the country (results expected in 2015) which will provide more information on population size estimates and behavioural characteristics of MSM in Namibia. Further, the 2014 GARPR states that Parliamentarians are seeking proposals for law reform on MSM.
South Africa

Legal Environment

Same sex relationships, as well as same sex marriages are legal in South Africa. The country abrogated laws which criminalized homosexual conduct and legalized same-sex sexual activity in 1998 (Global Legal Research Center, 2014). Same-sex marriages have been legal since November 2006 as per the Civil Union Act. As of 2002, adoption is also legal for same sex couples. The backbone of South Africa’s non-discriminatory laws is Section 9 of the Constitution, which states that the state may not unfairly discriminate against someone on the basis of their sexual orientation.

Civil Society, Perceptions, Obstacles and Support

Despite the fact that the South Africa constitution upholds the rights of LGBTI people, support for LGBTI human rights among the general population is not evenly distributed; gay rights supporters are more likely to be young, white, literate, and from urban areas (Dionne, Dulani & Chunga, 2014). While polls indicate that South Africans hold the most accepting views towards homosexuality in the region, the majority (69%) are not accepting of homosexuality (Dionne, Dulani & Chunga, 2014). Just under half (45.9%) of South Africans say that homosexuality is never justifiable (compared with 56.6% in Zambia and 94.7% in Zimbabwe). Van Vollenhoven and Els (2013) suggest that South Africa, with a democratic Westernized constitution, still struggles to practice these entrenched human rights. They recommend that homophobia should be addressed within the school system, in order to “teach” acceptance and diversity as one would any other subject.

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

In May 2014, South Africa elected the first Black gay Member of Parliament in Africa - Zakhele Mbhele - and also saw its first openly gay cabinet member appointed (Morgan, 2014, May 22).

HIV/AIDS

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

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

Legal Environment

While there are no primary documents detailing the legal status of homosexuality in Swaziland, and no information on the penalties imposed, Sodomy is considered a common-law crime the country (Global Legal Research Center, 2014). In 2005, the Government planned to include prohibitions of all male and female homosexual acts in a revised version of its Sexual Offences laws. The proposed penalties for same-sex sexual behaviour include a two year prison sentence or a fine (approx. $500). However, to date the proposal has not been adopted (Itaborahy & Zhu, 2014).

Civil Society, Perceptions, Obstacles and Support

Swaziland, sub-Saharan Africa’s last absolute monarchy, is a conservative country and societal discrimination against the LGBT community is prevalent. Organizations supporting the LGBTI community have trouble registering and members of the LGBTI community are routinely victimized. Their opinions are ignored and excluded at community meetings (DiDiRi Collective, 2013).

However, recent evidence of government support for LGBT people and organizations is promising. In the week of May 2013, Swaziland’s highest traditional authorities gave their blessings to gays and lesbians who wished to stand as candidates for positions in Parliament later in the year (DiDiRi Collective, 2013).

Further, Swaziland has a very small but galvanizing LGBTI civil society movement. Rock of Hope, their largest LGBTI organization, currently sits on the country’s Global Fund Country Coordination Mechanism (CCM) as a representative of key populations.

Lastly, anecdotal evidence of tolerance is emerging. In a meeting held in Mbabane in October 2013, an openly transgender representative from Rock of Hope explained to the group of government and civil society delegates what it meant to be a woman, biologically, but to identify as a man. This was followed by a demonstration of how to use a dental dam, which was met with friendly and curious laughter from the delegates.4

HIV/AIDS

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

Swaziland’s most recent GARPR states that the HIV prevalence among MSM aged 16-44 years is at 17.7%, with the percentage increasing with age (Government of Swaziland, 2014b). The report emphasizes that the HIV prevalence of MSM is lower than that of men in the general population aged 15-49 (20%) and lower than the total general population (27.4%). Condom use among MSM is estimated at 66% (with non-regular partners) and only 27.1% have been reached with targeted HIV prevention programmes. Swaziland’s 2014 GARPR does not report HIV testing data for MSM. The report also states that among MSM in Swaziland, female partnerships are common, but self and external stigma prevents MSM with female partners (as well as bisexual men) from disclosing their sexual orientation or their HIV status to their female partners. WSW, lesbian women, transgender and intersex people are not discussed in Swaziland’s 2014 GARPR.

4 This anecdote is the personal account of the author of this report, 30-31 October 2013, Mountain Inn Hotel, Mbabane, Swaziland.
Legal Environment

Section 158 of Zambia’s Penal Code criminalizes sodomy, stating that anyone who has carnal knowledge of any person against the order of nature, or permits a male person to have carnal knowledge of him or her against the order of nature is liable to serve up to 14 years to life in prison. Attempting to engage in sodomy is also a crime, punishable by 7-14 years in prison. The Zambian Penal Code also prohibits “indecent practices between persons of the same Sex” for which adults could serve 7-14 years in prison. If “indecent practices” are committed by a minor under the age of 16, they could instead be sentenced to community service or ordered to undergo counseling (Global Legal Research Center, 2014). Section 158(1) addresses any male who commits gross indecency, and Section 158(2) is repeated to address any female who does (Itaborahy & Zhu, 2014).

Civil Society, Perceptions, Obstacles and Support

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

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

There is a nascent LGBTI civil society in the country, with organizations like Friend of Rainka gaining visibility. However, Oberth (2014) notes that Zambia’s LGBTI organizations are often timid and “co-optable” in debate spaces which feature wider (and often homophobic) civil society, particularly compared to other countries in the region.

HIV/AIDS

The Zambia National AIDS Strategic Framework (2011 – 2015) includes data on MSM, indicating that they are estimated to contribute 1% of new infections in the country (Government of Zambia, 2010). The report also includes the female partners of MSM, recognizing bisexuality and/or social pressure which necessitate heterosexual relationships among gay men. The government expresses that more empirical evidence on size estimation of MSM and their partners is needed to adequately inform policy and programming. This is the extent to which MSM are included in the national strategy, and WSW, lesbian women, transgender or intersex individuals are omitted altogether.

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

**Legal Environment**

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

The constitution of Zimbabwe does promote equality for all people, yet it nonetheless also includes a “claw back clause” which undercuts these fundamental rights by recognizing the primacy of customary law over the Bill of Rights (DiDiRi Collective, 2013).

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

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

The organization Gays and Lesbians of Zimbabwe (GALZ) has been a long-time defender of LGBTI rights in the country, and indeed the region. Marc Epprect (2012; 2013b) writes extensively on the history of civil society resistance to LGBTI human rights violations in Zimbabwe, focusing on the history of GALZ as an organization. He notes how memoirs by founding members of GALZ show that the organization was formed as a result of strong lesbian leadership, though today much of their work is framed within the public health umbrella against risks MSM face with respect to HIV (Epprecht, 2012).

In January and February 2014, GALZ won a landmark legal victories as the courts ruled that the State returns GALZ property, which had been seized, and that GALZ was permitted to continue as an organization despite not being registered (Littauer, 2014, February 28).

