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ACKNOWLEDGEMENTS

This needs assessment report is a completion of a facts finding mission that Rainbow Identity Association (RIA) embarked on in 2012 with the support of COC Netherlands, to identify the gaps that exist within mainstream medical health service provision in relation to transgender, transsexual and intersex persons' experiences of the latter. Hence, RIA would like to extend its gratitude to COC for its partnership in making what is the first transgender and intersex focused exercise take flight. These findings will go a long a way as an advocacy tool as well as addition to already low count of trans and intersex literature in the country.

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DEFINITION OF TERMS AND CONCEPTS

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

Gender: The socially constructed roles, behaviour, activities and attributes that a particular society considers appropriate to attribute to and differentiate men from women.

Gender Identity: This refers to one's innate and private sense of feeling male or female, manly or womanly as an individual. Generally, one's gender identity often coincides with their biologically assigned sex physically such as genitalia, whereas differential gender identity refers to where one's feeling of being male or female does not coincide with their biologically assigned sexual makeup. This is the case for many a transgender, transsexual, gender non-conforming and intersex persons.

Cisgender: This term refers to a person(s) who have a gender identity and expression that coincides with that expected of a person of their biological sex. In Latin, the prefix 'cis-' is meant to denote two or more things being on the same side, in the case of cis-gender being the sex and gender of a person being on the same side. Put in simple, a cisgender man would be someone who fulfils the role expected of a person born male and behaving as a man in that sense. In basic terms, the opposite of transgender would be cisgender.

Transgender: People who have a gender identity, and often a gender expression, that is different to their sex assigned at birth by the default of visible primary sexual characteristics and may choose to live their lives in the gender of their identity and not in accordance with the social roles of the sex of their biology.

Transsexual: People who have a gender identity, and often a gender expression, that is different to their sex assigned at birth by the default of visible primary sexual characteristics and may choose to live their lives in the gender of their identity and not in accordance with the social roles of the sex of their biology. Transsexual individuals as compared to simply transgendered individuals, transsexuals choose to undergo various procedures aimed at reassigning their sex and bringing their biological makeup into congruence with their gender identity such as sexual reassignment surgery and/or gender-affirming hormonal replacement therapy through a process commonly referred to as transitioning.

Transman (FTM/F2M): This term refers to an individual who was born biologically female but has a differential gender identity of a male and identifies & lives their life as and perhaps may transition into being male. A transman though born female bodied is more comfortable with being referred to in male or manly pronouns such as 'he, Mr, Sir, man' e.t.c.

Transwoman (MTF/M2F): This term refers to an individual who was born biologically male but has a differential gender identity of a female and identifies & lives their life as and perhaps may transition into being female. A transwoman though born male bodied is more comfortable with being referred to in female or womanly pronouns such as 'she, Miss, Mam, woman, girl' e.t.c.

Gender Queer/Gender Non-Conforming: Refers to individuals who do not behave, act or have attitudes of the sex they were biologically assigned at birth and perhaps even the gender roles they were socially assigned, which includes in it trans, intersex and other non-labelled persons who simply do not live within the social roles they were raised in. Gender non-conforming persons may include in this bracket those known as gender fluid and gender ambiguous.

Intersex: This term refers to individuals who were born with ambiguous or unclear sexual characteristics of males and females. This is a condition in which an individual cannot be categorised as 100% male or female, which is often categorised by unclear genital makeup of the individual. Worthy to note is that, intersexism is multifold and appears in more than just the ambiguity in genital makeup, but may also be through an individual with medically normal genitalia but having the inner reproductive system of the opposite sex to the one presenting physically as genitalia and it may also appear through what is known as hormonal intersexuality where an individual has medically normal genitalia and reproductive system but having the endocrine system (or hormones) of the opposite sex to the one presenting physically as genitalia. There is a variety of manifestation of the intersex condition that is out there.

Transitioning/Sexual Reassignment: These terms refer to a number processes and procedures that an individual with a differential gender identity and/or sexual makeup may embark on so as to bring their biological make-up and gender identity into par or congruence so as to be able to live in bodies that resemble if not alike those of the sex and gender they identify with. These procedures may involve sexual reassignment surgery so as to surgically reassign and reconstruct one's biological sex. There is also hormonal replacement therapy which involves taking hormones of the gender and sex that one identifies as and perhaps wishes to transition into. When transwomen/M2F's transition they may take a combination of oestrogens and progesterone's so as to develop sexual characteristics of females, whereas transmen/F2M would undergo testosterone therapy to enable them to develop sexual characteristics of males.

Hormonal Replacement Therapy/Gender Affirming Hormonal Therapy: One part of sexual reassignment is the intake of hormones in order to generate changes in sexual characteristics of an individual to those of the sex or gender they identify as and wish to transition into. In the case of transwomen these hormones would be oestrogen and progesterone which would stem some hair growth and initiate breast growth whereas in the case of transmen the therapy would involve testosterone which breaks the voice and makes it deep and promotes facial and body hair growth, all this is done to reconstruct one's body to generate the sexual characteristics of the gender and sex one identifies as.

Gender Reassignment: This term is often mistaken to mean sexual reassignment, but gender reassignment is rather concerned with re-orientating and re-socialising an individual who identifies as trans from the gender they perhaps were raised as or been living in (that is if they were not brought up in the gender of their identity as is the case with most trans individuals), into the gender they wish to live in or transition into. This process often occurs at the stage of

psychotherapy were one is preparing to transition, so as to prepare them to permanently live in the gender of their identity. For the most part, transgender and intersex persons are brought up and socialised into the gender roles of their biological make-up hence the need to undergo gender reassignment so as to know, understand and live in the gender of their identity as preparation for the transition to follow.

Sexual Orientation: Refers to an individual's sexual identity in relation to which they are attracted to. Put in simple, sexual orientation is often used to refer to the manner in which one exercises their sexual and romantic self in relation to people of different sexes and genders. This means that an individual who identifies themselves perhaps as a man and is attracted to other individuals identifying as men would be called homosexual (yes orientation goes beyond just the biological sex of the individuals involved but as well their gender identity and expression, which is the whole package that one would be attracted to). Categorically there is homosexuality, heterosexuality, bisexuality, penn/pan sexuality, asexuality to name but a few).

HIV: Human Immunodeficiency Virus

AIDS: Acquired Immunodeficiency Syndrome

Trans-phobia: An irrational fear of, and/or hostility towards people who are transgender, transsexual, gender non-conforming and intersex who otherwise transgress traditional gender binaries and norms.

INTRODUCTION

Rainbow Identity Association (RIA) was born out of the need for transgender and intersex people to have representation in the mainstream human rights advocacy and lobbying within Botswana for this group of individuals. RIA was officially registered as an organisation on December of 2010 to add value to the plight of transgender and intersex people in their attempt to advocate for their rights, access to services and overall visibility that works to minimise stigma and discrimination in general society. RIA is an organisation that works to promote the status of gender minorities in Botswana and ultimately the greater region of Africa as a whole.

This needs assessment was designed to identify the gaps that already exist in health care provision within the mainstream spectrum for transgender, gender queer and intersex persons within Gaborone, Botswana. The status quo is one where we find many a transgender (trans), gender queer and intersex people disheartened and demoralised from seeking public medical health care due to substandard service provision from health care professionals. Furthermore and beyond just qualitative experiences of these individuals, the health care policy formulation is one which totally disregards the specific needs of trans, gender queer and intersex persons that somewhat differ from those of mainstream society.

The intent with this exercise hence was to unpack the factors that contribute to this status quo and perhaps what needs to be done in order to bring about formidable changes that would see this group of marginalised individuals begin to fully access the benefits due universally to all people in their various localities and local health points.

Rainbow Identity Association is of the opinion that an understanding of the bodies of the primary target group in this exercise being the transgender and intersex persons specifically, reveals that the bodies of such individuals are in part designed differently (through undergoing sexual reassignment and even the biological construct of intersex bodies) and in another part the conventional usage or expression of sexual bodies is defined by the manner in which transgender, gender queer and intersex persons use theirs. For these reasons; seeing that transgender, gender queer and intersex persons are in nature gender variant, it should be expected that they will as well be sexually variant to the point that the already available conventional prevention methods and items fail to take into consideration the unconventional needs of this particular group thereby effectively protecting and preventing this group from contracting HIV/AIDS. Lastly, RIA holds that for Botswana to reach its mandate of a nation of 0% new infections by the year 2016, such sub-populations as gender minorities as the transgender, transsexual and intersex need to be integrated into mainstream policy formulation that is tailored towards HIV/AIDS reduction and control.

NEEDS ASSESSMENT LITERATURE REVIEW

Background

Transgender and Intersex individuals have a point to celebrate since the existence of Rainbow Identity Association (RIA) (an organisation instigated for the sole purpose of safeguarding and advancing the rights of transgender (trans) and intersex individuals). The need to put in place an organisation such as RIA came from the lack of representation of the voice of the trans and intersex community in the greater LGBTI and Human Rights discourse in the country as a whole. As of current, RIA is the only registered organisation in the country that focuses primarily on trans and intersex issues. RIA offers various services to its membership and those in need of it thereto which include: **health services** that include referrals to counsellors and psychosocial support as well as dissemination of barrier and prevention methods, **capacity building** which includes trainings and education of various stakeholders and key players in society, **legal assistance** in the form of linkages with legal advice and breakage for those in need of litigation or legal representation on the account of the gender identity or expression, **advocacy** through awareness raising and trainings aimed at voicing out the needs and concerns of the trans and intersex community and lastly RIA provides **sporting and recreational services** in a safe environment for its membership all the while raising more awareness in the various localities through sport and recreational activities (Rainbow Identity Association, 2012: pamphlet).

