The Draft South African National LGBTI HIV Framework, 2017-2022 is a milestone in the country's response to HIV, AIDS, STIs, and TB for LESBIAN, GAY, BISEXUAL, TRANSGENDER, INTERSEX PEOPLE.
The South African National LGBTI HIV Framework, 2017-2022 (LGBTI HIV Framework) is a milestone in the country’s response to HIV, AIDS, STIs, and TB. A national, multisectoral effort to address the linked HIV/AIDS/STI/TB epidemics among Lesbian, Gay, Bisexual, Trans* and Intersex (LGBTI) people—is urgent and somewhat overdue. Due to HIV vulnerabilities which are unique to each sub-group, there is a need for a strategic document that focuses on the LGBTI groups to support the new National Strategic Plan on HIV, STIs and TB 2017-2022.

Several factors, including widespread social disapproval of homosexuality create barriers and stigma. Lack of access to necessary prevention commodities such as condom-compatible lubricants (often exacerbated by stigma and discrimination), lack of knowledge on the part of healthcare and social services professionals about LGBTI specific health, exclusion from equal opportunity to participate in the economy, and internalised stigma all contribute to LGBTI people’s vulnerability to HIV, TB and STIs. This framework adds substance to service provision, human rights, strengthened community networks, and other priorities of the national HIV response through a peer led approach. Addressing these specific challenges in a systematic, multisectoral way will improve the health and psychosocial outcomes of individual LGBTI persons and communities and create services that are more inclusive for all people living in South Africa.

Building on the knowledge of a wide range of stakeholders, data and evidence from research, particularly on MSM and trans*; and the lessons learned from civil society programmes for these groups, the LGBTI HIV Framework articulates a set of interventions that will improve the national response to LGBTI wellbeing. Moreover, the LGBTI HIV Framework aims to involve and engage more stakeholders in response to the challenges that confound LGBTI health. The LGBTI HIV Framework will serve as an aid to all stakeholders and implementers, informing their programming, their messaging, their research, and their monitoring and evaluation, and as a guide on how to tailor their programmes for the LGBTI community.

The Framework marks an exciting development in HIV programming in South Africa. Over the coming years, I look forward to all stakeholders building an environment that is affirming of LGBTI sexual identities and orientations, and which provides LGBTI people the necessary tools to realise their health and human rights goals.
ACKNOWLEDGEMENTS

The development of the South African National LGBTI Framework would not have been possible without the cooperation and collaboration of numerous stakeholders. The National LGBTI Framework has been the effort of a wide range of government departments, NGOs, research organisations, the SANAC LGBTI Sector and the SANAC Secretariat who worked together to establish consensus on all aspects of the framework.

All members of the Technical Working Group who made a substantial contribution of time and effort. Fareed Abdullah (CEO of SANAC) and Steve Letsike (SANAC Deputy Chairperson) who co-chaired the Technical Working Group, the Steering Committee consisting of Helen Savva (CDC), Mariette Slabbert (Wits RHI), Renugan Raidoo and Ben Brown (ANOVA Health Institute), Leigh-Ann van der Merwe (SHE), Dawie Nel (OUT Wellbeing), Brian Kanyemba and Nonhlanhla Mkhize (SANAC LGBTI Sector), Connie Kganakga, Lebowa Malaka, Rebonne Pettele (all SANAC Secretariat) must be acknowledged for their special efforts to keep the process on track.

We would like to thank the many organisations, institutions and individuals involved in this activity for their participation in and contribution to the development of the framework.
5.3.7 Counselling Support 29
5.3.8 Alcohol and Drugs 29

5.4 Human Rights 29
5.4.1 The Right to Confidentiality 30
5.4.2 Supportive Legislation and Policies, Including Law Reform 30
5.4.3 Legal Literacy and Services 30
5.4.4 Sensitisation of Law Enforcement, HCW, Social Workers 31
5.4.5 Access to Legal Support 31
5.4.6 Access to gender affirming treatment and surgery 31

5.5 Evaluation 31
5.5.1 Research 31
5.5.2 Monitoring and Evaluation 32
5.5.3 Data sources and flow 32

6. Central Roles and Responsibilities 33
6.1 Planning, coordination and management 33
6.2 Sustainability 34
6.3 Human and financial requirements 34
6.4 Costing and financing plan 34

REFERENCES 35

FIGURES
Figure 1. Theory of Change 16
Figure 2. Cascade of HIV prevention, diagnosis, care and treatment 18

TABLES
Table 1. Summary of Health Services 23
Table 2. Summary of Empowerment Services 26
Table 3. Summary of Psychosocial Services 30
Table 4. Human Rights Services 31
Table 5. Summary of Research Evaluations 32
Table 6. Monitoring and Evaluation Indicators 33

ACRONYMS AND ABBREVIATIONS

AIDS Acquired Immunodeficiency Syndrome
ART Antiretroviral Therapy
CBO Community-Based Organisation
CMD Common Mental Disorders
DBE Department of Basic Education
DSD Department of Social Development
DOE Department of Education
DOH Department of Health
DOJ Department of Justice and Constitutional Development
FBO Faith-Based Organisation
FTM Female-to-Male (trans man)
HCW Health Care Worker
HIV Human Immunodeficiency Virus
HPV Human Papilloma Virus
HTS HIV Testing Services
IEC Information, Education and Communication
KABP Knowledge, Attitudes, Beliefs and Practices
LGBTI Lesbian, Gay, Bisexual, Transgender and Intersex
M&E Monitoring and Evaluation
MMC Medical Male Circumcision
MSM Men who have Sex with Men
MTF Male-to-Female (trans woman)
NGO Non-Governmental Organisation
NSP National Strategic Framework
PEP Post-Exposure Prophylaxis
PHC Primary Health Care
PMTC Prevention of Mother-to-Child Transmission of HIV
PrEP Pre-Exposure Prophylaxis
PSS Psychosocial Support
SANAC South African National AIDS Council
SAPS South African Police Services
SBCC Social and Behaviour Change Communication
SOGIE Sexual Orientation and Gender Identity Expression
SRH Sexual and Reproductive Health
STI Sexually Transmitted Infection
TB Tuberculosis
UTT Universal Test and Treat
WHO World Health Organisation
WSW Women who have Sex with Women
KEY TERMS

Asexual Someone who does not experience sexual attraction to others

Assigned sex at birth The classification of infants at birth as either male or female, usually based on inspection of the external genitalia. Thus ‘assigned male at birth’ (AMAB) and ‘assigned female at birth’ (AFAB) should be used in place of such offensive and derogatory terms as ‘biological male/female’, male/female bodied, or ‘born male/female’ when referring to trans* people

Binary The understanding of gender and sex as being exclusively either male or female

Bisexual A person who is attracted on different levels (e.g., emotional, physical, intellectual) to and/or sex with both men and women and who identifies with this as a cultural identity

Cisgender A term describing a person whose perception and expression of her or his own gender identity matches the biological sex she or he was assigned at birth

Cross-dresser Someone who, for whatever reason, dresses in clothing associated with the opposite gender. This is a form of gender expression – someone who is transgender is not cross-dressing

Dysphoria/gender dysphoria Anxiety, distress or discomfort (often profound) associated with or resulting from the incongruence between one’s gender identity and assigned sex at birth