**HIV/AIDS**

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

Zimbabwe’s latest GARPR (Government of Zimbabwe, 2014) is completely silent on LGBTI people. In fact, the indicators are not even listed.
As is clear from the country profiles preceding this section, the legal environment for LGBTI people in Southern Africa varies greatly from country to country. South Africa – as the clear exception in the region – enshrines and protects the rights of all people, of all sexual orientations and gender identities. Marriage of same-sex couples is legal and adoption for same-sex couples is legal. Notably, South Africa is also the only country which promotes equality around gender identity; as of 2003, the law permits transmen and transwomen to legally change their sex in the country’s population registry, as well as on their identity documents (ARASA, 2014). The law also applies to intersex people. However, South Africa is the only country in the region (and indeed, the continent) to afford people these rights. In all other countries in Southern Africa, homosexuality is illegal, either expressly indicated in the penal code, or according to common-law. LGBTI people are criminalized to varying degrees across the region. In Angola and Mozambique, the punishment for homosexual acts is a short term of probation or physical labour. On the other hand, in Malawi and Zambia those convicted can serve up to 14 years in prison.

Table 1: Overview of Key Laws Affecting Key Populations

<table>
<thead>
<tr>
<th>Country</th>
<th>Same sex sexual conduct between men criminalized</th>
<th>Same sex sexual conduct between women criminalized</th>
<th>Laws prohibiting discrimination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Botswana</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Lesotho</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Malawi</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Mozambique</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Namibia</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>South Africa</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Swaziland</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Zambia</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Source: ARASA (2014)

Table 2: Penalties in Countries Where Homosexuality is Criminalized

<table>
<thead>
<tr>
<th>Fines, restrictions, or labour</th>
<th>Imprisonment of less than ten years</th>
<th>Imprisonment of ten years or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>Botswana</td>
<td>Malawi</td>
</tr>
<tr>
<td>Mozambique</td>
<td>Zimbabwe</td>
<td>Zambia</td>
</tr>
<tr>
<td>Swaziland⁵</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Han and O’Mahoney (2014)

Chanika, Lwanda and Muula (2013) argue that politicians and their supporters use rhetoric which isolates LGBTI rights, dissecting them out of the encompassing concept of human rights. Many constitutions in the region guarantee human rights, though sodomy provisions remain in the penal code. Part of this contradiction in the definition of human rights may stem from how different cultures value and protect the rights of the individual versus the rights of the collective. In Western cultures, the rights of the individual are paramount, whereas in many Southern African cultures, collective rights may be deemed more important. The African Charter on Human and People’s Rights (1981) is a good example of this. In another example, Amtaika (2013) argues that problems arise in Malawi when there is a perceived conflict between the rights of the individual and the rights of the collective. This is one way to potentially understand how so many countries in the region have Human Rights Commissions or other human rights institutions, yet deny these rights to LGBTI individuals.

⁵ Han and O’Mahoney (2014) place Swaziland in the ‘ten years or more’ category, though most evidence suggests this is inaccurate.
Table 3: Existence of National Human Rights Institutions

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

Source: ARASA (2014)

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

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

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

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

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

~ Festus Mogae, former president of Botswana, July 2012

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

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

Others, too, indicate that political economic contexts are central to efforts to destabilize pervasive homophobias (Epprecht, 2013c; Van Zyl, 2014). Understanding the locus of homophobia is important for shaping any kind of response to it.

**Political Challenges and Support**

In addition to legal challenges for LGBTI human rights, political challenges at the national level (see sections on Civil Society and HIV/AIDS Policy and Progress) and regional and international level.

At the international level, certain challenges exist in terms of UN bodies upholding LGBTI rights. Curiously, the rights of sexual minorities have a much stronger presence in the General Comments published by other UN treaty committees, outside of the Human Rights Committee.

**Figure 2: Reference to LGBTI rights in the General Comments of Treaty Committees**

Source: Gerber and Gory (2014)

At the regional level, Geber and Gory (2014) argue that the Human Rights Committee should be doing more to reconcile anti-homosexuality legislation in African penal codes with constitutions which often contradict these laws insofar as they often recognize the right to equality for all. Further, they also argue that such an approach would also be appropriate for members of the African Union (which all ten countries covered by this literature review are), because the African Charter on Human and Peoples’ Rights contains the obligation of States Parties to protect the rights of each and every individual ‘without distinction of any kind’ (Gerber & Gory, 2014).
In addition to the African Charter on Human and People’s Rights, other commitments and policies from the region are beginning to mount political precedence for increased human rights for LGBTI people. The report of proceedings from the African Union Commission’s 5th Inter-Agency Meeting on Coordination and Harmonization of HIV/AIDS, TB and Malaria Strategies (African Union, 2014), included – for the first time – mention of key populations and even the need for advocacy and support for MSM. Further, the newly proposed minimum standards or Integration of Sexual and Reproductive Health Rights and HIV/AIDS in SADC Region include several provisions which include LGBTI populations. For instance, the document states that gender sensitive responses “must recognize the needs of girls, boys, men, women and transgender people irrespective of their sexual orientation” (SADC, 2014, p. 23). The SADC HIV and AIDS Strategic Framework 2010-2015 also includes MSM as part of its priority interventions, including facilitating and coordinating sharing of information across the region and reviewing evidence from various member states (SADC, 2009).

Despite this political support at the regional level, there is still significant pushback in regional and international political spaces. A notable recent example is Namibia’s motion to join Egypt, South Sudan, Uganda, UAE, Malaysia, Djibouti and Bahrain in recommending the removal of the term “sexual orientation and gender identity” from the UNHRC SOGI resolution and replace it instead with “race, colour, sex, language, political or other opinion, national or social origin, property, birth or other status.” While this amendment did not pass, and the SOGI resolution did, Namibia’s objection to SOGI language represents a significant political challenge.

Many of the challenges that remain in the legal and political environment around LGBTI rights revolve around the importance and significance of religion in the Southern African region. The following section outlines this theme in the literature and the role that religion plays in the current landscape of LGBTI rights in the region.

Religion

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

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

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

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

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African sexuality is a term Tamale (2014) uses. She does, however, offer the caveat that she is not suggesting Africa is a homogeneous place, but she wants to draw attention to the shared experiences of colonialism, capitalism, imperialism, globalisation and fundamentalism.
There is empirical evidence to support Tamale’s (2014) assertion. Tinarwo and Pasura (2014, p. 521) examine a Zimbabwean diaspora community in Britain who discover lesbian, gay and bisexual identities, finding that the different religious and cultural contexts mean that the “boundaries of gendered practices and sexual behaviours deemed ‘acceptable’ and ‘unacceptable’, ‘good’ and ‘bad’ also seem to be shifting.”

Epprecht (2013c) too, illustrates the roots of homophobia in Southern Africa through traditional spirituality, Christianity and Islam. However, as Lee (2013) points out, Epprecht (2013c) argues that the recent surge in homophobia in Africa is not as much due to religion and religious doctrine per se, as it is related to particular fundamentalist interpretation of Christianity and Islam, most often promoted by foreign groups who come to Africa with an agenda. Tamale (2014) agrees, contending that the American Christian Right is using Africans and African churches as proxies for American culture battles, working closely with African religious and political leaders to oppose progress in the rights of LGBTI persons. Epprecht (2013c) makes the case for harnessing Southern African values of Ubuntu in order to shape the way religious leaders and communities interpret religious dogmas to include LGBTI rights. Similarly, van Klinken and Gunda (2012, p. 114) explore the opportunity for acceptance among African religious traditions. They argue that “African theologians are varying from silence and rejection to acceptance. Although many African theologians have taken up the cudgels against gay rights, some “dissident voices” break the taboo and develop more inclusive concepts of African identity and African Christianity.”