History of the Transgender and Intersex Discourse

Medical and Health practitioners the world around adhere to the prescriptions put forth by the American Psychiatric Association (APA) in the Diagnostic and Statistical Manual of Mental Disorders (DSM), of which the DSM IV is the current revised version in use the world over in the pathology of transgenderism/transexualism. The DSM has gone through various revisions which include the olden definitions of transgenderism/transexualism as a persistent sense of discomfort and inappropriateness about one's anatomic sex and desire to live as a member of the "opposite" (affirmed) sex (American Psychiatric Association, 1980: 263) , better known and classified as Gender Identity Disorder (GID) and as defined in the glossary of the DSM-IV-TR identifies GID as a persistent aversion toward some of all of those physical characteristics and/or social roles that connote one's own biological sex . The APA defines a mental disorder as follows:

> *"a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress… or disability… or with a significantly increased risk of suffering, pain, disability, or an important loss of freedom… Whatever its original cause, it must currently be considered a manifestation of a behavioural, psychological, or biological dysfunction in the individual."* (American Psychiatric Association, 2000: xxxi)

Gender identity disorders first appeared in the class of Psychosexual Disorders in the DSM-III (American Psychiatric Association, 1980: 261) with more focus on gender dysphoria but have since the discovery and recognition of the fact that not all transgender individuals are gender dysphoric shifted to a broad based analogy of transgenderism. Indeed, the focus of

pathology in successive revisions of the DSM has shifted further from Gender Dysphoria (defined here as a persistent distress with one's current or anticipated physical sexual characteristics (as witnessed in some individuals attempting and in some cases succeeding at self mutilation of their genitalia as an acute manifestation of the Dysphoria) or current ascribed gender roles toward nonconformity with assigned birth sex (Ehrbar & Winters, 2007: Convention Panel Presentation; Winters, 2005; Journal of Psychology & Human Sexuality, 2005: 71-89).

Historically, transgender diagnosis was focused primarily on attaining narratives of acute dysphoria of the individual towards their physical construct or biologically assigned anatomy, however more research and developments on this field have come to reveal the phenomenon (transgenderism) to be broader than just issues of one's assigned sex but also to encompass in it socio-personal constructs of an individual who identifies with the opposite gender constructs that in essence do not match those that would otherwise not be assigned for such an individual, which goes to prove transgenderism as a general non-conformity to ones's socially prescribed and assigned gender roles. The shift in focus from gender dysphoria to gender nonconformity in the DSM has been hailed as a step in the right direction towards a comprehensive understanding of transgenderism, however this very step implicated a growing number of gender variant and non-conforming people without any mental disorder(s), or dysphoria who might just have an affinity for roles assigned to those opposite to their prescribed gender but are not necessarily transgender. Furthermore, this broadening of the pathology of transgenderism almost coerces those transgender individuals without the acute dysphoria and ultimate "dysfunction" to be pathologised as disordered while being well ordered and functional on many levels beyond their gender identity. That being said, the use of pathological diagnosis has served the transgender and intersex communities of various countries around the world to coerce various stakeholders to provide the necessary protection, coverage and inclusion of differential public and private policy and legislature. The above is iterated by the World Professional Association for Transgender Health (WPATH) Standards of Care which states thus:

> *"The use of a formal diagnosis is often important in offering relief, providing health insurance coverage, and guiding research to provide more effective future treatments"* (WPATH, 2012: http://www.wpath.org/resource_medicine.cfm).

This use of pathology or formal diagnosis has propelled the American Medical Association to pass a historic resolution supporting health insurance coverage for gender confirming endocrine and surgical care under the auspice that gender affirming/ transition based medical and surgical care warrants a medical necessity for the gender non-conforming communities in need of coverage (American Medical Association, 2008: http://www.ama-assn.org/ama1/pub/upload/mm/16/a08_hod_resolutions.pdf). Derivatively, barriers to social legitimacy and access to transition related medical care remain insurmountable for many gender dysphoric, variant and non-conforming individuals in countries such as Botswana where the public health care system fails to integrate transition based/focused medical care (also known as gender confirming therapy/treatment in the form of Hormone Replacement Therapy, Sexual Reassignment Therapy & Surgery e.t.c) for transgender and intersex people in the greater National Health Policy. In recognition of this point, it remains to be seen whether the government of Botswana will be coerced in the future (of which is the aim of this exercise) to provide transition focused/ gender confirming medical care to transgender and

intersex individuals in light of GID, transgenderism, transsexualism, gender dysphoria and gender non-conformity still remaining pathologised in the DSM. With this said, it is the objective of civil society specifically those focusing on transgender and intersex issues to bring it to the cognisance of government that transgenderism and intersexism are medically recognised conditions in need of recourse and aid from government for affected individuals through provision of medical health support.

The problem of Transgender and Intersex Focused Research in Botswana

The transgender and intersex community in Botswana is an under researched group of gender minorities. The latest national HIV survey (Botswana AIDS Impact Survey III-BAIS III) of 2008; released in 2009, depicts a clear lack of understanding and inclusion of the transgender and intersex community in National Research that influences HIV Prevention and Care Policy in the country, thus leaving the transgender & intersex individuals not covered by public health service delivery. A meeting workshop with the Ministry of Health's HIV/AIDS Prevention and Care Department by Rainbow Identity Association (RIA) in May 2012 proved that beyond just the mere lack of inclusion of the trans and intersex persons in National policy but a more serious issue of lack of knowledge of the existence of transgender persons firstly, as heard from the Director of Department who stated that: "I was just in a meeting with some foreign dignitaries and officials whom upon questioning us on our lack of coverage of gender minorities, I told them that we did not have any transgender people in Botswana" (Lebelonyane, 2012: workshop remarks). A point to acknowledge however, is that the Director was quick to point out that the brief workshop could not have come at a better time as the National HIV/AIDS Prevention Policy had recently been returned from parliament for further review and showed a great need to want to collaborate with RIA to forge a way forward which would see transgender sexual health needs covered in the National Policy. In such forums as meetings and workshops targeting the needs of the transgender and intersex community proves a greater need to firstly conduct extensive workshops on what transgenderism and intersexism entails, while attempting to push the agenda of inclusion and coverage of their needs forward.

Further points of contention are surfaced by some of the more organisation based research that claims to include transgender persons in their discourse but failing to adequately address or interrogate the needs of such persons. One such example would be the BONELA research study on HIV Prevalence, Determinants and Human Rights in the Context of Men who have sex with Men of 2008. The obvious contention that stems from the above study comes from the fact that the study does not explicitly stipulate the gender identity of the transgender persons included in this study; whether they are transgendered men or transwomen is the question. Another major discontentment stems from the assumption or misconception that transgenderism is a form of sexual orientation as put forth under the survey demographics heading; in actuality, transgender individuals also have the whole spectrum of orientation in which they may identify as homosexual, heterosexual or bisexual and further the sexual practices of transgender persons vary such that they too may be MSM or WSW in spite of whatever sexual orientation they identify with might be. Hence, to just cluster transgender persons in the MSM discourse is both false and misleading as it does not target the root core of the needs, challenges and experiences of transgender persons which may cut across and may also differ from those of the cisgendered and sexual minority communities.

The Legal Stance on Transgenderism and Intersexism/Intersexuality

The legal atmosphere currently is what can be understood is silent and ambiguous on the topic of transgender/transexual and intersexual persons. Firstly, as discussed in guest lecture hosted by RIA for the University of Botswana Nursing department, one of the practicing nurses who is a Masters Degree student iterated how the nursing guidelines and principles currently do not put forth any prescriptions or perimeters in which operate when met with an intersex birth or new born baby. This lack of guidelines therefore make for little documentation of intersex persons nor any follow up medical health care, which also translates into general life thereafter. Put in simple we are aware of intersex individuals who have had sexual reassignment surgery performed on them as babies so as to assign such individuals one sex or the other, but have come out to seek recourse for incorrect assignment of sex but to no avail as there are no statutes that prescribe such surgeries yet all the while lacking in the legal framework to enable such individuals to reverse the effects of such surgeries and perhaps to enable trasitioning from one sex/gender to the other. This legal vacuum therefore generates further discrimination and exclusion of these individuals...
The Births and Deaths Registration Act puts forth that:

> *"15. (1) The High Court may, on application thereto by the Registrar or by any other person and on payment of the prescribed fee, by order authorize or direct the Registrar to alter any register of births, still-births or deaths in order to correct an error therein which, by virtue of section 14, the Registrar is prohibited from so correcting without such an order…(2) The High Court shall not make an order under this section unless the material facts, in connection with which the application is made, are proved to its satisfaction"* (1998, Chapter 30 (1), Section 14 and 15: 6-7).