Femme An identity or expression that leans toward femininity

Gay The term “gay” can refer to same-sex sexual attraction, same-sex sexual behaviour, and same-sex cultural identity. It is commonly used to refer to men who are attracted on different levels (emotional, physical, intellectual, etc.) to and/or have sex with other men and who identify with “gay” as a cultural identity

Gender and sex The term “sex” refers to biologically determined differences, whereas “gender” refers to differences in social roles and relations

Gender expression The way in which a person’s sense of gender manifests itself, usually as an extension of the person’s gender identity. This includes all domains in which gender is expressed, including dress, speech, and mannerisms

Gender fluid A gender identity that changes (i.e. is fluid)

Gender identity A person’s deeply felt internal and individual experience of gender, which may or may not correspond with their sex assigned at birth. It includes both the personal sense of the body—which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical, or other means—and other expressions of gender, including dress, speech, and mannerism

Gender non-conformity Displaying gender traits that are not normatively associated with a person’s biological sex. ‘Feminine’ behaviour or appearance in a male is considered gender non-conforming, as is ‘masculine’ behaviour or appearance in a female

Heteronormativity Related to ‘heterosexism’, it refers to the privileged position associated with heterosexuality based on the normative assumptions that there are only two genders, that gender always reflects the person’s biological sex as assigned at birth, and that only sexual attraction between these ‘opposite’ genders is considered normal or natural. The influence of heteronormativity extends beyond sexuality and also determine what is regarded as viable or socially valued masculine and feminine identities, that is, it serves to regulate not only sexuality but also gender

Heterosexism A system of beliefs that privileges heterosexuality and discriminates against other sexual orientations. It assumes that heterosexual is the only normal or natural option for human relationships, and posits that all other sexual relationships are either subordinate to or perversions of heterosexual relationships. In everyday life, this manifests as the assumption that everyone is heterosexual until proven otherwise. Heterosexual

Heterosexual Having sexual, romantic, and intimate feelings for or a love relationship with a person or persons of a gender other than one’s own. Homonormativity

Homonormativity The system of regulatory norms and practices that emerges within homosexual communities and that serves a normative and disciplining function. These regulatory norms and practices need not necessarily be modelled on heteronormative assumptions, but they often are

Homophobia Also termed ‘homoprejudice’, it refers to an irrational fear of and/or hostility towards lesbian women and gay men, or same-sex sexuality more generally

Intersectionality The interaction of different axes of identity, such as gender, race, sexual orientation, ability, and socio-economic status, in multiple and intersecting ways; resulting in different forms of oppression affecting a person in interrelated ways

Intersex A term referring to a variety of conditions (genetic, physiological, or anatomical) in which a person’s sexual and/or reproductive features and characteristics do not conform to dominant and typical definitions of ‘female’ or ‘male’. Such diversity in sex characteristics is also referred to as ‘biological variance’ – a term which risks reinforcing pathologising treatment of differences among individuals, but which is used with caution in this document to indicate an inclusive grouping of diversity in sex characteristics, including, but not limited to, intersex individuals

LGBT An abbreviation referring to lesbian, gay, bisexual, and transgender individuals

LGBTI An abbreviation referring to lesbian, gay, bisexual, transgender, and intersex persons who are not cisgender and heterosexual. “LGB” refers to sexual orientations, while “T” indicates a gender identity, and “I” a biological variant. They are clustered together in one abbreviation due to similarities in experiences of marginalisation, exclusion, discrimination, and victimisation in a heteronormative and heterosexual society, in an effort to ensure equality before the law and equal protection by the law. However, the possible differences between persons who claim these labels and those to whom these labels may be assigned ought not to be trivialised. The respective issues, experiences, and needs of these people may in fact differ significantly and in several respects. In solidarity with the activist position regarding this matter, however, in this document, reference is made to LGBTI, and distinctions among the diversity of identities that exist are minimised

Lesbian A woman who is attracted on different levels (emotional, physical, intellectual, etc.) to and/or has sex with other women and who identifies with this as a cultural identity

Men who have sex with men Men who have sex with men, regardless of whether or not they have sex with women or have a personal or social gay or bisexual identity. It also includes men who self-identify as heterosexual but have sex with other men. It encompasses the large variety of settings and contexts in which male-to-male sex takes place, regardless of the multiple motivations for engaging in sex, self-determined sexual and gender identities, and various identifications with any particular community or social group

Men who have sex with women A person who feels marginalised because of her or his sexual practices, or who resists the heteronormative sex/gender/sexual identity system

Non-binary An umbrella term for any gender identity that does not conform to the strict binary of being either male or female. Many non-binary people identify as transgender

Pansexual Attracted to people of any gender, or attracted to people irrespective of their gender

Queer An inclusive term that refers not only to lesbian and gay persons, but also to any person who feels marginalised because of her or his sexual practices, or who resists the heteronormative sex/gender/sexual identity system

Sexual behaviour Sexual behaviour is distinguished from sexual orientation because the former refers to acts, while the latter refers to feelings and self-concept. People may or may not express their sexual orientation in their behaviour

Sexual diversity The range of different expressions of sexual orientation and sexual behaviour that spans across the historically imposed heterosexual–homosexual binary
EXECUTIVE SUMMARY

The South African National LGBTI HIV Framework 2017-2022 (LGBTI HIV Framework) was developed to guide the work of all LGBTI stakeholders and implementers in South Africa. The Framework is inclusive of all sexual minorities living in South Africa, and recommends evidence-based and multisectoral HIV interventions to address the HIV epidemic in the country. The framework will continue to build consensus of LGBTI stakeholders from across South Africa on priorities, challenges, and goals related to providing appropriate, accessible and acceptable services for LGBTI people. While the National Strategic Plan on HIV, STIs, and TB 2012-2016 (NSP 2012-2016) identifies some groups of the LGBTI such as gay and bisexual MSM and transgendered people as key populations, it recognises that not enough has been done to serve these populations. Given this mandate, the LGBTI HIV Framework recommends activities that, by 2022, will bring us closer to addressing the vulnerabilities of LGBTI to HIV, TB and STIs with evidence-based practices and within an environment that is affirming of their human rights.

The development of the document, led by the South African National AIDS Council (SANAC) and the LGBTI Sector, involved consultation with a Technical Working Group (LGBTI-TWG) made up of various stakeholders including government, LGBTI organisations, experts on LGBTI programming, development partners and civil society organisations.

Many factors contribute to the HIV, TB and STIs vulnerability of LGBTI people. Stigma and discrimination based on sexual orientation and gender identity and expression, as well as lack of knowledge about LGBTI health needs, prevents sexual minorities from accessing the necessary prevention, care and sexual health services in the public system. Social stigma is linked with poor mental health outcomes, sexual and other violence perpetrated against LGBTI people, and diminished economic opportunities. Other contributing factors include misinformation about HIV and STI prevention among LGBTI people, unavailability of HIV and STI prevention commodities, high-risk sexual behaviours, and drug and alcohol use. Historical racial and socioeconomic inequality exacerbates the vulnerability of many LGBTI people, and diminished economic opportunities. Other contributing factors include misinformation about HIV and STI prevention among LGBTI people, unavailability of HIV and STI prevention commodities, high-risk sexual behaviours, and drug and alcohol use. Historical racial and socioeconomic inequality exacerbates the vulnerability of many LGBTI people, and diminished economic opportunities. Other contributing factors include misinformation about HIV and STI prevention among LGBTI people, unavailability of HIV and STI prevention commodities, high-risk sexual behaviours, and drug and alcohol use. Historical racial and socioeconomic inequality exacerbates the vulnerability of many LGBTI people, and diminished economic opportunities.