In the South African context, Vincent and Howell (2014) find that homophobia in the era of human rights discourse has been framed significantly by notions that homosexuality is ‘unGodly’. They remind us that for the majority of South Africans, the church is a highly significant space for community and social engagement; it is where attitudes and ethics are formed. As such, it is highly important to have an understanding of these terms in order to develop useful counter discourses.

Safety and Security

As a direct result of the hostile legal, political and religious environments in which most LGBTI people in Southern Africa live, violence, abuse and even death are regular threats for many people in these communities. Research from Swaziland shows that many MSM often feel they have no recourse to bring incidents of violence to the police (Kennedy et al., 2013). The same study also found that many Swazi MSM experience refusal from law enforcement to protect them from violence due to their sexuality. Even in South Africa, where LGBTI people have equality before the law, homophobic hate crimes are on the rise (Epprecht, 2012). While all LGBTI people potentially face safety and security issues as a result of homophobia and transphobia, lesbian and transwomen bear a disproportionate amount of this violence.

Makofane (2013) draws attention to the problem that some of the literature on the history of homosexual relationships in Southern Africa focuses too heavily on relationships between men, especially pointing to Epprecht’s (2008) book Heterosexual Africa?. Makofane (2013) says that the thin history on women who have sex with women and lesbian women in Southern Africa is troubling in the face of current challenges associated with the increased burden of homophobic violence carried by these women. In a study involving 592 WSW from Botswana, Namibia, South Africa and Zimbabwe, 31.1% reported experiencing forced sex (Sandfort et al., 2013). This study leads the authors to conclude that HIV/AIDS is a very serious reality for lesbian and bisexual women in Southern Africa, despite the belief of many that these women are not vulnerable to infection. Further, Sandfort et al. (2013) find that forced sex among WSW that was the important risk factor for HIV infection among the women in their study (Sandfort et al., 2013).

In Botswana, Namibia, South Africa and Zimbabwe, 31.1% of WSW report experiencing forced sex. This was the most important risk factor for HIV infection among these women (Sandfort et al., 2013).
Tamale (2014) also discusses how the bodies of LGBTI people – or any “sexual other” – become sites for violence and political inscription. She uses the example of terms like ‘corrective rape’ or ‘curative rape’ which suggest that one’s sexual orientation needs correcting or can be changed, and that there are circumstances when rape can be justified. She echoes the need to speak in terms which are more appropriate in describing the hateful elements of the crime, such as ‘homophobic rape’. Hames (2011), too, argues that it is important to speak with a critical consciousness whenever referring to any kind of violence.

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

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

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

South Africa is a particular “hot spot” for these kinds of homophobic hate crimes against LGBTI people (Brown, 2012). Sigamoney & Epprecht (2013) share interview and survey data on the subject from more than 1000 respondents from two urban townships in South Africa (Daveyton and KwaThema). Challenges associated with violence are not relegated to individuals, either, but permeate all levels of society. Williams (2012) outlines the shortcomings in the South African government’s prosecution of a homophobic hate crime. Supporting Williams’ (2012) arguments the Human Rights Campaign Foundation and Human Rights First (2014) cite that there is often a delay in prosecuting homophobic murders in South Africa. In addition to the legal system failing LGBTI people, Epprecht (2012) argues that the government’s role as a human rights leader in the region frequently falls flat, and that until very recently South Africa has been noticeably reluctant to incorporate LGBTI human rights in into its foreign policy (Epprecht, 2012). Most recently, in September 2014, civil society in South Africa lead a #DemandAccountabilitySA campaign to put pressure on the South African representative to the UNHRC to vote in favour of the SOGI resolution (amid rumours that he would not).

**Suicide and Self-Harm**

Studies have shown that 31% of South African LGBTI people have considered committing suicide and 21% had previous attempted it (Graham & Kiguwa, 2004). However, recent research on this subject is scant, particularly in Southern African, and is a gap in the literature which needs further study in order to understand how it can be prevented.

“**They are raped so they know they are not boys. [...] If she turns herself to a man, who is a real man between us? We have to show we are men.”**

Sigamoney & Epprecht (2013, p. 98)
Sex Work

For many LGBTI people sex work is a profession, a form of income, and a right; it is not in and of itself a safety and security issue. However, in some instances, sex work may create situations of increased vulnerability which further subjugate LGBTI people to risks of discrimination, harassment and violence. There are also a lot of overlaps between and among different kinds of violence LGBTI people experience. For instance, Lewis (2012) found that discrimination and intimate partner violence among WSW co-occurs. In the same vein, violence associated with sex work is layered with other forms of violence towards LGBTI people, including discrimination, harassment, denial of health services and abuse.

The frequency of sex work among the LGBTI community is not well-documented. One study found that 18.7% of the WSW surveyed from Botswana, Namibia, South Africa and Zimbabwe had engaged in transactional sex at some point in their life (Sandfort et al., 2013). Some of these women engaged in sex work with men only (3.4%), some with women only (8.1%) and some with both men and women (7.1%). Though the Sandfort et al. (2013) study finds that transactional sex is not associated with an increased likelihood of self-reporting HIV, other studies show that sex work is associated with lots of other health and safety risks, especially for male and transgender sex workers (Scorgie et al., 2013). Security risks such as stigmatization and breaches of confidentiality from health care workers and policy is perhaps most extreme among transgender sex workers (Scorgie et al., 2013). Tracey, a 25-year old transgender sex worker from South Africa, recounted the following experience after being gang-raped by clients:

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

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

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

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

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

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

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

Non-violent Human Rights Abuses

Safety and security issues for LGBTI people are not only related to physical violence. Often, non-violent human rights abuses are the most common as well as the least visible (Jacques, 2014). In a recent survey of MSM in Malawi, Namibia, and Botswana, many respondents sighted blackmail as one of the most common human rights abuses that they face (10.5% in South Africa, 18% in Malawi, 21.3% in Namibia, and 26.5% in Botswana) (Jacques, 2014). DiDiRi Collective (2013) also cites that 21.3% of MSM in Lesotho report being blackmailed. Phillips (2009) also finds evidence of blackmail, among LGBTI people in Zimbabwe.

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

A recent study of stigma and discrimination among MSM in Malawi, Namibia, and Botswana found that there was a strong relationship between discrimination and the fear of seeking out health services (Fay et al., 2011; as cited in Jacques, 2014). Further, as noted in the Angola Country Profile, recent research conducted in Luanda found that MSM who reported episode of homophobia were significantly more likely to be HIV positive (Kendall et al., 2014).

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

Behaviour and Identity

Much of the violence and discrimination directed at LGBTI people – while never justified – likely stems from a lack of knowledge and understanding as well as a fear of the unknown. With better education around what it means to have different sexual orientations and/or gender identities, much of the violence LGBTI communities face may be averted (Van Vollenhoven & Els, 2013). Understanding contextual difference, too, is important. Jacques (2014) illustrates how definitions and experiences of different kinds of sexuality are steeped in personal and cultural frames of reference. This means that within the region, experiences are vastly different; Jacques (2014) asserts how being gay or lesbian in Botswana is very different from being gay or lesbian South Africa.

This section explores literature which helps to delineate how identities and behaviours of LGBTI people can be the nuanced, dynamic and varied. Understanding this is critical in any effort to provide better programming for support, health care, and social protection. For example, Gerber and Gory (2014) problematize discourse choice by UN bodies which essentialize fixed Western concepts like “homosexuality” which may not reflect the more fluid forms of gender identity and sexual behaviour which have existed for centuries in Africa. Understanding the diversity of African LGBTI identities and how they change or stay the same, and how they align, or do not align, with behaviour is critical to effective rights-based programming (Kerrigan, 2013).