The problem with the interpretation and enactment of this section firstly stems from the fact that the Act does not interpret an amendment of one's gender and/or sex on their national registration documents as constituting the error thereto mentioned in the Act. Trans and intersex persons' transitioning and being in possession of national registration documents that reflect their sex at birth but not representing entirely the sex and/or gender they present as current; the two of which often are contradictory and such constituting the necessity to be corrected so as to be on par and to safeguard the dignity of trans and intersex persons wherever they are requested to provide verification of their national identity as often the case is that one's national ID perhaps is contradicted by the ender and/or sex the individual presents as physically and this often illicit harassment, discrimination, stigma and perhaps the violation of their right to dignity. Secondly, the provision put forward by subsection 2 of section 15, stipulates that for such an order to be issued there has to be satisfactory provision of evidence to legitimate the sex and/or gender (particularly the sex in the context of Botswana) that one currently is at the point of application for such an order. Problematic aspect to this provision is that, the satisfactory evidence required herein compels that the applicant be in possession of both primary and secondary sexual characteristics of the sex and/or gender applied to reflect on the national registry. This is not an issue for some few transgender persons who have access and amenities to sexual reassignment therapy that will infect transition the individuals into the sex and/or gender of their identity, the evidence therefore required (though not put forth in the Act, but recommended to successfully execute litigation in the High Court) include amongst them letters of recommendation and confirmation from a registered Medical Practitioner, General Practitioner/Doctor, Specialist (particularly an Urologist or Gynaecologist), Psychiatrist/Psychologist or Registered

Counsellor, affidavits from parents and/or guardians, affidavits from the applicants themselves all of which are intended at proving the legitimacy of the applicant having been born as one or the other sex and that they have indeed transitioned from such sex to the next and that they are indeed in possession of all characteristics that categorise them as that particular sex and/or gender they wish their national registry to reflect

The legal atmosphere does not explicitly stipulate a stance on transgender and intersex persons, particularly the Act mentioned above, seeking gender affirming therapy such as hormonal therapy, gender reassignment and sexual reassignment surgery so as to transition into the body and gender they most affiliate with. Put in simple, it is not unlawful for a male-to-female individual to access the hormone oestrogen so as to develop secondary sexual characteristics, but this legal vacuum does not put forward the guidelines that this individual should follow so as to have their ID/Omang amended to reflect their transitioning into the sex/gender they currently live in. Many transgender and intersex persons face the insurmountable task of having their national registration documents amended to reflect the gender and sex they live in and present as since there are no clear guidelines that guide such a process. Furthermore, the lack thereof clear legal paths on the matter of transgender and intersex persons makes for a misconception by many a service providers on what transgenderism and intersexuality are thus generating space for poor and sub-standard service delivery to this community of individuals, such as in health care delivery. Many a trans and intersex persons lament on how they often are not aware of how to seek legal protection when discriminated, harassed and or violated since even the law enforcement is not aware of how to treat transgender and intersex clients as the law is silent on this part.

The Nature of the Transgender and Intersex Community's Livelihood and Sustenance

Many a trans and intersex persons in Botswana, though not adequately documented, live under strife financial and economic circumstances brought upon by their exercise and expression of their gender identities. When meeting with trans and intersex individuals in different spaces, one will be compounded by recollections of job interviews where one individual is turned back from a position they are most qualified for just because they do not correlate to the sex that their national identity documentation depicts them as in their physical expression. Some individuals, recollect how they had to leave the work that they were employed for due to being reprimanded for not wearing a skirt to work when their ID/Omang represents them as being female while they are in fact a transman, as such were forced to resign from such an organisation/institution. There are many differential stories of individuals that all paint a picture of a work environment that is non-gender diverse in various parts of the country. Trans and intersex persons have no space in the work place to express themselves in the gender of their identity, primarily because there are no laws that safeguard the liberties of these individuals to function in the work environment as the people they genuinely are. The 2010 amendment of the Employment Act managed to safeguard the rights and liberties of people of diverse sexualities and sexual orientations under section 23 of that Act and thus rendered the discrimination, stigmatisation, and unfair treatment of anyone in the work place based on their assumed or known sexual orientation as unlawful and unconstitutional. The same section 23 asserts the same for any discrimination and unfair treatment of anyone based on their gender, the section reads thus:

> *"3. Section 23 of the Act is amended by- (a) substituting for paragraph (d) the following new paragraph- (d) the employee's race, tribe, place of origin, social origin, marital status, gender, sexual*

> *orientation, colour, creed, health status or disability; (b) inserting a new paragraph (e) as follows- (e) any other reason which does not affect the employee's ability to perform that employee's duties under the contract of employment."* (Employment Act, 2010: A.76).

As is depicted in the above extract of the Act, it safeguards individuals from discrimination and unfair treatment on the basis of their gender yet not extrapolating and unpacking the broad aspect of the gender discourse, which in it includes differential gender identities and expressions thereof. The exercise of this Act has been biased in that it fails to recognise that transgenderism and intersexism fall within the perimeters of gender, thereby concluding that it needs to be furthered to include gender expression and identity and not merely leaving it just as gender. The lack thereof gender diversity in the workplace has forced many a trans and intersex people not to choose mainstream employment where gender is simply categorised into male or female based on what their ID represents them as, of which in the case of trans and intersex persons the ID does not correspond with the physical appearance of the individual. Many who fail to attain employment are forced to live in poverty if they are not able to secure some alternate employment, some have to make the tough choice to conform to what their ID represents them as so as to secure some form of sustenance for themselves and as can be expected many have resulting depression and stress relating to the incongruence in their representation in the workplace. For this, many of these individuals settle for employment that underutilises their professional capacity, credentials and skills just so as to secure some form of sustenance that perhaps does not coerce one to dress and/or act according to the expected characteristics of the sex that is depicted by the ID of such individuals. In these instances in the work environment as it is, some of trans individuals are pushed into seeking alternative employment that does not to require them to report to a supervisor or superior such as commercial sex work, due to the fact that this trade does not necessarily place much emphasis on one's gender and the expression of it therefore and one is their own boss in that regard (Arnott & Crago, 2009: 39-40). The stress relating to the work environment for the trans and intersex who are employed, the underemployment and the unemployed individuals culminates into diverse self destructive tendencies that further places this minority group at high risk for contracting HIV/AIDS such as minor depression and acute-severe depression, disintegrated self esteem, post- traumatic stress disorder, violent outbursts and behavioural patterns, alcohol and substance dependency and abuse and even suicidal tendencies, as will be discussed further in the text to follow (BONELA, 2008: 12).

Transgender and Intersex Community Access to General Health

Repressive laws, silent statutes and the lack of integration of sexual and gender minorities into national health policy in Botswana continue to make it impossible for transgender and intersex persons to benefit from public health as the general population. This group of gender minorities lacks information regarding sexual health matters, HIV and STI prevention and modes of transmission that are specific to their needs since the national policies fail to recognise their existence let alone their needs therefore. This point is evidenced by the lack of documentation and statistical evidence of the transgender and intersex community in national surveys and research as seen in the Botswana AIDS Impact Survey III (BAIS III) of 2008 which in no part whatsoever covers HIV prevalence within this community of gender minorities yet operating under the auspice that it is a measure of HIV/AIDS prevalence and incidence in the whole country. Research around the world continue to prove and iterate that

repressive laws impede efforts of redressing the effects of HIV/AIDS, whereas countries where there are no punitive laws towards sexual minorities and gender variant persons HIV/AIDS initiatives have a higher success rate (BONELA, 2008: 8-9). This is reiterated by the words of former President of the Republic of Botswana, Mr. Festus G. Mogae when he spoke back in 2000 at the UNDP Human Development Report in the December of that year, that the people of Botswana needed to change their strongly held views about certain members of the society in order for the nation to effectively stop any future HIV infections. He urged this, to drive the point home that for the war on HIV/AIDS to be won in the country, the various minority and marginalised groups amongst them including prisoners, homosexuals and commercial sex workers need to be integrated into national prevention strategies (BONELA, 2008: 7). And this is still the same war that cannot be won without the integration of the transgender and intersex gender minority group.

Furthermore, and let it be known at this point that there is not much literature locally which specifically documents the experiences of transgender and intersex persons in accessing health care, that being said the following narratives are from trans and intersex persons in Rainbow Identity Association who shared their experiences in a needs assessment conducted for one of the HIV/AIDS projects in the organisation. These stories are some of the many in the wider country of trans and intersex persons' experiences with public health service providers which in essence demoralised and deterred them from returning to seek medical health assistance in public health institutions such as clinics and hospitals, due to the degrading, below standard and all right violating service provision they were rendered (these have been attached herewith as Annex A). If a member of the LGBTI community experiences homophobia, or transphobia and/or any other discrimination based on their identity, or feels that their needs are not recognised or addressed, that experience can highly manifest in them not returning for further medical consultation that might otherwise be necessary to their overall health and wellbeing (ILGA, 2006, as cited in BONELA, 2008: 9). The above is legitimated by the accounts of a target group of a sample of 5 that Rainbow Identity Association's 2012 ARASA HIV/AIDS Project worked with (attached herewith as stated above), to draw a narrative report of individual experiences with public health service provision as relating to the transgender and intersex community. The compounding conclusion that can be safely deduced from these is the great gap that still exists in so far as HIV/AIDS prevention is concerned, where there are still members of the population who still experience deterrence and fear of accessing general health care services while the prevalence rate in the country steadfastly growths as indicated by the Botswana AIDS Impact Survey III of 2008 (BAIS III) which concluded on a national prevalence rate of 17.6 percent compared to 17.1 percent in the BAIS II survey of 2004(Central Statistics Office, 2008: 2-4).

Transgender and Intersex Persons' Access to HIV/AIDS Prevention & Care

Thus far the status quo emphasises the latter part of the above paragraph to be true as stated by the BAIS III survey of 2008 (Central Statistics Office, 2008: 2-4); which estimated a national prevalence rate of 17.6 percent compared to 17.1 percent in the BAIS II survey of 2004. The same report indicates the new HIV infection rate to be estimated at 2.9 percent, this is a great concern for a country like Botswana with a relatively small population and such

an equally small population of gender minorities, an incidence rate of 2.9 percent is quite high considering that social minority groups are not covered by or integrated into the national HIV/AIDS prevention policies. What this point is driving home is that not only is the state legislature in Botswana not aware of or inclusive of the trans and intersex community but the current national HIV/AIDS policy does not recognise this group either, thus meaning body specific or appropriate HIV barrier or prevention methods for the above group are not available to them and thus leaves this sub community of individuals susceptible to contracting HIV/AIDS. Take the scenario where one is not within the personal capacity (money) to access such amenities as dental dams, finger cots, lubricants the lack thereby of these amenities in governmental health posts further exposes this sub communities and subsequently the rest of the population in the country to contracting HIV/AIDS (Oberth, *AIDS Accountability International CCM Community Consultation-Botswana* 2012 *Draft Report*, 2012: 2-4).