In order to address HIV among LGBTI people, this framework aims to address HIV/AIDS/STI/TB service provision through five interlinked packages. The packages are Health, Empowerment, Human Rights, Psychosocial, and Evaluation. The framework assumes that the 90-90-90 objectives to end the HIV epidemic can only be achieved if all five packages are synergistically implemented.

The South African National LGBTI HIV Framework aims to standardise service delivery through a multisectoral stakeholder response to HIV/AIDS/STI/TB for and among LGBTI in South Africa. But a framework, like this one, is just one necessary tool in the mission to realise an enabling environment for LGBTI people in South Africa. Beyond the framework, it is necessary that all stakeholders pool resources, build consensus, and engage in advocacy to ensure successful implementation.

South African National LGBTI HIV Framework |9
Draft Plan July 2016 - Subject to Change Draft Plan July 2016 - Subject to Change
DRAFTDRAFT

Sexuality

Sexuality is a central and lifelong aspect of being human and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.

Sexual health

Sexual health is a state of physical, emotional, mental and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

Sexual orientation

Each person’s profound emotional and sexual attraction, and intimate and sexual relations, in relation to the gender of the person’s partner(s)

Trans*

Trans* people generally self-identify with a gender that does not correspond to the sex assigned to them at birth. The term trans* is used with an asterisk at the end to signify that “trans-” may be followed in any number of ways (e.g. “transsexual,” “transgender,” and “transvestite”). The asterisk also acknowledges other gender identification categories and social gender roles, such as genderqueer and androgynous, among others.

Transgender

Transgender people have a very intense experience of their gender being different to that assigned by birth. Transgender people sometimes seek some form of medical treatment to bring their body and gender identity closer into alignment.

Transphobia

An irrational fear of and/or hostility towards people who are transgender or who otherwise transgress traditional gender norms.

Transsexual

A medical term mostly used to describe people who (may) seek medical and surgical treatment to bring their body and gender identity into alignment.

Transvestite

A person who dresses in the clothing of the opposite sex for various reasons sexual or not. Not because they want to change their sex or gender.

Transitioning

The process of undergoing treatment to change assigned sex.

Transman

An individual who starts his life with a female body but whose gender identity is male. FTM = female to male.

Transwoman

An individual who starts her life with a male body but whose gender identity is female. MTF = male to female.

Gender reassignment therapy

This refers to having surgery in order to change primary and secondary sexual characteristics.
1. INTRODUCTION

LGBTI communities are at higher risk of HIV infection and HIV-related illnesses. This health risk is due to several factors including stigma and prejudice (Johnson, 2008 #731) towards non-binary genders, and violence directed towards members of these communities due to their sexual orientation or gender identity. Stigmatisation may stem from the general society, faith-based organisations (FBO), and in the family, and significantly from public service employees such as health providers. The National Strategic Plan on HIV, STIs, and TB 2012-2016 (NSP 2012-2016) identifies out of the LGBTI, Gay men and Transgender people as key populations and states that not enough has been done to ensure access to and utilisation of health services (South African National AIDS Council, 2011 #689; Daly, 2016 #715). Globaly, gay and other men who have sex with men are 13 times more likely to be infected with HIV, while transgender people are 19 times more likely to be. Furthermore, results from various monitoring projects are showing that where there has been further criminalization of LGBTI populations, there has also been an increase of fear in the communities, greater concern that health care workers might report them, growing cases of organized gangs threatening and extorting individuals on the basis of their sexual orientation, and more physical attacks (UNAIDS, May 2016, www.unaids.org #732).

South Africa has one of the most progressive constitutions in the world with regards to protection of sexual minorities (De Vos, 2007 #708; Klein, 2008 #709). In 1996 South Africa became the first country in the world to publish a constitution that protects people from discrimination on the grounds of sex, gender and sexual orientation. South African laws are very advanced regarding legal emancipation of people under the LGBTI banner and is also progressive in allowing one to apply for a legal adjustment of one’s sex description without having to undergo genital surgery (Klein, 2008 #709; Republic of South Africa. Parliament, 2004 #677).

However, despite the many supportive structures, LGBTI people still face many obstacles as there is a considerable gap between the progressive legal code and the much more conservative South African society (Klein, 2008 #709).

BACKGROUND

Stigmatisation and discrimination affects the LGBTI community in a number of ways. The first is that it creates psychological difficulties related to rejection. Rejection can manifest as depression and these difficulties often leads to harmful behaviour such as excessive alcohol and drug use. Stigma may also be internalised where issues of self-esteem and self-worth are negatively impacted (Hahn, 2012).

Health services are often inadequate and inaccessible as some healthcare workers (HCW) display negative and stigmatising attitudes or do not have adequate clinical skills to provide targeted LGBTI health care. Preventative tools such as dental dams for lesbians and condom-compatible lubricant are not available in public facilities. The lack of access to comprehensive sexual and reproductive health and rights in the transgender community are linked to HIV infections (Nduna, 2012 #670). Fear of discrimination and internalised stigma, result in these individuals not seeking or delay seeking health care, or in increased risk-taking behaviours (Evans, 2016 #5). This often leads to self-medicating, avoiding prevention tests and screening, and approaching health services as a last resort and therefore very late. Health programmes designed for the general population are sometimes inadequate to cater for the additional needs of the LGBTI populations. Members of the LGBTI community are vulnerable in differing ways to HIV, STIs and TB. MSM and transgender women are vulnerable to HIV mainly due to delayed access to and low utilisation of health services (Rispel, 2009 #734). The South African government provides few specialised health and social services focusing on LGBTI people (Rispel, 2009 #734). Several community-based organisations (CBOs) have established programmes to fill this gap, working closely with government. These groundbreaking partnerships between the South African government and civil society ensures equitable services to LGBTI people and this Framework should be used to further strengthen and scale up such partnerships.

The South African National LGBTI HIV Framework has been developed to guide all LGBTI stakeholders in HIV and STI prevention, care, and treatment for all members of the LGBTI populations in South Africa and the framework is inclusive of all sexual minorities living in South Africa. The LGBTI HIV Framework will bring us closer to a world in which members of the LGBTI populations can realise their health and human rights in an environment that is affirming of their sexual orientations and identities.
The opportunity to be threatened, humiliated and to live in fear of being beaten to death is the only ‘special right’ our culture bestows on homosexuals.”

-Diane Carman / Denver Post
be offered medical male circumcision, it is particularly effective to reduce HIV infection for MSM who also engage in vaginal sex.

HIV Prevalence and HIV-related morbidity

Several studies conducted since 2008 have found HIV prevalence in MSM populations across South Africa ranging from 10.4% to 49.5% (Baral, 2011 #629; Tucker, 2013 #773; Rispel, 2009 #734; Lane, 2014 #549; University of California, 2015 #560). The Human Sciences Research Council’s (HSRC) Marang Men’s Study found HIV prevalence of 22.3% in Cape Town, 48.2% in Durban and 26.8% in Johannesburg (Jooste, 2014 #513). The prevalence varies considerably between urban and rural areas and according to socio-economic status.