The focus of this section is on current behavioural and identity studies which shed light on different kinds of sexualities which are part of the lived realities of many LGBTI people in the region. While historical sexualities in Southern Africa are not the focus, Marc Epprecht’s (2013b) Hungochani: The History of a Dissident Sexuality in Southern Africa (Second Edition) is an excellent resource on the subject. Epprecht (2013b) meticulously documents examples of same-sex relationships and alternative gender identities in pre-modern Zimbabwe, South Africa, and
Lesotho. His intention is to gather empirical evidence to disrupt the political myth that homosexuality in Africa is a Western import.

Heterosexual Partnerships and Bisexuality

One of the first things to consider and to understand is that many LGBTI people who are exclusively attracted to people of the same sex, may still desire to raise a family and have children who are biologically their own. In addition, some people may feel familial or societal pressure to partner in a relationship that is contrary to their sexual orientation but which will allow them to reproduce. One study among WSW in Lesotho found that the women felt very strong pressure to marry from their parents for cultural reasons, as well as financial gain:

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

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

McNamara (2014) highlights how in Malawi, homosexuality is commonly perceived as an act rather than an identity, which shapes the way motivations for other partnerships are formed. Further, among those self-identifying homosexual men and women, he notes how family lineage may be a stronger force than personal identity. One of the lesbian women he spoke to mentioned that she planned to cease “practising” homosexuality soon and would return to her village to have children.

Similar findings from research in Lesotho show that almost half of MSM reported future plans to marry a woman. Of those who said this, the majority (64%) said they wanted to do so in order to please their families, while the others (36%) indicated that they wanted to marry in order to have children (Miller, 2014).

MSM with Female Partners

Female partnerships are quite common for MSM in Southern Africa for a number of reasons, not limited to societal pressures to marry or have female, a separation homosexual identity and homosexual acts, bisexuality, and strong desires to pass on lineage through childbirth (McNamara, 2014; Miller 2014). In McNamara’s (2014) research in Malawi, all the gay men he interviewed or interacted with had concurrent female partners. Miller (2014) found that 34% of MSM surveyed in Lesotho had had sex with a woman in the past year. Miller (2014) also found that concurrent partnerships among MSM in Lesotho were common. In his research, 82% of MSM reported multiple concurrent partnerships in the last year, 33% of which indicated that their multiple partners included both men and women. Evidence from Mozambique also indicates that many MSM there have female partners (Nala et al., 2014). In Maputo just 11.4% of 496 MSM reported that they had never had sex with a woman, and just 15.9% of 353 MSM in Nampula/Nacala had never done so (Nala et al., 2014). This evidence also points to lower condom use among MSM when they have sex with their female partners, as compared to their male partners. For example, in Maputo, 86% of MSM used a condom the last time they had sex with a male partner, but only 66.6% of MSM used one the last time they had sex with a female partner (Nala et al., 2014).

WSW with Male Partners

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

Sandfort and Reddy (2013) argue that high levels of bisexual behaviour among MSM in African countries is likely due as a consequence of the pressure to get married or to procreate. However, as possible evidence to the contrary, Miller’s (2014) study reveals that while 37% of the MSM surveyed reported having sex with women because it was what is expected of them, 58% suggested that it was instead because they enjoyed it. Further, in a study among MSM in Swaziland, 34.8% self-identified as bisexual and 12.1% had children (Risher et al., 2013). As noted above in the country profile of Swaziland, self and external stigma prevents bi-MSM from disclosing their sexual orientation or HIV status to their female partners (Kingdom of Swaziland, 2014).

Differently to MSM who have female partners in the region – who report high levels of bisexual identity – WSW in the region report a comparably higher rate of strictly homosexual attraction and identity. In Sandfort et al. (2013), 76.9% of the 591 WSW from Botswana, Namibia, South Africa and Zimbabwe said they identify as lesbian.

Gender Identities

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

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

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

In closing this section, one of the most important ideas in the literature is the emphasis on how a person’s sexual orientation and gender may not be the most important way that person identifies. Trystan Cotton aptly notes “In Africa (and the diaspora), gender and gender transitioning form only one dimension of people’s lives. And it’s not always the most salient thing in their daily struggle to feed and house themselves” (Boellstorff et al., 2014, p. 431).
Availability and Accessibility of Health Care for LGBTI People

The complex identities and behaviours of many LGBTI people in Southern Africa, paired with a lack of understanding of this communities, leads to a lack of targeted health and social welfare programs (Jacques, 2014). Even in South Africa, where LGBTI people enjoy equal rights - service delivery for LGBTI people can be extremely poor. Müller (2014) argues there is still a great need to provide South African health professionals with the correct training and ongoing professional development to provide adequate care to the LGBTI community. A recent survey in South Africa found that only 10 out of 93 Health Sciences Faculty taught LGBTI health as part of their curricula (Müller, 2013). Of those who did, there was no opportunity for learners to challenge their own views and attitudes towards LGBT patients (Müller, 2013).

Delayed Entry into Care

Evidence from all across the region shows that delayed entry into care – or a lack of access to care altogether – is one of the biggest issues for LGBTI people in terms of their right to health (Cloete, Kalichman & Simbayi, 2013; Kennedy et al., 2013; Langen, Odumosu & Ricardo, 2014; Müller, 2014; Wirtz et al., 2014). Reasons for the delay are many and varied. One of the most commonly cited reasons is fear of stigma and discrimination. Risher et al. (2013) find that for MSM in Swaziland experiences of legal discrimination, suicidal thoughts and sexual violence are also significant factors which lead MSM to delay or avoid seeking health care.

This is one of the key reasons for poorer health outcomes among LGBTI people in the region, and needs to be given prominent consideration. For this same reason, it is important to also recognize that prevalence of disease is not the only measure of vulnerability to poor health; access to care and supportive systems which enable people to remain in care if they need to are equally important. Put differently, though the WSW population in Southern Africa may have a lower HIV prevalence than the general population, they are also much less likely to be able to access quality and appropriate treatment, care and support, making their health outcomes much worse.

A health needs assessment has been recently conducted by 15 LGBTI organisations from Botswana, Namibia, South Africa, Lesotho, Swaziland, Mozambique, Zimbabwe, Zambia and Malawi, reaching over 2500 LGBT people in 27 locations (Langen, Odumosu & Ricardo, 2014). Results from this survey confirm – on a wide scale in the region – that LGBTI people have low uptake of HIV/STI testing, limited knowledge on safer sex practices, misconceptions about risk and risk-behaviours, difficulty accessing commodities such as dental dams, condoms and lubricants, limited ability to negotiate the use of protection, particularly in situations involving transactional sex. Some of the LGBTI people in this survey reported being denied health services. The research also confirms delayed health seeking behaviour due to fear of stigma and negative attitudes from health care workers (Langen, Odumosu & Ricardo, 2014).

Further, evidence from a study of WSW in Lesotho shows that while 12.4% experienced STI symptoms in the past year, only 4% were diagnosed at a clinic, indicating a significant gap between health issues and uptake of health services among this group of women (Poteat et al., 2014). In addition, Risher et al. (2013) found that 61.7% of the 323 MSM they surveyed in Swaziland reported fear of seeking healthcare.