Though Botswana offers free Ante-Retroviral Treatment/Therapy to citizens living with HIV, a great concern stems from the standard of general public health accorded trans and intersex persons. Many a trans people are demoralised and deterred from accessing public health services, that inclusive of sexual reproductive health services, thus leaving them susceptible to lack of access to ARV treatment therefore. In bettering the services accorded trans and intersex people, there might be hope that trans and intersex individuals will feel more encouraged to seek health services at their local clinics and hospitals without fear of the stigma and discrimination based on their gender identity and expression and sexual status. The trans and intersex community. The fear associated with double or secondary victimisation due to one's gender identity and/or sexual status partnered with perhaps living with HIV continues to act as a deterrent to many of sexual and gender minorities' access to HIV/AIDS prevention and care (Arnot & Crago, 2009: 46-47). This is the case within the trans and intersex community where the fear of testing positive for HIV and living as either a trans and/or intersex individual is compounded by the fear of secondary victimisation and stigmatisation, all of which exacerbates the lack of accessing the free and voluntary nature of HIV/AIDS testing and counselling and Ante Retroviral Therapy. Due to the lack of social research specific to trans and intersex persons like the former Minister of Health, Lesego Motsumi states (Ministry of State President, 2009: 16), there is currently a serious lack of knowledge and understanding even of how many trans and intersex persons are living with HIV/AIDS let alone the nature and extent of their access to care and treatment.

Compromised Mental Health exacerbating Compromised General Health

A study undertaken in the Provinces of Gauteng and Kwa-Zulu Natal in South Africa concluded on the linkage between the stigmatisation of members of social minority groups and various stress related and mental health problems. The lack thereof emotional support and social integration for these groups subsequently manifested in diminished self concepts, confidence and lowered self esteem, which therefore culminates into other mental health problems, that may include anything from minor depression to acute-severe depression, disintegrated self esteem, post- traumatic stress disorder, violent outbursts and behavioural patterns, alcohol and substance dependency and abuse and even suicide. One fifth of the

Gauteng participants and 17% of the Kwa-Zulu Natal participants had previously attempted suicide (BONELA, 2008: 12). This is a percentage which most research around the world on trans and intersex issues is quick to point out as generative, that the experiences of trans and intersex persons though contextual from country to country, have a common thread of impact which often than not culminates into some of the above behavioural patterns, which one can quickly draw upon from Annexure A. It is written that in most cases, the use of alcohol and drugs as a coping mechanism accentuated the depression (*Ibid.*: 12). In obvious expectation, one cannot help but be compounded by the deadly equation that is forming before our eyes where we have silent legislature on transgender and intersex issues partnered with non inclusive HIV/AIDS prevention policies, summed together with a less than encouraging public health care system but followed by a clearly growing HIV/AIDS prevalence rate all at the disadvantage of the transgender and intersex community. Having said all that adding the destructive behavioural patterns mentioned earlier in this paragraph to the above mentioned equation, one might notice that the minority groups (specifically in the context of this exercise the trans and intersex group) is an at risk community that ultimately renders any HIV/AIDS prevention strategies ineffective if this group is not integrated into the greater national prevention strategies.

Adopting a Human Rights Based Approach to HIV/AIDS Prevention & Care and General Health Provision

It is enshrined in the 1984 UN Declaration of Human Rights which Botswana is a signatory of that; all human beings by virtue of being born human beings are entitled to all the rights enshrined in this chatter and all subsidiary chatters, treaties and agreements aimed at advancing these basic rights. It further states that all rights are inalienable, meaning that one cannot exist without the other (UN High Human Rights Commissioner, UN Declaration of Human Rights: www.un.org/en/undhr) e.g. the right to life cannot exist without the right to adequate health care and that transcends to HIV/AIDS prevention and care for all. If we are to follow this human rights model, the inclusion and integration of the transgender and intersex population would be seen as advancement in the proliferation of basic human rights to all citizens of the country, which would in subsequence bring the state closer to its goal of reaching 0 percent HIV infections by the year 2016(Ministry of State President, 2009: 19). In actuality, this move would further translate into the protection of the general population's right to live in a healthy HIV free nation and ultimately the right to life; failure to protect at risk groups equals placing the whole nation at risk and adopting a non-biased human rights approach would solve the latter (BONELA, 2009: 20-24).

Botswana is also a signatory to the International Agreement reached at the 4th World Conference on Women held in Beijing: China in 1995, which translates into Botswana having to subscribe to the rights enshrined in the Sexual Health Charter and is obliged to ensure that the sexual rights of all persons are respected, protected and fulfilled, including sexuality education, through which information, skills building and values clarification will enable people to make choices and control of their sexual lives. As written in the BONELA Needs Assessment Report (2008: 8), the exercise of these rights cannot effectively take place in the presence of social and legal coercion, discrimination and violence as evidenced by the deterrence to use public health care by some of the trans and intersex individuals as mentioned earlier in this paper. In a nutshell, if the integration of transgender and intersex

needs in the greater national HIV/AIDS policy is to be looked at from a human rights protection and proliferation point of view then a reduction in the HIV/AIDS prevalence and incidence rates might be attainable.

The stance of the National Strategic Framework for HIV and AIDS 2012-2016

The National Strategic Framework (NSF) is in its second revision (NSF II), having been an improvement of the NSF I of 2003-2009 which aims primarily to reduce the spread, prevalence and incidence of the HIV epidemic by the year 2016 in itself is quick to point out the weaknesses and perhaps opportunities for improvement that already exist in the national response to HIV/AIDS. In the foreword of the then Minister of Health Lesego Motsumi in the NSF II:

> *"there are areas in our response to HIV and AIDS that need to be reviewed and refined so as to find ways in which they can be most effectively sustained over the long term, while others require more intensive focus and energy as well as greater resources in order to achieve greater success"* (Ministry of State President, 2009: 2).

The trans and intersex individuals and community should be viewed as an area which its integration and inclusion into the future revisions of the NSF provides an opportunity to review and refine the country's health services relating to HIV/AIDS. It often is mentioned by some health care providers and practitioners that national health provision is a matter of the consideration of the majority of the population as evidenced by national statistics (Dr . from Gaborone DMSAC). However, HIV/AIDS does not function like a philosophy democracy where the voice of the majority supersedes all, the exclusion of most at risk populations (MARP's) such as the transgender and intersex community in the fight against HIV/AIDS places the whole national population (earlier referred to as the 'majority') at risk since transgender and intersex persons relate sexually and intimately with all kinds of individuals from all walks of life as such their non-integration only serves as an impediment to the prevention of new infections between various communities of the population; an unprotected gender minority renders the nation unprotected. The NSF II acknowledges that there are various groups in the population with special or unique needs that still lag behind in the design of prevention interventions. It further iterates that previous national programmes have been thus far generative in their demographic categorisations such as gender, age, occupation e.t.c. However, to better the efficacy of national responses to HIV/AIDS, the demographics of target groups needs to be diversified so as to develop a much deeper and intimate understanding of all people who make up the target groups in need of interventions (Ministry of State President, 2009: 14). The integration of the trans and intersex community in the national HIV/AIDS response might require more resources to accomplish but it is necessary to bear the cost of those resources if better success is to be achieved in the redress of the epidemic (Ministry of State President, 2009: 2). Further analysis of gaps and challenges to the NSF laments on the limited research that has previously gone into the social sciences field in the country. The NSF acknowledges the significance of ethnographic studies

that could facilitate perhaps a better understanding of MARP's which could enable a better understanding and response to drivers of the epidemic (Ibid.: 16). The trans and intersex community through this exercise should therefore be perceived as offering further understanding of MARP's as put forth above and as offering opportunity for a more intimate needs assessment and address point of view for the NSF.

> *The NSF II further makes its case in its guiding principles by linking itself to the country's VISION 2016 under the pillar of Human Rights in stating that: "The national response upholds individual and human rights by promoting the dignity, non-discrimination and welfare of all people, whether infected or affected by HIV and AIDS and ensuring equal access to health and social support services regardless of race, creed, religious or political affiliation, sexual orientation or social-economic status"* (Ministry of State President, 2009: 18).

In refining the above pillar, gender identity and sexual status should form part of the grounds on which an individual might not be discriminated or denied general health and HIV/AIDS related health care, as supported by Annex A, so as to include as greater of the population as possible in its national HIV/AIDS responses. The above mentioned equal access to health support stems from the basic human right to adequate health for all and that right extends to being handles in a dignified manner when accessing health care so as to illicit openness and comfort, as well as safe environments for trans and intersex persons when accessing sexual and reproductive health care services. This can better be achieved by raising more awareness and hosting educational forums with the health care providers on the ground in clinics and hospitals of the needs of transgender and intersex persons (not forgetting the top-down approach which would cover the National Aids Coordinating Agency and District Multi-Sectoral AIDS Committees) so as to channel better intervention from a better service delivery stance. The guiding principles of the NSF further iterates the significance of a more Evidence Informed Response since evidence forms the basis for programme and policy development relating to HIV/AIDS and by so saying, the needs assessment to follow will form part of this evidence base for the future NSF development (with Annex A already forming part of it). Lastly, the NSF holds gender sensitivity in high regard as it iterates that a better understanding of the various needs of women and men, girls and boys will better the services provided to them therefore which would illicit better results in the national HIV and AIDS response (Ministry of State President, 2009: 18). The gap and opportunity in this objective of the NSF stems in that when discussing the issue of gender and its relation to HIV/AIDS, there must be a multifocal approach to the constitution of women as not only limited to cis-gendered women or men but to realise and perhaps add onto the latter that transgendered women form the basis of the gender 'women' and that transgendered men also make up the bracket of 'men' and as such the two cannot be divorced from the whole gender discourse in HIV/AIDS. The understanding of transmen and transwomen offers an understanding of the diversity of the gender scope and such opening avenues to further the national HIV/AIDS response into. Furthermore, intersex individuals need to be looked as constituting the

diversity surrounding the gender discussion and such cannot afford to be left out of national responses since they have physical health care needs that require extra sensitivity since they border on the common prescriptions of what male and female or men and women are. In extending gender sensitivity to the above mentioned gender minorities, the situations mentioned therefore in Annex. A might be reduced if not eliminated, a scenario which might illicit more trans and intersex friendly HIV/AIDS services which could secure a more accommodating health care that might provide more evidence for accurate mapping of future national responses to HIV and AIDS such as the prevalence and incidence of HIV/AIDS within the trans and intersex community and ultimately the greater population.