MSM in South Africa are also affected by other STIs at relatively higher rates than in the general population, and a history of having contracted STIs has been found to be associated with HIV infection in the MSM population (Burrell, 2010 #775). There is a lack of data on STIs among South African MSM, but one study conducted in Cape Town found STI prevalence of 31% in this population when testing for chlamydia and gonorrhoea (Rebe, 2015 #776).

National population size estimates for MSM in South Africa range from 750,000 (Shisana, 2014 #624) to 1.2 million. A number of studies in progress in 2016 will help to further define this number.

1.2.1 Transgender People

Transgender people (trans*) are individuals whose gender identity or gender expression differs from what is typically associated with the sex they were assigned at birth. People under the transgender umbrella may describe themselves using one or more of a wide variety of terms, including transsexual, transgender, and transvestite. When serving trans* people, use the descriptive term applying to their needs (Stevens, 2008 #709). The rights of people with variations of sex development were first explicitly secured through an amendment of section 1 of Act 4 of 2000 (Promotion of Equality and Prevention of Unfair Discrimination Act) in January 2006. Even though people with variations of sex development are protected under the Constitution no legal documents recognise intersexuality. Since 2003 South African health care professionals have been enabled to change gender assignment gender at birth, opting to wait until the individual is able to make an informed choice. In cases where parents insist on immediate surgical interventions, a multidisciplinary team is convened to make decisions (Klein, 2008 #709). This team collaborates to protect the intersex child and to ensure that the privacy and dignity of the individual and family are protected (Kemp, 1996 #755).

Psychosocial care provided by specialised mental health staff should be an integral part of management to promote positive adaptability to team decisions about gender assignment/reassignment, timing of surgery and sex hormone replacement (Hughes, 2006 #732). Intersex people are subject to increased stigma than other non-conforming identities and orientations. In some societies, female infertility precludes marriage, which could affect employment prospects and financial independence. Religious and philosophical influences may influence how parents respond to the birth of an intersex infant, while poverty and illiteracy negatively affect access to health care (Hughes, 2006 #732).

Although medical interventions for intersex individuals are largely surgical, birth of an intersex child prompts a long-term management strategy that involves a myriad of professionals working with the family. Intersex individuals face intense problems that are associated with gender assignment, including the diagnosis, genital appearance, surgical options, need for life-long replacement therapy, the potential for fertility, views of the family and sometimes circumstances relating to cultural practices (Hughes, 2006 #732).

HIV Prevalence and HIV-related morbidity

Intercourse and trans* populations are the most understood of all the non-conforming groups (Johnson, 2008 #731) and data on HIV prevalence and incidence is urgently needed.

3. GOALS AND OBJECTIVES

3.1 GOAL

The goal of the South African National LGBTI HIV Framework is to provide consolidated guidance to reverse the burden of disease from HIV, STIs and TB and to promote a rights- and evidence-based environment for LGBTI people in South Africa. This will be achieved through the implementation of five interlinked service packages: health, empowerment, psychosocial, human rights, and evaluation.

3.2 FIVE YEAR OBJECTIVES

1. Health: To reduce HIV, STI and TB among LGBTI populations in line with the 90-90-90 UNAIDS treatment targets, through
   i. Providing a package of LGBTI-appropriate HIV and HIV-related health care services over two years to
      • 200 000 MSM
      • 5000 trans* individuals
      • 20 000 WSW
      • 700 000 Transgender* people
   ii. Ensuring that 95% of the LGBTI community use condoms and condom-compatible lubrication correctly and consistently
   iii. Ensuring that:
      • 90% of LGBTI living with HIV know their status,
      • 90% of LGBTI who test positive are linked to UTI
      • 90% of MSM and transwomen* who test negative are offered PrEP
      • 90% of LGBTI on PrEP are virally suppressed
      • 90% of LGBTI are retained in the programme

2. Empowerment: To empower LGBTI populations through a participatory programme that will strengthen the LGBTI networks and organisations to better address the social and economic factors that restrict economic opportunities.

3. Psychosocial: To reduce internalised and external stigma and discrimination against LGBTI and to offer harm reduction support.

4. Human rights: To develop and implement effective mechanisms to deal with human rights abuses and violence against LGBTI people, and to promote the rights of people with variations of sex development.

5. Evaluation: To establish ethically based evidence for the delivery of acceptable, accessible, appropriate and available services for LGBTI in South Africa within a humanrights-based framework.

3.3 GUIDING PRINCIPLES

The following guiding principles underpin The South African National LGBTI HIV Framework:

- Community-led: the LGBTI community will be involved in the planning, implementation and review of the Framework and its implementation.
- Rights-based: strategies are rooted firmly in the promotion and protection of human and legal rights, including prioritising gender equity and gender rights.
- Evidence-based: initiatives are based upon evidence and statistical data.
- Multi-sectoral: South African Government, civil society, private sector and all other stakeholders will be meaningfully engaged in the implementation of this Framework.
- Leadership and accountability: All stakeholders accept responsibility to implement the Framework.

4. PROGRAMME APPROACH

4.1 THEORY OF CHANGE

The theory of change posits that implementing these five packages will lead to increased access to HIV and HIV-related services and to the creation of an enabling environment to improve the health of LGBTI people and to reduce the number of new infections and mortality related to HIV. Improved services coverage and effectiveness will result in greater access to commodities and services, such as condoms and condom-compatible lubricants, substance use interventions, stronger community networks, increased access to justice and human rights, will decrease LGBTI exposure to HIV, STIs and TB by encouraging less risky sexual behaviour and prompt access to and utilisation of health services.

This theory recognises that specific health risks are due to the experience of stigma and discrimination, and subsequent marginalisation, and suggests that an enabling environment is critical to the success of the Framework. An enabling environment is one where all role-players, such as health and social care workers, law enforcement officials, legal representatives and community and civil society organisations work together to reach the goal of reducing HIV incidence and HIV-related mortality.

The theory of change also highlights the central role that violence in all its forms, evidence gathering and associated harms and impacts. LGBTI populations are under-researched and this framework will contribute to evidence for South Africa's best practice. Programmatic data will be collected
with a monitoring and evaluation grid, which will inform operations research. Surveillance data will contribute to accurate population size estimates for accurate target setting, programme evaluation, and the development of treatment cascades for the individual LGBTI populations.

### 4.2 KEY FEATURES

Evidence indicates that effective HIV prevention, care and treatment packages for the LGBTI community should include combinations of biomedical, behavioural and social, and structural interventions tailored to local contexts (World Health Organization, 2014 #301), delivered by peers from the local community.

Key features of The South African National LGBTI HIV Framework are as follows:

- A peer-led approach that utilises peers drawn from the target community, to identify high-risk individuals, provide psychosocial support, provide a range of relevant information, guide individuals to access services and enhance prevention outreach interventions. Peers are the backbone upon which service provision is implemented and facilitated, and through whom the community is enabled to access services. Alignment between all service providers will promote the roll out of this peer led model, accommodate the mobility of the population, and contribute to meeting the aims and objectives set out by the framework. A peer led model includes the opinions of LGBTI community, allows organisations to access LGBTI community effectively, and facilitates access to healthcare and safer sexual behaviours.
- Tailored to local conditions, including resources, services, socio-economic and cultural circumstances.
- Collaborative implementation between South African Government Departments, specifically Departments of Health, Social Development, Justice, Basic Education, Higher Education, parallel NGO services, and CBOs.
- Inclusive of community ownership and LGBTI community voices, which includes community and CBO participation in the planning, design, resourcing, management and implementation of an HIV prevention, care and treatment response
- Learning oriented and emphasise ongoing capacity development, while also being adaptive
- Subject to continual monitoring, evaluation, operations research and reporting; and
- Flexible and easy to adapt changing epidemic patterns.