Recent research has documented the experiences of HIV-positive MSM in Swaziland, finding that there are feelings of dual stigma, violence from police, stigma from healthcare workers and mental health challenges (Kennedy et al., 2013). Stigma and discriminating associated with being MSM was cited as the most common reason for not seeking health care. One young Swazi MSM recounts:

“When they say ‘bring your partner’, and then you bring the same sex partner, they are like, ‘yah, this is why you are having this [HIV], this is why’, and they will be throwing words at you […] so then you get embarrassed, sometimes you’ll decide to leave without being treated, and where are you taking that sickness to?” (Kennedy et al., 2013, p. 3-4).
Kennedy et al. (2013) argue that services for MSM who are living with HIV are essentially non-existent in Swaziland. Stigma faced by MSM from health workers has been documented and shows that many MSM feel they cannot seek certain services, especially related to anal health: “As for people in general, with them it’s easy for them to go to hospital, but with us it’s difficult. You can’t say it’s painful in your anus - what will you say the cause for that is?” (Kennedy et al., 2013, p. 4).

In response to this challenge, Baral et al. (2012) show that training of health care workers is the largest priority for improving HIV prevention among MSM in Africa. However, Wirtz et al. (2014) show that it is not always prejudice or lack or training on sexual diversity that makes it difficult for healthcare workers to treat some LGBTI patients. Clinic staff that treat MSM in Malawi indicated that they felt afraid to treat patients because they feared legal repercussions would befall them as service providers. Wolf et al. (2013) cite similar findings from other countries in Africa.

Disclosure of Sexual Orientation to Health Workers

If LGBTI people are able to overcome barriers to care highlighted above, a further theme in the literature is the challenge then of disclosing one’s orientation or gender identity to health care workers in order to receive appropriate care. Risher et al. (2013) found that only 25.6% of Swazi MSM disclosed their sexual practices to health care workers. Similarly, Poteat et al. (2014) found that 25% of WSW in Lesotho shared their sexual history with staff in clinics and hospitals. Matebeni et al. (2013, p. S39) also highlights the difficult experiences of WSW telling health workers about their sexuality:

“You go there and they tell you about condoms and that you have to use them [...] you tell them “I don’t do men”. You get someone who is empty [not informed] and the topic for counselling changes. “How do you do it? [have sex with women]” You just get agitated when you are supposed to be dealing with the news that you are HIV-positive and the conversation has now changed because you are gay” (Lesego, 29 years old, Pretoria).

Unpublished interview data from AIDS Accountability International shows a profound misunderstanding of why it is important and necessary for LGBTI people to be able to disclose their orientation to their health care workers in order to receive appropriate care. A key informant from the World Bank in Zambia said “Who wants to have a facility where they say ‘I am LGBT I am MSM give me health services’? You go there because you are a patient.” (unpublished interview, 18 April 2012).

All of this suggests that LGBTI populations are not able to get proper care if they are not able to disclose their orientation or their sexual history. This challenges the argument that a public health approach, rather than a rights-based approach, might be more effective in Africa (Epprecht, 2012; Oberth, 2012), which is discussed in the next thematic section.

The Public Health vs. Human Rights Approach

There is a critical debate in the literature which examines the potential benefits and drawbacks of taking a public health approach to service provision for LGBTI populations, rather than a human rights-based angle. There is emerging evidence that strategies which foreground health concerns and tone down sexual rights are having some successes in challenging legal and policy contexts in Southern Africa (Epprecht, 2012; Oberth, 2012).

One of the issues associated with a Western hard-lined human rights approach is that they often neglect to consider that LGBTI identities do not necessarily negate a person’s loyalty to family, religion or their country. In this way, a human rights strategy that includes mocking African leaders, belittling the importance of ‘imported’ religions and insulting ‘immutable’ cultures can be directly alienating to African LGBTI people. Evidence from Swaziland supports this idea, finding that some HIV-positive MSM rely on their pastors for support, and turn to their religion for comfort (Kennedy et al., 2013). Approaches that do not take this into account can provoke wider nationalist reaction against the LGBTI community (Epprecht, 2012).
Epprecht (2012) and Oberth (2012) both refer to the public health approach as something of an “interim” solution which makes strategic and careful use of the health agenda in order to subtly advocate for the broader sexual and human rights of LGBTI people. Research from key informants in Botswana, Malawi, Namibia, South Africa, Swaziland, Zambia and Zimbabwe highlights that many respondents felt the “public health now, human rights later” approach was a strategy that was currently working for them, in terms of advocating for LGBTI people to be included in policy and programming (Oberth, 2012).

Edwidge Mutale, The Permanent Secretary in the Ministry of Gender in Zambia explains how legal and religious barriers prevent discussion LGBTI issues, but the public health angle – HIV specifically – allows for discourse on the issue:

“In Zambia, it’s illegal. Traditionally, it’s taboo, so we don’t even want to talk about it. From a religious point of view, this is a country that has got Zambia being a Christian nation embedded in its constitution, so again that is a no-go area. So for us that position is very clear. However, when it comes to HIV and AIDS, we can talk about it and tell them” (Oberth, 2012, p. 24-25)

Epprecht (2012, p. 225) asks: “Can a public health approach to promoting sexual rights and, hence, enabling or abetting the development of politically self-confident gay identities, work in Africa?” Research has shown that for many, the right to health has proven a useful entry point into dialogue which activists, governments and development partners alike believe will pave the way for broader human rights for LGBTI people in Southern Africa (Oberth, 2012). Epprecht (2012) acknowledges a trend in literature suggesting that the public health approach could push the rights agenda ahead more effectively than the gay rights movement. HIV/AIDS may have been a motivating factor for a wider “sexual rights” movement in many African countries, however, this possibility is not without questions that need raising: “How will women who have sex with women be included in an approach that necessarily emphasizes the high-risk nature of many current MSM practices? How can a stigmatized population avoid further stigmatization if publicity focuses on the health dangers they pose to the general population?” (Epprecht, 2012, p. 233). The public health strategy remains deeply controversial within the LGBTI movement, with many groups – particularly trans-activist and feminist-identified LGBTI groups.

“How can a stigmatized population avoid further stigmatization if publicity focuses on the health dangers they pose to the general population?”

(Epprecht, 2012, p. 233)

Funding for LGBTI health programs

Almost all of the support for LGBTI programming in the Southern African region comes from external funding partners, since most national governments are either ambivalent towards or completely disregard the need to invest public money in evidence-based programs for these communities. As a result, outreach and service provision is led primarily by civil society organizations, which often struggle to adequately finance their programs (UNAIDS, 2014b). For example, the National AIDS Coordination Agency in Botswana recently reported that more than 75% of services for MSM and transgender populations are provided by civil society (Government of Botswana, 2014).

Government reporting on HIV/AIDS spending for key populations highlights a lack of accountability to these groups from their public servants. While domestic spending on HIV in Southern Africa is rising, generally, this increase has not has not improved this situation for LGBTI people, since that public money is often not available or accessible to organizations working on LGBTI human rights (ARASA, 2014). For example, Zambia’s most recent National AIDS...
Spending Assessment (NASA) indicates that no public funds went to MSM. Botswana’s NASA says that most-at-risk groups were not specifically targeted, but a small amount was spent by the private sector. The NASAs from both Malawi (Government of Malawi, 2010) and Swaziland (Government of Swaziland, 2008) reveal a downward trend in the already scarce proportion of support dedicated towards MSM. In South Africa, the Department of Health’s High Transmission Area Program is one of the only examples of state funding for key populations in the region, though this amounts to just $2.5 million (0.2% of total), all of which went toward prevention programming (Government of South Africa, 2012b). The South African government’s 2012 NASA states that spending data on interventions targeting MSM could not be found. WSW and transgender people are not mentioned at all in these reports.