Conclusion

Evidence suggests strongly that ambiguous and silent statutes on the issues of transgender and intersex persons continue to impede on the successful execution of HIV/AIDS prevention and care initiatives. Furthermore, empirical evidence as put forth by the BAIS survey in Botswana continue to show a growth in the national HIV/AIDS prevalence and incidence rates. As stated by former State President; Mr. Festus Mogae, it is paramount that there be a paradigm shift of mentalities and ultimately policy towards social minority groups so as to encapsulate them also in the various HIV/AIDS policies within the country that aim to fight and win the war against HIV in the country. These words could not be more necessary in light of evidence that suggests that the country's public health systems does not accommodate but rather demoralises and deters transgender and intersex persons from accessing various health care services that might otherwise be seriously necessary such as pap smears and other sexual health services, in light of the HIV/AIDS pandemic. A human rights based approach is a highly recommended model of recourse, in which the integration of minority group rights into the greater human rights discourse might see the protection and prevention of further HIV infections within minority groups such as the transgender and intersex, thus subsequently protecting the rights of the rest of the general population such as the right to adequate health; which culminates into living in an HIV free environment. Without integration of gender minorities (trans and intersex sub-community), the war against HIV/AIDS might be a futile one, as evidenced by the general rising national prevalence and incidence rates from the BAIS II of 2004 and BAIS III of 2008, due to most at risk groups being left out of national strategies and initiatives aimed at the redress of HIV/AIDS. Continued marginalisation, discrimination and violation of transgender and intersex individuals and communities will continue to render this group an 'at risk group' in light of HIV/AIDS, hence placing the whole nation at risk in the process.

THE FACTS FINDING

METHODOLOGY

STUDY RATIONALE; Status Quo

This facts finding study or needs assessment was designed to identify the gaps that already exist in health care provision within the public sphere for transgender, gender queer and intersex persons within Gaborone Botswana. The status quo is one where we find many a transgender (trans), gender queer and intersex people disheartened and demoralised from seeking public medical health care due to substandard service provision from health care professionals due to their differential gender identity and/or sexual makeup. Furthermore and beyond just qualitative experiences of these individuals, the health care policy formulation is one which totally disregards the specific needs of trans, gender queer and intersex persons that somewhat differ from those of mainstream society.

The intent with this exercise hence was to unpack the factors that contribute to this status quo and perhaps what needs to be done in order to bring about formidable changes that would see this group of marginalised individuals begin to fully access the benefits due universally to all people in their various localities and local health points.

Furthermore, service delivery as it relates to transgender, gender queer and intersex persons is not only dissatisfactory to the above mentioned group but as well fails at the provision of holistic prevention of contracting HIV/AIDS while engaging in sexual activities. An understanding of the bodies of the primary target group being the transgender and intersex persons specifically, reveals that the bodies of such individuals are in part designed differently (trough undergoing sexual reassignment and perhaps even the biological construct of intersex bodies) and in another part the conventional usage or expression of sexual bodies is defied by the manner in which transgender, gender queer and intersex persons use theirs. For this reasons; seeing that transgender, gender queer and intersex persons are in nature gender variant, it should be expected that they will as well be sexually variant to the point that the already available conventional prevention methods and items fail to take into consideration the unconventional needs of this particular group thereby effectively protecting and preventing this group from contracting HIV/AIDS.

HYPOTHESIS

Going into this study and prior to the sampling stage of the study, we went into the exercise with an informed guess that many trans, gender queer and intersex persons fear accessing public health care due to its unwelcoming and unaccommodating manner that it responds to them when attempting to. Furthermore it is the informed guess of the organisation that health care professionals are not knowledgeable of what the specific needs of trans, gender queer and intersex people are, hence making it difficult for satisfactory service to be rendered to the above group of individuals.

THEMATIC AREAS & OBJECTIVES

1. The main objective of this study is to first identify the health needs of the trans, gender queer and intersex population and determine appropriate models of prevention & health care provision
2. The study aims to assess the knowledge base of service providers on trans, gender queer and intersex health needs, particularly those relating to sexual reproduction and HIV/AIDS prevention & care
3. It is also the aim to assess the vulnerability of the trans, gender queer and intersex population to HIV/AIDS

It is the expectation of this exercise that at the end of the study, we will have at least an overview of the knowledge base of the various stakeholders on transgender, gender queer and intersex concepts and the needs of these individuals. It is expected that at the end of this exercise, we will also be in possession of an overview understanding of the sexual behaviour and patterns of the trans, gender queer and intersex population which might in essence gives us an inside look into the sexual patterns and circles that exist in the this population of marginalised individuals as has not been the case in the past. We expect as well that at the end of this exercise, the shortcomings or shortfalls of service delivery towards this population under study as well as the opportunities for improvement that may be identified.

RESEARCH DESIGN

The study piloted with 10 individuals who either identified as transgender, gender queer or intersex who had been asked to share their honest experiences within the public health sphere in trying to access medical care, originating or living in at least Gaborone or the adjacent areas. These experiences were the basis on which this study would legitimate its need in using these differential experiences as a tool to measure the status quo as it is. Primarily the primary target being the trans, gender queer and intersex individuals were to be recruited from within the membership of the organisation itself and even outside; the various communication tools that the organisation used for its various activities were used to recruit and inform the primary target group of the study and how to access it. Since this target group was to self administer the questionnaire of this study, the participants accessed the study by collecting it physically at the Rainbow Identity Association (RIA) offices or on-line by accessing an electronic copy of the questionnaire. The service providers however were interviewed for their input on this study and these were conducted in the comfort of their own offices of usual business. The service providers interviewed were selected from a pool of organisations that RIA has collaborated efforts with as well as independent bodies that render sexual & reproductive health and HIV/AIDS prevention & care services on both a public and private sphere. Due to the nature of the study site being the greater Gaborone, there was not much inconvenience for the participants of this study and such there were no incentives issued to the participants for participation in this study.

Since the study intended to unearth attitudes, experiences, patterns and theoretical understandings, the research methodology was designed in a descriptive and exploratory

manner so as to describe all these attitudes and experiences for the user of the study findings to clearly understand, all the while exploring reasons as to why the status quo is as it is, as well as what can and perhaps still needs to be done to bring about reform. In essence, the study took on both a qualitative and quantitative approach so as to attach numbers (where possible) to various attitudes and practices in this area under scrutiny, though it is worthy to note that the study was predominantly qualitative in nature.

This was done with the aid of the two questionnaires that were developed for the primary and secondary target groups. The primary target group's questionnaire was a self administered type whereas the secondary target group was interviewed on their part. Both questionnaires were anonymous except on the part of service providers who could choose to divulge their true identities and those of their places of work as well or not.

TARGET GROUP

This study was centralised to Gaborone: Botswana, targeting self identifying transgender, transsexual, gender queer and intersex persons aged between 18 and 35 years and living within Gaborone or adjacent areas, in them including Lobatse, Molepolole and Mochudi. The size of this target group was a total of 50 individuals who fit within the above categories of the primary target group. Furthermore, the study targeted 30 service providers who rendered sexual reproductive health and HIV/AIDS prevention & care services within the vicinity of Gaborone as the locality of their practice.

RESEARCH METHOD

This study chose to go with a qualitative approach to acquiring all data that was sought after, as stipulated above with the intent to explore the reasons for trans and intersex persons' experiences of health care provision as well as the deeply personalised experiences and opinions of health care service providers in dealing with this gender variant sub-population of individuals. Quantitative representations were used sparingly where necessary but the findings analysis is predominantly qualitative in nature.

SAMPLING

This exercise had already a pre-set primary target group of transgender, transsexual and intersex persons, hence sampling was purposeful but random using a snowball approach where recruitment was primarily based on Rainbow Identity Association (RIA) contacting its members to alert them of the study and requested that they (the organisation's members) as well pass this information on the study to others who fit the category of the target group but not belonging to RIA to take part in the exercise; hence the snowball effect.

The secondary target group was specifically targeted as stipulated earlier in the discussion from a pre-existing pool of sister organisations to RIA, partners and affiliates who were approached in writing informing them of this exercise so as to solicit their participation.

DATA SOURCES

Two research tools were developed that were targeted at both the primary and secondary target groups involved in the study. Instrumentation was done in a manner that involved

anonymity for the primary target group in a self administered manner. The secondary group was given an option to be fully identified in the discussion of results or to remain anonymous if they so chose but were interviewed for their contributions so as to lead the questions and probe for deeper responses.

ETHICAL CONSIDERATIONS

Recruitment for participation into this exercise was purely voluntary and anonymous, particularly for the primary target group whereas the secondary target group had an option of anonymity or full identity. The primary target group was not followed for participation but rather informed of the study and its access point, which on voluntary basis one was able to access it from the RIA offices where the research was received from and submitted upon completion to the study coordinator alone who kept the completed research tools with her and away from the office. The questionnaire on the part of the primary target group was self administered in seclusion so as to minimise limited responses from shyness or apprehension from having someone ask the questions from the questionnaire. Respondents from the primary target group were instructed not to write their identity anywhere on the questionnaire since their participation was to be fully anonymous in nature. To ensure, confidentiality, the research data was only handled by the editorial team and the study coordinator and not made accessible to the RIA office, its staff and organisational members.