#### Figure 1. Theory of Change

<table>
<thead>
<tr>
<th>Packages</th>
<th>Outcome</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>Reduced HIV/STI/TB incidence</td>
<td>Reduced morbidity &amp; mortality</td>
</tr>
<tr>
<td>Empowerment</td>
<td>Networks, careers</td>
<td>Empowered LGBTI</td>
</tr>
<tr>
<td>Psychosocial</td>
<td>Decreased violence and stigma</td>
<td>Improved well-being</td>
</tr>
<tr>
<td>Human rights</td>
<td>Human rights framework</td>
<td>Protected human rights</td>
</tr>
<tr>
<td>Evaluation</td>
<td>Operations research data / PSE</td>
<td>Evidence-informed Plan and Rollout</td>
</tr>
</tbody>
</table>

Negative experiences with HCW contribute to the erosion of a sense of safety leading to LGBTI individuals either avoiding seeking care or accessing care as a last resort:

- In Western Cape 16% of LGBTI people either delayed or avoided health care due to fear of stigma {Muller, 2016 #726}
- Lesbians are less likely than heterosexual women to access preventive and routine tests such as screening for cervical and breast cancer
The LGBTI communities are diverse communities ranging from poor people living in informal settlements to highly empowered individuals; there is a wide range in education levels, values and world views. It is not possible to develop programmes which will be appropriate for all people within a specific population. The greatest need is amongst the poor and disadvantaged who are the ones who face the most discrimination and are the ones dependent on public health services. The main effort of the framework is therefore to target the disadvantaged sector of each of the populations.

The LGBTI community is geographically widespread but it exists within each geographical community. It is important that interventions implemented work on both of these levels.

5. BASIC PACKAGES OF SERVICE

As the HIV epidemic, specifically among LGBTI and other key populations, continue to be fuelled by social-structural factors including stigma and discrimination, violence, lack of community empowerment, and violations of human rights, and lack of evidence, it is assumed that the health objective can only be achieved through violations of human rights, and lack of evidence, it is assumed that the health objective can only be achieved if objectives 2, through 5 are also achieved.

5.1 HEALTH SERVICES

5.1.1 Appropriate and Adequate Health Care Services

All LGBTI communities face difficulties with inadequate or inappropriate health care service delivery although this may be in different ways. The problems can be summarised as described below.

5.1.2 HCW Attitudes

HCWs often base practices on an assumption of sameness, rather than ensuring equal access to services (Klein, 2008 #709). This often leads to unhelpful and disempowering interactions between HCWs and sexual minority clients (Nei, 2009 #741). These negative attitudes from HCW towards LGBTI people range from discomfort and insensitivity to open hostility and sometimes denial to provide services (Muller, 2016 #726). Some HCWs regard gender diverse people as ill or perverse. There is also sometimes curiosity about sexual practices that invades the privacy of LGBTI individuals. This problematic attitude sometimes means that LGBTI people do not receive appropriate services and do not disclose their health concerns and risks. A recent study with 80 transgender and gender non-conforming people showed that access to health care, especially to HIV care, is a major concern (Stevens, 2012 #730). The report found that health services are discriminatory and health workers provide sub-standard care to transgender and gender nonconforming persons.

5.1.3 HCW Knowledge of LGBTI issues

HCWs must be aware of and trained in the health issues affecting LGBTI individuals and need to understand how the intersection of gender identity and sexual orientation affects their health and risk for HIV, STIs and TB. It is important to offer services that are embracing of diversity, and inclusive of LGBTI communities so as to ensure services are appropriate to the client and that the client is willing to disclose their concerns to the HCW. There is a complete lack of knowledge of HIV and STI transmission regarding WSW, for example many HCWs believe that a PAP smear is not needed for lesbians. The result of this is late detection of cancer. This lack of information points to inadequate training of HCWs at medical schools and nursing colleges.

5.1.4 Health Programmes

Health programmes are targeted at the general community and may not be appropriate for the LGBTI communities. To address these issues The National LGBTI HIV Framework will:

- Provide LGBTI-sensitive and appropriate HIV services throughout the country.
- Standardise programme materials including job aids, training materials and communication materials.
- Amend all relevant policies and guidelines to reflect MSM, WSW and trans* issues.
- Develop new policies where these are not in place.
- Design strategies to ensure the adequate supply of internal and external condoms and condom-compatible lubricants.
- Create structures to ensure the supply of health materials not currently available such as equipment for anal and cervical cancer screening.
- Ensure that all HCWs are appropriately trained on LGBTI issues and specific health needs.

5.1.5 Community-based outreach

Community-based outreach is an effective method of reaching people, particularly those who face barriers to obtaining mainstream services, as is often the case for people from the LGBTI communities. Mobile outreach is a highly effective means of delivering HIV prevention interventions such as HIV Testing Services (HTS), condom programmes and targeted communication, as well as a useful access point for referral to opioid substitution therapy and antiretroviral treatment (ART). Hence, outreach is an essential component of all HIV-related programmes.

5.1.6 Prevention

Comprehensive Condom and condom-compatible Lubricant Programming

Increasing the availability, accessibility, affordability and use of dental dams, and internal and external condoms.
and condom-compatible lubricants through targeted distribution programmes is an essential component of the HIV response. Consistent and correct use of condoms reduces sexual transmission of HIV and other STIs in both men and women. PrEP can be offered as one component of a comprehensive set of HIV prevention interventions. In settings with high levels of drug shortages, and poor adherence.

Condom promotion campaigns must increase awareness, promote the acceptability and benefits of condom use and help to overcome social and personal barriers to their use. All condom programmes should address the complex gender, religious and cultural factors that could impede condom use, and promotion and marketing tools should be inclusive of MSM, WSW, and trans* people.

Along with promotion and supply, information and skills-building in negotiating condom use and use of the correct lubricants programmes must be offered. Behavioural interventions can encourage consistent condom use.

5.1.7 Treatment as Prevention

Pre-exposure prophylaxis (PrEP)

Oral pre-exposure prophylaxis (PrEP) is the daily use of antiretroviral drugs by HIV-uninfected people to block the acquisition of HIV. Studies have demonstrated the effectiveness of PrEP in reducing HIV transmission among MSM and transgender women. Willingness to use PrEP varies and the main factors that influence PrEP use include effectiveness, side-effects and cost. There are concerns with PrEP use related to risk compensation, drug shortages, and poor adherence.

According to the WHO, oral PrEP for MSM has proved feasible in variational settings and acceptability studies (including among young men who have sex with men). PrEP is best offered as one component of a comprehensive set of HIV prevention interventions. In the introduction of PrEP, it will be important to assess the barriers and facilitators to existing HIV prevention strategies in the specific population and context.