Based on the extremely limited funding from governments, a mapping of the funding landscape from major development partners is the best approximation of the existing support for key populations in the region. The largest partner is by far the United States Government’s President’s Emergency Plan for AIDS Relief (PEPFAR), which accounts for 72% of the total HIV/AIDS funding in the eight countries.

Table 4: PEPFAR Grants in Southern Africa Supporting LGBTI Populations

<table>
<thead>
<tr>
<th>Country</th>
<th>Prime Partner(s)</th>
<th>Activities</th>
<th>Amount (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Botswana</td>
<td>Tebelopele VCT</td>
<td>A KP pilot project (for MSM) in an urban center providing HTC, TB screening, PHDP care and support.</td>
<td>$300,000</td>
</tr>
<tr>
<td>Lesotho</td>
<td>PSI</td>
<td>Letlama project: behavior change for MSM and TGs (condoms, faithfulness); HTC for MSM.</td>
<td>$175,000</td>
</tr>
<tr>
<td>Malawi</td>
<td>PSI</td>
<td>EBT-Prev project for safer sexual behaviors among sex workers and MSM and TG (“Think about It, It’s your Choice” campaign).</td>
<td>$1,396,185</td>
</tr>
<tr>
<td>Namibia</td>
<td>Lifeline/Childline Namibia</td>
<td>Deliver mobile HCT targeted to key populations</td>
<td>$92,084</td>
</tr>
<tr>
<td>South Africa</td>
<td>Anova Health Institute, HSRC, SANAC</td>
<td>Enhance local organizations’ capacity to conduct routine HIV surveillance for MSM. Prevention pilot studies for MSM. HIV behavioral surveillance survey.</td>
<td>$6,776,576</td>
</tr>
<tr>
<td>Swaziland</td>
<td>PSI, Johns Hopkins</td>
<td>Couples HIV testing (for MSM and WSW) and strengthen community systems (capacitate stakeholders).</td>
<td>$652,000</td>
</tr>
<tr>
<td>Zambia</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Source(s): PEPFAR Country Operational Plans (2013)

Followed by PEPFAR, the second most significant funding partner in the region is the Global Fund to Fight AIDS Tuberculosis and Malaria, which makes up 17% of total HIV/AIDS funding in the region. However, a recent regional analysis covering Botswana, Malawi, Namibia, Swaziland, Zambia, and Zimbabwe, found that only 0.07% of Global Fund money went towards gay men, MSM and transgender individuals (Ryan et al., 2013). Part of the problem is that some countries simply aren’t requesting funding for these programmes. In a recent analysis of proposals to PEPFAR and The Global Fund from Southern Africa, it was found that only 3/27 Global Fund proposals targeted MSM, and only 12/35 PEPFAR proposals did (Ryan, Macom & Moses-Eisenstein, 2012). However, in other cases, countries are requesting support but are their proposals are being denied by funding partners. This shows a clear gap between country-identified needs for key populations and the available funding. In their Round 10 proposals to the Global Fund, Botswana and Malawi both requested support for MSM programming - $1,634,056 and $2,610,623, respectively – yet neither was funded. Further, while Namibia did receive support for MSM, it was roughly half the amount the country needed and requested (Ryan et al., 2013).

In addition, from this already scant allocation, trends are moving in a negative direction. From Round 9 to Round 10 there was a decrease in the number of proposals to the Global Fund that contained behavioral interventions for MSM and transgender people (Gurkin, 2011).
Based on this, Batist et al. (2013) and Wolf et al. (2013) both contend that the current coverage of quality HIV/AIDS services for MSM are not sufficient to reverse the epidemic’s trend. They also point out how this challenge is further aggravated by stigma, discrimination and limited government investment in LGBTI programming.

Another challenge is that there is a myth that there is a flood of funds into Africa to support LGBTI programming, in order to further Western agendas. Abbas (2012) highlights how the reverse is actually true, and the LGBTI movement in Africa has made tremendous progress with very minimal financial support. It is also important to note that African LGBTI organizations are not passive recipients, simply waiting for support from foreign donors. People on the ground have been taking bold stances in support of human rights and equality. Activists have been providing direct assistance to LGBT organizations and individuals (Human Rights Campaign & Human Rights First, 2014).

Further, while there is some money for LGBTI organizations in general, this does not necessarily go towards special services that the trans community needs (Jobson et al., 2012). The Open Society Initiative of Southern Africa (OSISA) is one of the only organizations to separate their funding streams for trans organizations and trans initiatives, due to the unique nature of the needs of that programming.

One model which might improve this is to create a basket fund to support LGBTI in Southern Africa. The Ford Foundation and Open Society Institute have previously proposed this for East Africa, and other funding partners agree it can be a way for the money to sit closer to the end users and for donors to coordinate (Sida, 2008).

Civil Society, Representation and Advocacy

There is a severe lack of funding for LGBTI organizations – and particularly transgender organizations - which may in part be due to a lack of data on populations size estimates, health and HIV/AIDS risks and human rights violations (Jobson et al., 2012).

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

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

LGBTI civil society faces a number of other hurdles, not least of which is basic survival as organizations due to funding shortages. LGBTI civil society

“We try to avoid the whole ‘toyi-toyi’ and what not because it’s not our approach and it’s not working for us. The softer approach has helped a lot.”

~ Key Informant, LeGaBiBo, Botswana

(Oberth, 2013, p. 150)
organizations (CSOs) face political challenges of being denied registration or closed down by government, as well as participation obstacles when trying to represent their constituencies in decision-making spaces.

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

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

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

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

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

Part of this strategy of ‘invisibility’ (Currier, 2012b) or ‘non-confrontation’ (Epprecht, 2013c), is evident in the names of many LGBTI organizations. Epprecht (2012) discusses how the names of LGBTI advocacy organizations have historically used unobtrusive language, which does little to alert any opposing parties to their focus on sexual rights. For example, a leading LGBTI organization in Malawi calls itself “The Center for the Development of People”. Similarly, in Swaziland the largest LGBTI organization is called “Rock of Hope”.

It is also important to note that Currier’s (2012b) examination of circumstances within which Namibian and South African LGBT organizations increase their public visibility or withdraw is not always a choice; many times organizations are forced to take less visible positions due to political antagonism towards the movement. Evidence from Zimbabwe also confirms this imperative that LGBTI CSOs face. One key informant from SAF AIDS, in an unpublished AIDS Accountability International interview, said “In the work that we do, where there haven’t been any political rallies, or political rhetoric, you can actually work and people can talk. But, the minute there is a speech, then there is an upset” (unpublished interview, May 2012). These processes of visibility, invisibility, and visibility again, are non-linear patterns of development for LGBTI organizations, a dynamic which Paternotte (2014) highlights as an important dynamic to understand.
Williams (2012) highlights how difficult it can be for civil society – especially LGBTI organizations - to hold the state to account in criminal matters. She discusses the case of the State vs. Madubaduba and two others, where the South African NGO “OUT LGBT Wellbeing (OUT)” participated in the supported the victim, Deric Duma Mazibuko, advocating for harsher sentencing for homophobic attacks. They were not successful; Mazibuko’s three attackers were sentenced to perform correctional supervision and community service.