LIMITATIONS TO THE EXERCISE

Firstly to note is the fact that, the chosen primary target size and sample area were far too small to make generic conclusions of the status quo or true nature of trans and intersex persons' lives in the wider country. However, still these findings gave a foundation on which to commence a more nationwide exercise in the future, but at this point only reflect the experiences of Gaborone as the research area. As well, the primary target group characteristics only limited the data collected to an age cohort ranging from 18 years to 35 years only hence the older generation of trans and intersex persons was not reached which provide other differential experiences perhaps or corroborate those of the cohort targeted by this exercise.

Much probing could have been done that had to do with the prevalent use and preference of the female versus male condoms by the primary target group, which could hence provide for clarity of where focus needs to be in so far as dissemination of condoms should be like. Further probing was not done as well on the power relations within and with trans and intersex persons in intimate partner relationships which would inform the levels of sexual autonomy within these relationships. Some of the primary target potentials were deterred from accessing the study due to experiences with general discriminatory and stigma attitudes in society, hence feared taking part in the exercise thereby reducing the target size reached as was expected.

Furthermore, since this was the first of its kind, this exercise intended to bring to the fore the various themes that cut across the trans and intersex community, the research was hence too compact and lengthy as such disadvantaging certain parts of the questionnaire that were not answered in depth and satisfactorily as would have been expected. However, with that said,

the compact nature of the research tool brought to the fore the fact that perhaps some of the themes covered by the research needs to be taken individually and targeted for much in depth responses.

A major challenge came in that this exercise took off at a time when other studies of its calibre were taking place in which participation in such research was financially incentivised therefore rendering the fact that this particularly one did not provide financial incentive as demoralising for some, thereby limiting the population reached.

The research tool proved to have had a typing error or spelling error in the type of sexual orientation known as 'penn-sexuality' which in fact is to be spelt as 'pan-sexuality'; which defines an individual's who is attracted to people and engage sexually with people not because of or based on their gender or sex. The team considers this not to have had much detrimental impact on the findings of the true population of pansexual individuals within the trans and intersex community. This is due to the fact that though written differently, the two words have the same diction and such for any person identifying as such but knowing the correct spelling of the type of orientation would still be expected to tick it since they are pronounced the same either way. However, the team is confident that should this misspelling have any impact on the findings would be of low level of impact since pan-sexuality is already a minor type of orientation to the greater community as a sexual identity much so within the trans and intersex community in relation to the rest.

The research permit sought for this study proved to be a more exhaustive process than was initially expected to be and such highly compressed the time needed to commence data collection and ultimately the volume of the secondary target groups reached and included in this report. This was due to the fact that the permit was never issued and such, some service providers retracted their input and responses from being used in this research without the latter and such made for a relatively smaller portion of the discussion in this report since the population ultimately used was far less. That being the case though, the team is confident that the data collected on this group still attest the claim that there are attitudes that pre-exist within service providers relating to gender minorities such as the trans and intersex. The findings prove as well that there is further research or probing that needs to be dealt with, within service providers such as the linkage between social and cultural upbringing and how it impacts on the attitudes and services accorded persons who perhaps who transgress the principles of their respective social and cultural upbringing such as the trans and intersex individuals.

NEEDS ASSESSMENT FINDINGS REPORT

PRIMARY TARGET GROUP FINDINGS

1. Respondents' age

Age Cohorts	Frequency	%
20-24	6	26.1
25-29	8	34.8

30-35	4	17.4
No age marker	3	13

The highest age range or cohort of respondents was the age range from 25 to 29 years with 34.8%.

2. Gender Markers/Demarcations

2.1. Sex Assigned at birth

Sex	Frequency	%
Male	6	26.1
Female	12	52.2
Intersex	2	8.7
No sex marker	2	8.7

2.2. Fulfilled Gender Roles

Gender Roles	Frequency	%
Man	7	30.4
Woman	5	21.7
Man & Woman	5	21.7
Neither man nor woman	6	26.1

2.3.Gender Identity

Gender Id.	Frequency	%
Transman	9	39.1
Transwoman	5	21.7
Gender Queer	9	39.1

Worthy to note is the fact that, though 8.7% of the respondents indicated to have been born intersex did not retain that status as their identity but rather identify as transmen.

3. Sexual Orientation according to Gender Identity

Sexual Orientation	Gender Identity		
	Transman	Transwoman	Gender Queer
Homosexual	3		4
Heterosexual	5	4	2
Bisexual		1	
Pennsexual	1		
Asexual			
None Identified			3

33.3% of those identifying as transmen identify as homosexual, whereas 55.6% of the transmen identify as heterosexual and the latter 11.1% identifying as pennsexual. 80% of the total of those identifying as transwomen identified themselves as heterosexual with the remainder 20% identifying as bisexual. Those self identifying as gender queer consists of 44.4% homosexuals, while 22.2% regards themselves as heterosexuals and the remainder 33.3% having not ticked any of the listed orientations nor did they enlist any other. A cumulative tally of all the respondents we arrive at 30.4% of the respondents identifying as homosexual, while 47.8% fall within the heterosexual category, 4.3% identifies as bisexual and pennsexual respectively and 1.3% of the respondents did not categorise themselves into any sexual orientation class or category.

4. Occupation

Occupational Status	Frequency	%
Employed	11	47.8

Unemployed	12	52.2

Of the major group being the unemployed at 52.2%, 41.7% indicated that they are still studying.

4.1. Occupation according to Gender Identity

Gender Identity	%	
	Employed	Unemployed
Transman	55.6	44.4
Transwomen	40	60
Gender Queer	44.4	55.6

Of the total number of respondents identifying as transmen 55.6% of that total is employed whereas 44.4% is unemployed. Of the total of transwomen, only 40% is employed while the remaining 60% indicated to be unemployed. Lastly from the gender queer group, 44.4% indicated to be employed while 55.6% is unemployed. Of the total group of the 52.2% unemployed respondents, 41.7% indicated to still be scholars. Of the total number of the scholars 80% is constituted by the gender queer individuals with the remaining 20% constituted by transmen.

SEXUAL BEHAVIOUR & PRACTICES

5. Sexual Practices

Sexual Practice	Frequency	%
Fingering	10	43.5
Fisting	2	8.7
Thigh Sex	2	8.7
Rimming	2	8.7
Use of dildos and other sex toys	7	30.4
Clitoris on clitoris	4	17.4
Anal penetration	5	27.7
Vaginal penetration	11	47.8
Oral sex	14	60.9

6. Awareness of HIV risk in sexual practices

Of the total of 10 individuals practising fingering, 2 (being 20% of that total) were not aware or knowledgeable of the HIV risk involved in fingering. Furthermore, 3 out of the total of 7 (42.9%) individuals that listed themselves as having used dildos and other sex toys iterated that they were not aware of the HIV risk involved in the use of such items. The total of 17.4% of individuals who engaged in clitoris on clitoris sexual practice expressed a lack of awareness of the HIV risk involved in this type of sexual act, other than the above listed the most of the respondents expressed an understanding of their risk to HIV in the various sexual acts they engage in.

7. Knowledge, access to and availability of relevant barrier methods for sexual practices

The most prevalent barrier methods known to the respondents were collated into the following table in accordance with the sexual acts divisions in this exercise as per the responses from the respondents:

Sexual Practice	HIV Barrier method/item
Fingering	Gloves, finger cot/ finger dom

Fisting	Gloves
Thigh sex	None
Use of dildos	Condoms
Clitoris on clitoris	None
Anal penetration	Condom, Lubrication
Vaginal penetration	Condom
Oral sex	Condom, dental dam
Rimming	None

In synthesising the above table with table5, it is apparent that the 8.7% of respondents who practice thigh sex have no knowledge of the barrier methods/items to use in order to minimise chances of contracting HIV in this mode of sexual interaction. Furthermore the 17.4% of respondents engaging in clitoris on clitoris type of sexual interaction also are not aware of the relevant HIV barrier methods much like the 8.7% engaging in rimming. All of this point out a major gap in so far as availability of optimum HIV prevention/barrier dissemination is concerned. However, this inavailability is not only limited to the above mentioned practices for which the main actors of which are not knowledgeable of the relevant barrier methods for the latter, but out of the total of respondents engaging in fingering only 3 out of the total of 10 (30% of the total 43.5% engaging in fingering) were aware of and had the barrier methods needed for this act readily available on them at all times when initiating sexual interaction. Furthermore, a strong connection was built by the respondents between condom usage and the necessity of lubricants/lubrication while engaging in anal penetrative sex, however only 1 respondent out of a total of 5 (20% of the total 27.7% engaging in anal penetration) engaging in anal penetrative sex iterated to at all times always having a condom and lubricant of choice ready at hand before initiating sexual interaction. With knowledge that lubrication is necessary during anal sex so as to prevent tearing and haemorrhage during sex which might expose one to the high risk of coming into contact with potentially HIV infected blood during this kind of sexual act, the inability for the most of respondents to have any form of lubrication on them during sexual interaction indicates yet another major gap in so far as optimum availability and dissemination of barrier methods/items is concerned. Finally, of the total of 14 respondents who engage in oral sex who put forth a condom and dental dam as the most prominent barrier methods for this act, only 6 (42.9% of the total for oral sex) explained to always having at least a condom for those who use it for oral sexual intercourse whereas the remainder which in actual fact using dental dams (that being 8 respondents out of the 14) only 1 pointed out to the fact that they always had dental dam(s) on the ready before instigating sexual interaction. That then means the remaining 7 respondents that make up 50% of the total of individuals practising oral sex do not consistently use the relevant barrier methods needed to prevent HIV transmission through oral means.