Post-exposure prophylaxis (PEP)

Post-exposure prophylaxis (PEP) reduces the likelihood of acquiring HIV infection after possible exposure to HIV. Antiretroviral medicines have been prescribed as PEP following sexual assault, possible exposure through condomless sex and when condoms break or slip off. PEP is currently the only way to reduce the risk of HIV infection in individuals who have been exposed to HIV. As such, it is widely considered an integral part of the overall prevention strategy. Despite its short duration, reported completion rates and uptake of PEP are low. Therefore, counselling and other adherence support measures are recommended. PEP should not be considered 100% effective.

Universal test and treat (UTT)

Viral load is the single greatest determinant of the risk of HIV transmission. When someone is virally suppressed (undetectable), the risk of HIV transmission is significantly reduced. From September 2016, early initiation of antiretroviral treatment, regardless of CD4 count, or universal test and treat (UTT), will be available to all people that test positive for HIV. Early initiation is especially important in key populations such as MSM and the trans* community.

Prevention of mother-to-child transmission (PMTCT)

PMTCT is the use of antiretroviral therapy to reduce the transmission of HIV from an HIV-positive mother to her child. PMTCT should be available for WSW and trans men who are pregnant.

Medical Male Circumcision for HIV prevention (MMC)

MMC is not recommended to prevent HIV transmission during receptive anal intercourse (World Health Organization, 2014 #301). MSM and trans* individuals will still benefit from MMC if they also engage in vaginal sex. MSM should not be excluded from MMC services where it is offered for HIV prevention.

5.1.8 Behavioural Interventions

There are a number of behavioural risk factors which differ from one LGBTI population to another. Knowledge

Amongst WSW there is a belief that there is no risk of HIV transmission in female-to-female sexual interaction. They are each other in many ways:

• There is the belief that no protection needs to be used
• Little use is made of HIV diagnostic testing and often the HIV test is only done when the individual becomes ill
• There is a lack of HIV programmes targeted at the lesbian community
• There is little knowledge of HIV and STI transmission in the lesbian community and among HCWs

Amongst MSM and transwomen there is little knowledge of condom-compatible lubricants; and low knowledge on the importance of STIs in HIV transmission. For trans* people who are undergoing hormonal therapy as part of their gender reassignment, there is little understanding of HIV risk and ART interactions. All clinicians should be familiar with hormone treatment for transitioning.

5.1.9 Sexual Practices

Certain sexual practices increase the risk of HIV transmission due to biological factors. Condomless receptive anal sex puts an individual at risk for HIV and STIs.

Reported condom use among MSM and trans women is low and condoms are often not used with regular partners because of the perception that condom use reduces sexual pleasure and/or shows mistrust and infidelity. The use of alcohol and other drugs impairs safer-sex decision making. Inconsistent and incorrect condom use combined with having a high number of partners increases individual risk of contracting HIV or STIs.

Transactional sex, where there are power differences characterised by age differences and differences in economic status, pose a risk for transwomen or MSM when negotiating safe sex. It is important to distinguish transactional sex from sex work. Sexual interactions during normal patterns of socialising are reportedly frequently characterised by a transactional element and these “transactions” would usually involve individuals buying alcohol for potential sex partners, who frequently identify as heterosexual.

Trans* and MSM may resort to sex work when faced with unemployment. Sex worker populations globally have a higher risk of HIV infection due to their multiple overlapping vulnerabilities. Recent research on sex work, conducted in four South African cities, found that male sex workers were 2.9 times more likely than female sex workers to have condom-less intercourse (USCFS 2015).

To reduce their risk of acquiring STIs or HIV, people must understand their risk exposure, have the knowledge, skills and conviction to reduce that risk, and an enabling environment in which to exercise this knowledge. Behavioural interventions provide information, motivation, education and skills-building to help individuals reduce risky behaviours and sustain this positive change. Behavioural interventions may address individuals or groups. One-on-one counselling must focus on awareness of personal risk and risk reduction strategies; for example, counsellors or community workers may discuss risk behaviours, relate a participant’s activities directly to HIV risk, and consider strategies to reduce this risk. In contrast, peer-to-peer interventions and group sessions must focus more on awareness of risk overall, with group sessions offering the added benefit of group support for finding behavioural interventions to help individuals support safer behaviours and sustain this positive change.

**Recommendations for adolescent LGBTI**

Adolescents deserve specific consideration as at this stage in their development the urge to explore and experiment normally develops ahead of decision-making ability. Adolescents’ evolving cognitive abilities are an important consideration in the design of behavioural interventions for them. Adolescence is also a critical stage for identity development and LGBTI adolescents might be even more vulnerable during this stage (Erikson, 1968 #770).

Skills-based interactive and participatory approaches for adolescent LGBTI communities, including online, mobile health, peer and outreach approaches, have proved acceptable to adolescents and have shown promise in some contexts (Nutbeam, 1997 #771).

All forms of HTS must be voluntary and adhere to the five Cs: consent, confidentiality, counselling, correct test results and connections to care, treatment and prevention services. Confidentiality is especially important for the LGBTI community.
Effective social marketing campaigns that promote testing, treatment and other services and social bio-behavioural change interventions are part of the comprehensive package. These may take place face-to-face or through broadcast mass media and digital media such as the Internet. Choices of content and approach, as well as of the medium, should be based on good formative analysis of the local situation. Although the logic of behavioural interventions is primarily based on individual awareness and decision-making about risk, such interventions can operate at the community level. For example, interventions may involve training opinion leaders to communicate with their peers, thus changing perceptions of social norms about risk and risk avoidance. There is insufficient evidence to make general recommendations for all LGBTI communities.

5.1.10 HIV Testing Services (HTS)

HTS are the essential first step in enabling people with HIV to know their status and link to HIV prevention, treatment and care services. Due to the high HIV prevalence, HIV-negative MSM and trans women are encouraged to test 3-monthly. For those who test negative, HTS is an important opportunity to put those at risk for HIV in contact with primary prevention programmes, like PrEP, and to encourage testing. HTS must always be confidential, voluntary, and free from coercion. Like all testing services, HTS for the LGBTI communities need to emphasise the WHO 5 Cs of HTS: consent, confidentiality, counselling, correct results and linkage to care. Furthermore, HTS must be part of a comprehensive prevention, care and treatment programme. It is important that there are clear and robust links between testing and HIV prevention, treatment and care services; poor links prevent people from acting on their test results.

Members of the LGBTI communities sometimes test late due to fear of stigma and discrimination thus increasing their health risks. Community-based and mobile outreach testing, linked to prevention, care and treatment, has the potential to reach greater numbers of people than clinic-based HTS – particularly those unlikely to be tested due to fear of stigma. In all epidemic settings accessible and acceptable HTS must be available to adolescents and provided in ways that encourage testing especially for the MSM and trans* communities. Young MSM and trans* people must be able to obtain HTS without required parental or guardian consent or presence.

5.1.11 Linkage to and Enrolment in Care

HTS is just the first step in the continuum of HIV care; a positive HIV diagnosis without linkage to HIV prevention, care and treatment has limited benefit. Ensuring that people are linked and enrolled in HIV clinical care is necessary to realise the full health and prevention benefits of antiretroviral treatment. Unfortunately, substantial losses occur at every step of the HIV care continuum. These losses are particularly great among people from LGBTI communities.