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

HIV/AIDS Prevalence, Policy and Progress

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

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

<table>
<thead>
<tr>
<th>Country</th>
<th>KPs Included in Current National Strategic Plans</th>
<th>KPs Included in Multi-sectoral Strategy According to National Composite Policy Index (2012)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MSM</td>
<td>WSW</td>
</tr>
<tr>
<td>Angola</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Botswana</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Lesotho</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Malawi</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Mozambique</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Namibia</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>South Africa</td>
<td>Yes</td>
<td>No⁷</td>
</tr>
<tr>
<td>Swaziland</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Zambia</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

⁷ While South Africa’s NSP does not include WSW, a number of the Provincial Strategic Plans do.
HIV among MSM

From Table 5, it is clear that MSM are comparably well-recognized by National HIV/AIDS Strategic Plans in the region. However, though policies may address this population, knowledge about prevention and behaviour changes remains exceedingly low among MSM populations in Southern Africa, indicating that they are still left out of the response.

For example, one study in Lesotho found that some MSM were not at all aware that unprotected sex between two men posed an HIV risk, and these men expressed that there is a need for including men who have sex with men in HIV knowledge and prevention campaigns (Miller, 2014). Further, the same study found that multiple partnerships are more common among the MSM community than among the general populations. 80% of Miller’s (2014) MSM respondents reported having more than one partner in the last year, compared with just 35% in the general population (Government of Lesotho, 2012). Miller (2014) also finds that more than 20% of MSM in Lesotho believe HIV can be cured. Miller also found that while 88% of respondents claimed to know three ways of preventing HIV when asked to name them, only 37% actually could. Lastly, Miller’s (2014) findings show that of MSM reported sexual activity with women in the last year, 28% reported inconsistent condom use or no condom use at all.

Evidence from MSM in Malawi shows low levels of HIV knowledge on prevention coupled with low perceptions of HIV risks (Wirtz et al., 2014, p. 4):

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

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

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

Table 6: Mapping of Data Reporting from Global AIDS Response Progress Reports in Priority Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>MSM Indicators</th>
<th>WSW</th>
<th>TG</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prevalence</td>
<td>Prevention</td>
<td>Condom Use</td>
</tr>
<tr>
<td>Angola</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Botswana</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Lesotho</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Malawi</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Mozambique</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Namibia</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>South Africa (2012)</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Swaziland</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Zambia (2012)</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Source(s): Global AIDS Response Progress Reports (2014)
Despite consensus that MSM are more likely to be HIV-positive than the general population (Baral et al., 2007; Beyrer et al., 2012; Beyrer et al., 2013; Kennedy et al., 2013; UNAIDS, 2014), the data reported by the governments in many Southern African countries (Botswana, Lesotho, Namibia, South Africa and Swaziland) do not suggest this is true. There are a number of reasons why this might be the case. Perhaps the studies used to source MSM data reported in these Global AIDS Response Progress Reports are not accurate. Government AIDS data generally, not just on LGBTI, should always be regarded with a certain degree of skepticism (issues of self-reporting bias). Harvey (2012) argues that there is a bias in the scientific data on HIV among sexual minorities in Southern Africa – especially government data – since the political and social contexts within which it is collected, analyzed and published is not inclined to recognize this group of people. He says “Trepidation over Western liberalism may well discourage these nations from collecting data geared towards prevention from “the gays” or even MSM” (Harvey, 2012, p. 72).

Or, perhaps there are political motivations for reporting MSM data that is lower than the general population. Though the government of Botswana reports 13.1% HIV prevalence among MSM, recent studies found it to be much higher, at 19.7% (Beyrer et al., 2010). Further, Beyrer et al. (2010) find HIV prevalence among MSM in Zambia to be much higher than in the general population, at 32.9%, as compared to 15.7% in all adults 15-49.

Another issue is the lack of age disaggregated data available in the GARPRs. This warps the HIV prevalence among MSM. Often, MSM recruited for studies are young MSM. Evidence from most prevalence studies shows that HIV prevalence increased significantly with age among MSM. For example, a study conducted by Wirtz et al. (2013) among 338 MSM Malawian found 12.5% overall prevalence of HIV among their sample, yet, among MSM 26 years and older, prevalence of HIV was much higher, at 28.1%. Further, among Malawian MSM 30 years and older, HIV prevalence has been found to be 35.3% (Baral et al., 2009). Baral et al., (2009) find similarly high HIV rates among older (30+) MSM in Namibia (31.4%) and Botswana (46.7%).

Risher et al. (2013) instead suggest that a more useful comparison is to look at MSM vulnerability compared to other men (not the general population), which helps to control for the reality that the Southern African HIV epidemic is female-predominant. Wolf et al. (2013) show that studies from South Africa, Swaziland, Lesotho, Malawi, Namibia, Botswana and Zimbabwe, have shown MSM to have equal or greater disease burden of HIV, syphilis and hepatitis B, when compared to men in the general population. Further, Wolf et al. (2013) indicate that HIV prevalence among MSM in Southern Africa appears to be seemingly isolated from recent overall declines in prevalence, which is another important factor in assessing overall vulnerability of this group.

**HIV among WSW**

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

Matebeni et al. (2013) argue that the findings of their research indicate that lesbian women cannot be regarded as a ‘no-risk’ group within the context of HIV in Southern Africa. In fact, previous research conducted in South Africa with 72 HIV positive WSW, demonstrated that same-sex desire offered no protection from HIV (Cloete, Sanger & Simbayi, 2011). Echoing this finding, Poteat et al. (2014, p. 130) argue that their data from 250 WSW in Lesotho show that “self-identity as a lesbian was not associated with a lower likelihood of HIV or STIs.” This is because WSW engage in a number of different sexual behaviours with their female partners, some of which may carry a risk of HIV exposure. For example, WSW may have unprotected oral sex during menstruation or share sex toys after vaginal or anal penetration (Richardson, 2000). In the Sandfort et al., (2013) study of 591 WSW in Botswana, Namibia, South Africa and Zimbabwe, self-reported HIV prevalence was 9.6%. The conclusion reached by the authors, is that the
most important factor for self-reported HIV infection was not risky behavior with female partners, or even sex with men (per se). Instead, Sandfort et al. (2013) find that forced sex is the most important risk factor for self-reported HIV infection among the WSW in their study (see section on Safety and Security).

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

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

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

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

Survey data from Poteat et al. (2014) among WSW in Lesotho sheds further light on how WSW can contract HIV, possibly related to low use of HIV protection. They find that among WSW in their study, 48% used a condom the last time they had sex with a man, and only 13.4% used protection (dental dam) the last time they had sex with a woman (Poteat et al., 2014). The percentage of WSW, who use protection the last time they had sex with a man and the last time they had sex with a woman was only 5.2%.

Knowledge, too, has been shown to be quite low among WSW, in no small part due to lack of information targeted at these women through government and NGO campaigns. Among WSW in Lesotho surveyed by Poteat et al. (2014), the majority (74%) had some knowledge about preventing HIV/STIs during sex with men, but only 38% had received any information about prevention during sex with other women.

The general assumption (and misconception) that lesbians are insulated from HIV makes it all the more difficult for lesbians and WSW to reconcile their realities, disclose their status, and seek appropriate care. The participants also suggested that their inability to disclose their sexuality due to stigma hampered their ability to access safe sex information that they wanted in order to protect their partners.
“I have never mentioned that [I’m a lesbian] because of the stigma associated with disclosing your sexuality. Some of the [HIV] organisations I am involved with for example - is a Christian organisation. Talking about my sexuality to them would be so hard” (Tambu, 40 years old, Zimbabwe) (Matebeni et al., 2013, p. S42).