Adding to the above, in bringing issues of access points or dissemination posts for barrier methods/items, respondents expressed the ready availability of condoms many in a public spaces including hospitals, clinics, bars, workplaces, hotels & lodges and public toilets however all the respondents who accorded the inavailability of their needed barrier methods to their inavailability in such public spaces as the ones listed above more especially in government hospital and clinics. Respondents lamented on the fact that dental dams needed to protect them from contracting HIV during oral sex and lubrication that is much needed for anal sexual protection are not available in public clinics and hospitals which therefore perpetuates them not having these items readily available when sexual interaction is initiated therefore being left susceptible to contracting the HI Virus.

8. Sexual Partner Characteristics

69.6% of all respondents stated to being unknowledgeable of their sexual partners' HIV status prior to engaging in sexual interaction, while a staggering 52.2% attested to having engaged in sexual interaction with their partner without any HIV prevention/barrier items upon probing verbally that the potential partner was HIV negative. Furthermore, 82.6% of all the respondents expressed that they had at some point in their stable permanent/regular relationship. The decision to cease the use of prevention items was indicated as one taken by 39.1% of the respondents themselves as individuals, while 13.0% of the respondents indicated that their sexual partners suggested the ceasation and a greater 47.8% indicated that the decision was a mutually suggested one between them and the sexual partners. Still within these stable permanent/regular sexual relationships only 8.7% indicated that they go for regular HIV tests with their sexual partners, 17.4% of the total respondents indicated to going for HIV tests every 6 months, while 43.5% indicated that they had only done an HIV test once in their relationship and 30.4% of the respondents had never gone for an HIV test with their sexual partner since their relationship began. The group of respondents who indicated to never having gone for an HIV test with their partner for reasons that most of them feared rejection, discrimination and stigma of being transgendered and/or intersex, furthermore iterated that they felt fearful of having to explain the mode of sexual interaction they engaged with as such would not wish to go for such HIV counselling and testing services. Finally, some of the reasons that came across were the fact that 73.9% of the respondents' reasons were derived from prior bad experience with service providers where they expressed to having been treated to substandard service, were made into a spectacle where they felt embarrassed and humiliated such that they decided never to go back to health service providers (particularly government based as most iterated) due to fear of being violated again.

9. Alcohol and Drug use in relation to HIV

100% of all the respondents indicated to consuming alcohol; of this total 13.0% of the respondents expressed consuming alcohol once a month, whereas 30.4% attested to the lot once a week, 43.5% explained that they consumed alcohol 2-3 times in a week as compared to the 4.3% who attested to consuming alcohol 4-5 times in a week and finally an 8.7% representation of respondents expressed to consuming alcohol everyday of the week. With these representations of alcohol consumption above, 91.3% of the respondents expressed that they had engaged in sexual interaction with their partners while under the influence of alcohol. 17.4% of the respondents expressed to smoking dagga/marijuana and the total of the marijuana smoking group attested to having engaged in sexual interaction whilst under the influence of dagga/marijuana.

Further analysis indicate that, of the alcohol consuming group, 82.6% of the respondents attested to having used an HIV barrier method/item while under the influence, 13.0% of the alcohol consuming lot expressed to having not used any barrier method/item the last time they had sexual interaction while under the influence of it while only 4.3% stated not to remember whether any barrier method was used the last time they had any sexual interaction while they were under the influence of alcohol. Furthermore, the total of the marijuana smoking respondents expressed to have used some barrier method/item while under the influence of dagga/marijuana. Of greater concern though, is the correlation between the consumption of alcohol and the expressions of the inavailability of some necessary barrier methods/items needed for safe sexual interactions.

Worthy to note is that none of the respondents expressed using any other substances or drugs such as histalics (ectstacy), cocaine or heroin or any other injectable drugs.

10. Knowledge & Perceptions of HIV/AIDS

In response to rating the most risky sexual interactions for the transgender, gender queer and intersex persons, 100% of the respondents attested to understanding vaginal penetrative sex as a high risk form of sex, while 13.0% identified all the acts from vaginal to oral to anal sex as most risky. 26.1% identified oral sex as high risk whereas 91.3% ticked anal sex as being a high risk form of sexual interaction. For that reason, when probing for which sexual practices the respondents felt should be promoted amongst the transgender, gender queer and intersex community, the most of respondents at 47.8% felt that the use of dildos and other sex toys should be promoted amongst this community as a measure of reducing HIV transmission, followed by 30.4% of the respondents who encourage oral sex as a safer mode of sex in light of HIV transmission reduction while 39.15 of the respondents encouraged fingering and lastly 17.4% were for rimming. While on the topic of knowledge and perceptions on HIV/AIDS barrier methods and family planning, a 69.6% of all the respondents lamented on their lack of usage of any family planning methods for a plethora of reasons the most recurrent of which were that their preferred mode of prevention was not readily available in public spaces such as dental dams, all the while some of this section of respondents felt no need to use any prevention method for reasons that they were not in any way likely to conceive with their respected partner and others expressed that going for these family planning interventions at clinics and hospitals was not an option since nurses and doctors treated them in a manner that made them to never wish to go back due to their sexual status or gender identity and such just did not bother with family planning methods/items.

11. Interpersonal communication/negotiation on sexual safety

In negotiating and perhaps advocating for personal sexual safety with permanent/regular partners, 73.9% of the respondents expressed to having negotiated for HIV prevention methods/items use for reasons that the topic arose from them discussing their gender identity and sexual status perhaps with their new permanent/regular partner, while some did so for reasons that they needed to protect themselves against contracting STI's and HIV ultimately and the latter indicated that such discussions were meant to explore options of how to protect each other given the inavailability of needed barrier methods but felt that the partner deserved to know this. When probed for evidence of such discussions with casual/non-regular sexual partners 34.8% of those attesting to having casual sexual partners iterated that they discussed HIV prevention methods/items with such a partner for reasons that they wished to protect themselves from contracting STIs from someone they met once off or were just casual with, while a 47.8% did not enter into discussions of HIV prevention with a casual sex partner for reasons that they made sure to have their preferred method/item at hand before initiating such sexual interaction, while others iterated not to have done so out of shame or embarrassment of having to discuss their gender identity and/or sexual status. Of the respondents' sexual partners of choice, probing was done to ascertain whether the respondents knew the relevant prevention methods to use 4.3% of the respondents who are/have been sexually active with transmen and transwomen respectively iterated to being aware of the relevant barrier or prevention methods to use with the latter, while another 4.3% of the same group sexually attracted/involved with transmen was not aware of the relevant barrier methods/items to use with this kind of sexual partner. 43.5% attested to have been involved or still involved with intersex men but not aware of the barrier method/items to use

whilst engaging with these men. Finally 17.4% of the respondents stipulated to know the barrier methods to use with cis-gendered male partners while 56.5% of the same lot stated to know the same for cis-gendered female partners. For those who were aware of the various HIV prevention methods/items needed for use with their sexual partners of preference indicated to have gotten such information from the internet, Rainbow Identity Association and from sexual partners they engage with. This also generates a clear gap in HIV/AIDS prevention care services since none of the respondents indicated having got this information from either health care providers or the media, or from school neither from community health workers, other NGO's or any of the other options that had been put forth in the questionnaire nor listed any other that was not.

12. Sexual Violence

8.7% of the respondents expressed to having been sexually abused/assaulted sometime in their life. One respondent expressed the choice not to report the case as was afraid of prejudice since they identify as gender queer and as expected did not receive any PEP post this assault though they expressed that no HIV prevention method/item was used in the assault by the perpetrator(s). No psycho-social support was given to that effect. The respondent further stated that they became dependent on alcohol to get by after this assault but failed to fill in the latter enquiry on whether during their alcohol dependency they would regard their sexual behavior as responsible. However, the respondent who had reported their sexual assault to the police regretted the decision as they were treated badly when expressing the nature of their gender identity at the initial stages of reporting and documenting the series of events to the authorities. The respondent lamented that they were treated funny after disclosing their gender identity and that the perpetrator was let loose on the basis of not enough evidence but was given PEP. The latter respondent expressed that they had underwent psychological support post the sexual assault such did not need alcohol or any other substances as coping structures. Worthy to note is that all of these respondents were born male bodied though the first identifies as gender queer while the latter lives as a woman and identifies as transwoman.

13. Awareness of HIV/AIDS prevention and care services

73.9% of all respondents attested to knowing their HIV status and of that total 47.8% indicated to having gone for their last test over 12 months before responding to this research questionnaire, whereas 26.1% indicated to have been last for a test within the past 12 months prior to this study and of the remaining lot 21.7% indicated not knowing their status and the modal reason was the fear of discrimination, stigma and humiliation about their gender identity and/or sexual status. With that, all of the respondents expressed having gone to access public health care at some point, while 39.1% stated as preferring to use private medical health care, 49.8% indicated to have accessed voluntary counselling and testing services while 17.4% stated that they had accessed social support groups and only 4.3% of the respondents had accessed prevention of mother to child transmission services. In accessing some of the above mentioned HIV/AIDS care services 82.6% of the respondents express that they had at some point disclosed their gender identity or sexual status to service providers hence, when asked to rate the level of service delivery rendered to them upon this disclosure 8.7% of this total indicated the service as satisfactory, whereas 17.4% stood at neutral while 47.8% rated the service accorded them as unsatisfactory and an 8.7% of the respondents lamented to having been denied services upon knowledge of their gender identity or sexual status. Cumulatively one will realise a dangerous pattern trickling down throughout this paper of disgruntled and disheartened transgender, gender queer and intersex persons who feel demoralised from seeking HIV/AIDS related services in general due to

unsatisfactory service accorded them by service providers as indicated by the above figures which when summed up depict that a 73.9% of all the respondents were holistically not satisfied with the service accorded them after disclosure of their gender identity or sexual status which becomes an impediment to service delivery and ultimate redress of HIV prevalence and transmission within this community and to the greater society; thereby rendering 0% new infections by the year 2016 for Botswana just a pipe dream. With that said, all of the respondents expressed that they would rather ask a friend if they needed advice on safer sex with their partner, while 78.3% responded as comfortable to ask for such advice from permanent sexual partners that they engage sexually with and 87.0% preferred to probe for such information from LGBTI service providers but a 21.7% of the respondents preferred to acquire such information from private medical health care.