A number of psychological and social barriers hinder linkage to care for people newly diagnosed with HIV. The perceived stigma associated with attending an HIV clinic continues to be a barrier to early care enrolment. For members of the LGBTI community, especially, lack of family support, family rejection and fear of disclosure also hinder access. Additional issues related to socio-economic factors may also hinder linkage to care, particularly for trans* people.

5.1.12 Antiretroviral Therapy

The use of ART for HIV in the LGBTI populations should follow the same general principles prescribed in the national guidelines. LGBTI communities may experience discrimination and marginalisation that can impede their access guidelines to health care, including treatment for HIV. It is important to ensure that they have access to immediate and appropriate HIV treatment and care.

Providers should be aware of other medication and substances that are taking when antiretroviral treatment is initiated and new drugs that are added during ongoing treatment. For many from the LGBTI community, this may include recreational drugs, drugs for coinfections and co-morbidities, and among trans* people and intersex gender affirming hormone therapy. Possible drug interactions add complexities when prescribing antiretroviral drugs and monitoring of treatment. Counselling on the possible consequences of drug interactions and an environment that promotes and enables reporting of adverse reactions are critical components of high-quality care for all people with HIV and STIs. It must be emphasised that alcohol is NOT contra-indicated for people on ART.

5.1.13 Prevention and Management of Co-Infections and Co-Morbidities

An essential part of HIV treatment and care is the management of opportunistic infections such as TB and viral hepatitis. Viral hepatitis B and C disproportionately affect MSM and trans women as a result of sexual transmission. Catch-up hepatitis B immunisation strategies should be instituted and HCV serology testing and linkage to care should be offered due to fear of stigma. In all epidemic settings accessible and acceptable HTS must be available to adolescents and provided in ways that encourage testing especially for the MSM and trans* communities. Young MSM and trans* people must be able to obtain HTS without required parental or guardian consent or presence.

Preventative Screening

Mammograms and PAP smears should be part of routine annual care for WSW and trans men to assist early detection of breast and cervical cancer and anal screening for HPV and prostate cancer screening for MSM and trans women.

5.1.15 Hormone Therapy for Trans* People

Transgender people who inject hormones for gender affirmation should use sterile injecting equipment and practice safe injecting practices to reduce the risk of infection with blood borne pathogens such as HIV, hepatitis B and hepatitis C. Where hormone therapy for gender affirmation is used, it is important to ensure that appropriate preparations are used, to avoid incorrect dosing, and to properly manage any adverse events, as well as to reduce sharing of injection equipment.

Table 1. Summary of Health Services

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Specific activities</th>
<th>Description</th>
<th>Inputs</th>
<th>Implementation considerations</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Health Package</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective 1: To reduce HIV, STI and TB incidence and mortality rate among LGBTI in line with the 90-90-90 treatment targets</td>
<td>Provide LGBTI-sensitive and appropriate HIV services throughout the country</td>
<td>HTA clinics – at least 1 per district</td>
<td>DoH meeting</td>
<td>Determine network for LGBTI services</td>
<td>DoH</td>
</tr>
<tr>
<td></td>
<td>NGO clinics</td>
<td></td>
<td></td>
<td>Prepare for ‘friendly’ service delivery</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CBGs</td>
<td>Funding</td>
<td></td>
<td>Parallel services where these exist</td>
<td>NGOs</td>
</tr>
<tr>
<td></td>
<td>Mobile outreach with PE</td>
<td></td>
<td></td>
<td>Develop PE job description Mobile van availability</td>
<td>DoH/NGOs</td>
</tr>
<tr>
<td></td>
<td>Standardiseprogrammatic materials</td>
<td>Job aides: treatment algorithms</td>
<td></td>
<td>Adapt national guidelines for LGBTI communities</td>
<td>SANAC</td>
</tr>
<tr>
<td></td>
<td>Sensitisation manual: counselling material</td>
<td>Design Layout Printing Funding</td>
<td></td>
<td>In collaboration with DoH, CDC</td>
<td>SANAC</td>
</tr>
<tr>
<td></td>
<td>Communication materials</td>
<td>ID docs for trans*</td>
<td>Meetings - HA</td>
<td>Requires implementation and training</td>
<td>Home affairs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>WLC SOP – trans*</td>
<td>Meetings - DoH</td>
<td>Lobby for national rollout</td>
<td>DoH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dental dams – LB</td>
<td>Meetings DoH</td>
<td>Lobby for updated policy</td>
<td>DoH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MMC for MSM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Surgery for trans*</td>
<td>Meetings DoH</td>
<td>Requires additional trained DoH</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hormone therapy algorithm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>PEP for trans* &amp; MSM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Design strategies to ensure the adequate supply of internal and external condoms and non- -compatible lubricants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Scented Internal condoms</td>
<td>Design condom &amp; lube distribution</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adequate supply External condoms</td>
<td>Framework for LGBTI</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Accessible where needed Dental dams</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bottled lube C-Cube</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Distribution plan</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5.2 EMPOWERMENT SERVICES

Psychosocial difficulties, stigma and discrimination as well as general income inequity, poverty and gender inequalities contribute to the economic disempowerment of the LGBTI community. Many members of the LGBTI community are economically disadvantaged and have low levels of education and income. Barriers to access to health care, including HIV treatment and care, are compounded by the lack of economic resources and access to health care. Stigma and discrimination also negatively impact the access of LGBTI people to employment, education and housing.

The strategies for the empowerment of LGBTI people focus on the development of opportunities to enable them to participate in decision making processes, to access information, to take control of their health and human rights and to build and maintain networks of support.

5.2.1 Health Information and Education Services

The information and education services, which offer information and support on gender affirmation and this is also not widely available to trans* people. Where clinic staff are not trained, trans*individuals must be referred to specialised clinics and services, which offer information and support on medical and surgical gender affirmation.
vulnerable, which can restrict their ability to negotiate for safe sex, discuss fidelity with their partners, or leave risky relationships.

5.2.1 Skills Building

The Framework is underpinned by a peer-led approach to strengthen CBO capacity. Skills development is a crucial component for the economic empowerment of LGBTI community. The development of skills includes providing skills building workshops and training for peer educators (PE) on providing health education, condom negotiation, care seeking and managing their financial affairs.

Employment/Economic Empowerment

The inability of trans* individuals to obtain gender-congruent identity documents makes it extremely difficult for them to obtain employment in the formal sector. Gender non-conforming people may also have left school early because of pressures to conform, and have consequent difficulties accessing employment. On average, male and trans* sex workers are responsible for two or more children and many are care workers managing their financial affairs.

Core package of services

- Personal development
- Skills building
- Employment/economic empowerment
- Standardised IEC
- Campaigns
- Outreach
- Community networks
- CBO capacity
- Empowerment programme/safe spaces

In South Africa, low levels of education is one of the social/structural factors which increases LGBTI vulnerability to HIV infection. Trans* and gender non-conforming people may leave school early because of their difficulty with wearing uniforms and/or pressure to conform. Adult education for the LGBTI community is therefore critical for mitigating the vulnerability of LGBTI community, expanding their life choices, reducing risk and promoting resilience. This would include facilitating linkage to adult basic learning and training (ABET), bursary schemes and scholarships to attend educational institutions.