This perception also affects service providers, ultimately making it even more difficult for WSW to access health services. Anecdotal evidence from South Africa shows that lesbian women have been refused HIV tests because as WSW they “did not qualify for an HIV test” and were told to go home (Müller, 2014).

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

**HIV among Trans and Intersex people**

While there is relatively good MSM data, and some WSW data, there is a very significant lack of research on transgender populations in Southern Africa, and almost no data on how HIV/AIDS impacts these individuals (Jobson et al., 2012). Jobson et al. (2012) argue that transgender Africans are currently invisible in epidemiological research and they are almost certainly being ignored in HIV service provision. This invisibility stems in part from the tendency to subsume transgender individuals into MSM or WSW categories within HIV data and research (Jobson et al., 2012). Jobson et al. (2012) suggest that research on HIV vulnerability among transmen in Africa, in particular, is a significant need and a gap in our current knowledge.

A recent study which documented sexual experiences and assessed HIV vulnerabilities among LBTI women in Bulawayo, Zimbabwe sought to explore the how lack of research and policy for this group affects health outcomes (Ndondo, Maseko & Ndlovu, 2013). Among the 29 LBTI women in their study, perception of HIV risk were very low, despite frequent sexual activities that involved exchanged of bodily fluids. Ndondo, Maseko and Ndlovu (2013) found that the majority of Zimbabwean LBTI women in their study never practised safe-sex, in part because they lacked awareness of LBTI-specific prevention methods.

Ndondo, Maseko and Ndlovu (2013) also found that these women rarely sought HIV counselling and testing services, despite reporting frequent forced sexual experiences. The authors conclude that heteronormative assumptions around HIV and STI vulnerabilities as well as heteronormative service provision were major barriers to care, along with stigma and discrimination at health centers.

It is critically important that the link between gender identity and HIV risk be better understood in southern Africa. Gender identity affects people’s sexual choices (or lack of choices) in a very direct way, which clearly related to HIV vulnerability. For example, transwomen may elect to be the receptive sexual partner as a way of reaffirming their gender identity, though this behaviour places these people at elevated risk of infection (Jobson et al., 2012).

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

One of the most oft cited piece of work on homosexuality and imperialism is the 2008 Human Rights Watch Report (recently reprinted in an abridged form – see Human Right Watch, 2013) *This Alien Legacy: The Origins of African “Sodomy” Laws in British Colonialism*. This report makes a compelling case for the examination of the irony that Christianity – an imported colonial religion – is used as a bolstering mechanism to declare homosexuality as “unAfrican”, despite the fact that the laws against gay relationships in ex-British colonies are products of imperial mechanisms to limit and contain the racial “other”.

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

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

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

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

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

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

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

In Malawi, particularly, this discussion was inextricably tied to debates about foreign aid and Western influence (Biruk, 2014, McNamara, 2014), though not a unique circumstance. Currier (2012b) discusses the concept of “gay-for-pay” in Namibia, whereby sexual minorities are often accused of only engaging in same-sex behaviors, or only claim to have LGBTI identities in order to obtain money from Western donors. One small study of 50 MSM in Lesotho found that a very small proportion (4%) reported money as their rationale for having sex with men; the vast majority (81%) reported having sex with men because that is their choice and their preference (Miller, 2014). Other evidence from Mozambique (Maputo) indicates that circumstances may be different there; just under half (47.7 %) of MSM in the country’s IBBS (2011) reported received money, goods, or services in exchange for anal sex with another man in the past year (Nala et al., 2014).

In a review of Currier’s recent book Out in Africa (2012a), Epprecht (2013a) notes how she finds mixed evidence for the impact of “queer imperialisms”. He says that the big international development organizations, particularly ones such as Hivos, do not come across as promoting an assertively ‘un-African’ gay identity. Epprecht (2013a) says that organizations like these actually seem cautious in consultation with African activists. The push to create broad pan-African networks has resulted in some localized tensions in the beginning, but Epprecht (2013a) says that this kind of structure will likely be helpful to the interests of African LGBTI in the long run.
McNamara (2014) argues that the conflation of homosexuality with Western dominance is in part the fault of heavy-handed donors. In other words, for countries in Southern Africa to deny Western influence of aid money is also a way of reaffirming economic and political independence. Others, however, suggest that this anti-donor, anti-homosexuality rhetoric was hijacked by politicians for their own political gain (Chanika, Lwanda & Muula, 2013). In what they call ‘the sexualized politics of donor aid in Malawi’ Chanika, Lwanda and Muula (2013) argue that politicians in Malawi used the language of queer imperialism – the idea that donors are bringing homosexuality to Africa - to galvanize political support, even from women’s groups with the “Atikwatira ndani mukamakwatirana?” campaign (“Who will marry us?”). They also locate this within the politics of poverty – or what they call ‘the homophobia of poverty’ – whereby women sided with the government against homosexuality, since they feared it would mean they would not be financially looked after by a husband. In another perspective, Wroe (2012) argues that the moral issues that are at the centre of many aid conditions (i.e. LGBTI human rights) mean that dissident voices have more room to make demands of their government (Wroe, 2012). This view has significant evidence to the contrary suggesting that LGBTI organizations in Africa do not want LGBTI conditions attached to the support that they receive from donors, as it hurts their ability to convince opposing forces that their movement is an African one, and not one driven by Western agendas (see section on Civil Society).

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

**Identification of Knowledge Gaps**

- There is a need to further explore the publish health vs. human rights debate by conducting close studies of institutional decision-making and policy formulation processes.
- Comprehensive fieldwork assessing comparative viewpoints of health, rights, and status quo advocates working on the ground will help to create a larger pool of good practice to inform future programming.
- There is a need to rethink what ‘African sexuality’ means and how those meanings have been constructed by analyzing the disjunction between North African and Sub-Saharan (and in Southern Africa, Allophone vs. Lusophone experiences).
- There is a growing body of work around WSW and HIV, but a regional IBBS which includes this group is needed.
- Information on suicide and self-harm remains a significant knowledge gap.
- Trans and intersex research is significantly marginalized within LGBTI literature in the region.
- SRHR for LGBTI people more generally needs more attention. Integration, too, needs to be investigated.
- Employment and livelihoods research for LGBTI people needs expanding (current focus is heavily on sex work).

**Recommendations for Focal Areas Going Forward**

- There needs to be a shift in focus away from policy and law reform at the top and towards changing people’s attitudes on the ground. Many African governments are currently acting in good faith to the constituencies they represent, since the majority of Africans hold strong negative attitudes toward homosexuality and do not believe it should be legal. A truly sustainable response will only be created when populations demand accountability from their governments; demand equal rights for all.
- Critical examination of the way in which foreign organizations or foreign donors implement programming and conduct advocacy needs to be carried out. Research into strategies for avoiding or disrupting the problem of “Queer Imperialism” via-a-vis funding for LGBTI programming needs better understanding.
- Improved data and improved data quality on the size, identities, behaviours, health needs and organizational capacities of LGBTI populations will be critical. As one key informant from Zimbabwe points out, “Without data, it’s not well understood, and it’s easy to dismiss something you don’t understand” (Oberth, 2012, p. 29).
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Colophon


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