SECONDARY TARGET GROUP FINDINGS: Health Care Service Providers

85.7% of service providers expressed the lack of local literature on trans & intersex persons as an impediment in understanding & best serving transgender, gender queer and intersex persons. All service providers expressed how their work ethic and service delivery guidelines are non-discriminatory towards all people hence transgender, gender queer and intersex persons should feel comfortable in accessing various of their services; contrary to the experiences of transgender, gender queer and intersex persons on the ground as expressed by the figures above in this paper.

90.5% of service providers expressed that they are not adequately equipped to deal with transgender, gender queer and intersex persons, as they do not yet understand the specific/differential needs of this group, however expressed a concern that this sub-community needs to be more lenient on service providers as for the most who have come across this group do so on a first time basis and such a little curiosity and shock on their part should be understood. Furthermore, service providers expressed that this sub-community of individuals should understand that the onus is on them to inform and educate service providers as much as possible since there is not enough literature out there particularly that addressed or brings to the fore the challenges and needs of local transgender, gender queer and intersex persons.

52.3% of service providers identified transgender, gender queer and intersex persons as vulnerable to contracting HIV due to specific barrier items needed by this group e.g. condoms that fit transmen, lubricant that is needed by transwomen being unavailable particularly in the public domain.

33.3% of the service providers expressed their professional opinion that this group of persons under discussion do not practice safe sex or are not adequately protected in sexual contact since they are not catered for in the already available prevention methods in the public sphere currently as indicated above.

One of the service providers with the Ministry of Health under the HIV/AIDS Prevention & Care Department (who is a qualified and still practicing nurse) expressed how they feel abused as nursing staff due to the instant expectation from gender variant persons to understand them immediately and failure to do so leaves them disgruntled when they still deal with the shock themselves and in need of professional consultation with some of their colleagues, though earlier in the text it is explained how some of these gender variant persons have been denied services upon expressing their gender identity or sexual status; a gap that needs to be dealt with if gender variant persons are expected to become a part of the greater response to HIV/AIDS in the country.

RECOMMENDATIONS

Of greater realisation in these needs assessment is the lower levels of understandings of trans and intersex persons by health service providers. Hence, vigorous and in depth consultative & educative interaction needs to be established between civil society bodies focused and vested in transgender and intersex human rights issues, so as to augment the level of knowledge or thereby the lack of knowledge on transgender and intersex persons. This interaction needs to be focused on reaching high levels of health management and policy formulation then trickling that information and knowledge down to the grassroot service providers (nurses, doctors, counsellors e.t.c) on the ground in clinics, hospitals and testing centres where there is interaction with trans and intersex persons on various occassions. With a more knowledgeable health system, we expect a reduction in the percentages of trans and intersex persons being deterred from seeking and accessing differential health needs including HIV/AIDS prevention and care, hence bringing the country closer to reaching 0% new infections by 2016 through reaching down to and providing HIV/AIDS related services to gender minorities such as the transgender, transsexual and intersex persons.

Furthermore, a human rights based approach needs to be incorporated into service provision so as to encourage and sustain a more humane and warm system which embraces understanding of the various constructs of people and the need for their dignity to still be respected regardless, when seeking health related services specifically sexual reproductive and HIV/AIDS prevention and care services in light of reduction of possible STI/HIV transmissions between and with trans and intersex persons. Of greater need to sustain the knowledge base of service providers is the availability of trans and intersex specific literature that is at the disposal of nurses, doctors and counsellors on the ground in clinics, hospitals and counselling. And most importantly, this literature needs not be too generic but rather be HIV/AIDS and sexual reproduction specific on trans and intersex persons

It is also apparent that the history behind the lack of availability of prevention items for trans and intersex persons, is the jurisprudence that there are certain sexual practices that are not encouraged or more specifically criminalised by the country's constitution and penal code. However, there needs to be understanding and encouragement to expand the understanding of sexual practices on a national level since most if not all of sexual practices are not constrained to any sexual orientation or gender identity but rather run across all levels of human sexual relations. Of great importance is to note that, HIV/AIDS prevention material and items needs to be widened to cater for all and not any specific sexual practices such that all people in the country regardless of orientation and gender identity are protected against contracting STI's and HIV/AIDS.

To arrive at far reaching effects of the greater human rights approach to the lives of trans and intersex persons, the health sector of government needs to link up its provision of services and discourse with other governmental departments so as to incorporate a holistic approach to service provision for social development purposes and human rights proliferation. This needs to transcend into even the ally organisation in the health sector network of governmental and non-governmental entities. Much more importantly stemming from this exercise is the need for policy review and appraisal of existing policies such as the health policy need be made explicit in the standards of care to be accorded gender minorities across board so as to guide the manner in which to handle gender minorities and their differential needs to those of mainstream society.

This paper highly recommends that HIV/AIDS services and most importantly HIV/AIDS messaging needs to be expanded so as to take into account and even specifically do targeted messaging to trans and intersex persons which in essence widens the scope and reach of incorporative community mobilisation around HIV/AIDS issues particularly with reaching the 0% new infections by 2016

mark. Important to say is that, the inclusion and specific targetting of trans and intersex persons in health service provision needs to be looked at as a stepping stone to reaching 0% new infections by 2016.

CONCLUSIONS

Evidence suggests strongly that ambiguous and silent statutes on the issues of transgender and intersex persons continue to impede on the successful execution of HIV/AIDS prevention and care initiatives. Furthermore, empirical evidence as put forth by the BAIS survey in Botswana continue to show a growth in the national HIV/AIDS prevalence and incidence rates. As stated by former State President; Mr. Festus Mogae, it is paramount that there be a paradigm shift of mentalities and ultimately policy towards social minority groups so as to encapsulate them also in the various HIV/AIDS policies within the country that aim to fight and win the war against HIV in the country. These words could not be more necessary in light of evidence that suggests that the country's public health systems does not accommodate but rather demoralises and deters transgender and intersex persons from accessing various health care services that might otherwise be seriously necessary such as pap smears and other sexual health services, in light of the HIV/AIDS pandemic. Evidence brought forth by this needs assessment corroborates that many a trans and intersex persons fail to utilise the fullness of health services due to attitudes and practices in service providers that deter them from seeking these services on a public sphere though some do not afford private medical care as an alternative.

A human rights based approach is a highly recommended model of recourse, in which the integration of minority group rights into the greater human rights discourse might see the protection and prevention of further HIV infections within minority groups such as the transgender and intersex, thus subsequently protecting the rights of the rest of the general population such as the right to adequate health; which culminates into living in an HIV free environment. Without integration of gender minorities (trans and intersex sub-community), the war against HIV/AIDS might be a futile one and the target of 0% new infections by 2016 might just remain a pipedream for a very long time. Continued marginalisation, discrimination and disregard of transgender and intersex individuals and communities by pre-existing policies and levels of service provision will continue to render this group an 'at risk group' in light of HIV/AIDS transmissions, hence rendering the whole nation at risk in the process. It is very clear that the time has come in which, the system needs to be reviewed and developed so as to better serve the whole nation and not just the majority of privileged members of society who were not born gender variant such as trans and intersex persons.

ANNEXURES

Annex A: Focus Group Questionnaire (Pilot Group)

Participants: Lolo Teemane (a transgendered woman), Brandon Tshabatau (a transgendered man) and Pacs Phakwa (a transgendered man) (Selected from the Needs Assessment meeting hosted on the 21st of April 2012 at Rainbow Identity Offices)

Below are the narratives of the participants in their own words.

General consultation with health care providers:-

Lolo: When asked to pay the consultation fee at a local clinic, she was was denied assistance upon her national ID reflecting her as male. The officer at the helm of all this then called other colleagues to come see the spectacle that they were dealing with on that day (that being Lolo). Lolo decided to leave without having accessed the needed medical attention she went to seek and upon returning later, a male nurse was called to come assist her because her ID stipulates that she is 'male'.

Pacs: States that he no longer uses government clinics and hospitals, or rather avoids them at all cost, because once upon going to a local clinic to seek medical care for an aching ear he was apparently interrogated on whether he was male or female and upon his explanation of his transgender status the nurses began to show signs of fearing him which deterred him from every going back to that specific clinic. He, tried a different clinic in which upon consultation with a medical doctor there his transgender status resurfaced and the doctor insisted on Pacs realising that if and when has menstrual periods that equals them being female. For that, Pacs was further deterred from accessing public medical health care.

Brandon: Explains that he once went for a much necessary pap smear to test for cervical cancer. Brandon explains that he too was interrogated by a doctor in the consultation room of his gender/sex which he iterates that he explained his transgender identity but was sadly told to leave the consultation room for he looks male and such men do not do pap smears. He explains how when he was exiting the clinic he noticed that he was further discussed (having expressed it as them gossiping about him in the hallway) by the consulting doctor and some other doctors and nurses whom he had not consulted with. Brandon too explains that he never again attempted to return for another pap smear consultation.

Access to prevention and barrier methods:-

Lolo: States that she uses both male and female condoms which she can get at a local clinic. Lolo explains how at one point she was interrogated by a nurse infront of other patients in the hallway on whether she was male or female and what she was doing with female condoms, Lolo narrates that she had an asthmatic attack on that day at that point which ultimately lead to her fainting right there on the hallway. Since there are no lubricants available in public clinics and hospitals, she buys her own lubrication with her own money.

Pacs: Explains how it frustrates him that there are no oral sex barriers methods available not only in public health posts but in the country as a whole. Pacs laments on how if and when he engages in oral sexual practices he has to do so without any protection from contracting HIV.

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