5.2.2 Strengthening Community Systems

Community systems are systems used by communities—both as individuals and as organised collectives such as CBOs—to discuss, organise, and deliver responses to the challenges faced by that community. LGBTI people can improve their health outcomes by being equipped with the capacity, resources (including funding), skills, and tools to address the challenges in adopting protective behaviours and accessing health services. Embedded deeply in the social, political, and economic contexts that determine the various barriers to care that LGBTI individuals must overcome, strong community systems are crucial in designing, implementing, monitoring, and evaluating interventions, and in addressing the stigma, discrimination, and other barriers to care.

5.2.3 Campaigns and Outreach

The MSM, WSW, and trans* populations might not be geographical communities in the usual sense but still identify as a sub-community. This provides difficulties in that they are not concentrated in a particular space as with geographical communities and lose the opportunity to use their identification with their group. Sensitisation campaigns should be mainstreamed both locally and nationally through media and social media to reach all members and the general population. LGBTI organisations should be used in these campaigns, if feasible.

5.2.4 Community Networks

Social cohesion and social participation is an important aspect in enhancing community health. Networks which strengthen the community should be established. This could be both on a local level within geographical areas but could also be done nationally through social media.

5.2.5 CBO and NGO capacity

Developing a collective identity and building the capacity of LGBTI organisations are effective ways of empowering the LGBTI communities. The LGBTI CBOs and NGOs have knowledge of LGBTI issues, are connected to the communities and are trusted by the LGBTI populations both as a source of information and as a source of support. Expanding CBOs and NGOs with additional resources including funding, will ensure sustainable equitable services to LGBTI communities, that are community owned.
Peer support and community mobilisation can facilitate social cohesion, mutual support, and development of self-help groups and networks. The South African National LGBTI HIV Framework will provide support to and facilitate LGBTI-led initiatives to build a collective identity.

### 5.3 Psychosocial Services

Given the hostile environment in which many members of the LGBTI communities live, a number of factors, both internal to LGBTI community and external in their environments, have an impact on their psychosocial well-being. Psychosocial support is an important component of a holistic service offered to LGBTI community. Psychosocial support is conventionally offered by psychologists and social workers, but can also include the care and support offered by HCWs, counsellors, social workers, peer educators, family members, friends, neighbours, and other community members.

The psychosocial service package comprises a number of components which address different elements of psychosocial support.

#### 5.3.1 Stigma and Discrimination

South Africa has one of the most progressive constitutional and legal frameworks worldwide for the protection of the rights of LGBTI individuals [De Vos, 2007 #708]. Legal protection, however and the values enshrined in the Constitution does not address the harmful effects of prejudice and stigmatisation prevalent in South African society, and the realisation of equal rights in everyday life is challenging [Ne, 2007 #741]. The Bill of Rights in the South African Constitution explicitly prohibits discrimination based on gender, sex, or sexual orientation [1996 #736]. Discrimination ranges from everyday experiences of discrimination to human rights violations, hate crimes against sexually and gender non-conforming minorities, and high levels of gender-based violence generally. Research shows widespread hostility to and sometimes violence against lesbians [Sandfort, 2013 #717], antagonism towards the trans* community [Graves, 2013 #850] and frequent experiences of verbal abuse among South African MSM. One study found that 24.5% of the MSM in their sample from Cape Town reported experiencing at least one human rights violation in their lifetime [Baral, 2011 #629]. This is an important health issue as the daily experience of stigma and discrimination has important direct and indirect effects on health and wellbeing which relate to HIV infection:

- Mental health: Experiences of stigma and homophobia are associated with depressive symptoms, and in South African research has found that frequent experiences of stigma is linked to mental stress [Stoloff, 2013 #778; McAdams-Mahmoud, 2014 #783], for example, reported high rates of common mental disorders and alcohol and substance use in their small sample of MSM in Cape Town, South Africa.
- Experience of stigma often results in problematic coping strategies such as substance use and engaging in high-risk sexual activities for MSM [McAdams-Mahmoud, 2014 #783].
- Experiences of stigma and discrimination have been linked to increased HIV risk behaviours [Tucker, 2014 #772; Arnold, 2013 #784]; condomless anal intercourse amongst MSM was associated with higher levels of depression [Tucker, 2014 #772], and this relationship was moderated by the level of homophobic stigma reported by participants. Tucker et al. [Arnold, 2013 #784] found linkages between experiences of homophobia, poor mental health outcomes, and condomless anal intercourse. Research suggests that transwomen may use receptive anal sex as a means of gender affirmation [Sevelius, 2013 #865].
- Risk of violence and, for lesbians, risk of rape is an important risk for HIV infection. One research study in Southern Africa found that 31.1% of the lesbian and bisexual women in their survey had experienced forced sex by men or women [Sandfort, 2013 #717].

#### 5.3.2 Internalised Stigma

Internalised stigma happens when LGBTI individuals are subjected to negative perceptions, intolerance, discrimination and stigma and as a result, turn those ideas inward believing them to be true. It leads to negative attitudes towards self, resulting in poor self-worth and self-esteem and internal conflict:

- The ability to properly manage our lives including health is dependent on the belief in abilities and self-worth. Lowered self-esteem and a sense of inadequacy often result in negative health outcomes. There may also be the inability to negotiate safer sex practices leading to vulnerability to HIV and STIs.
- Intimate partner violence may also be related to internalised stigma. Internalised stigma has been linked to lower levels of HIV-related knowledge and greater endorsement of HIV-related conspiracy beliefs [Tun, 2012 #785; Vu, 2012 #786].
- Feelings of inadequacy and the expectation of stigma and discrimination may also lead to people not

---

**Table 2. Summary of Empowerment Services**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Specific activities</th>
<th>Description</th>
<th>Inputs</th>
<th>Implementation considerations</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 2: To empower LGBTI communities through a peer educator led programme to strengthen community networks and to address the social and economic factors that restrict opportunities</td>
<td>Skills building</td>
<td>ABET Scholarships</td>
<td>Funding</td>
<td>Availability of additional funding</td>
<td>DoH, NGO / CBO</td>
</tr>
<tr>
<td></td>
<td>Employment</td>
<td>Career pathing</td>
<td>In-service PE training</td>
<td>Available funded positions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Workplace policies</td>
<td>Gender neutral bathrooms</td>
<td>Employment equity</td>
<td>Requires policy change</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Strengthen CBO networks</td>
<td>Establish quarterly meetings</td>
<td>Skills building workshops</td>
<td>Funding</td>
<td>Train CBO skills to expand services</td>
</tr>
<tr>
<td></td>
<td>Strengthen LGBTI communities and community groups</td>
<td>Create platforms</td>
<td>NGOs</td>
<td>Availability of additional funding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NGO services</td>
<td>Clinics Mobile outreach</td>
<td>Align existing services with DoH Funding</td>
<td>DoH</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social grants</td>
<td>Linkage with social workers</td>
<td>Shortage of social workers</td>
<td>DSD</td>
<td></td>
</tr>
</tbody>
</table>
Topics for Counselling

- General HIV counselling issues (diagnosis, PrEP, disclosure, pre-ART, adherence)
- Developing self-worth and assertiveness
- Developing effective intimate relationships
- Developing effective coping strategies
- Managing substance use
- Depression and suicidal ideation
- For trans* people: Transitioning

5.3.3 Mental Health Services, Counselling and Care

The full range of HIV related counselling appropriate to the different LGBTI communities will be provided by HCW and PE. The HCW will be sensitised to the issues relevant to each of the LGBTI communities.

5.3.4 Peer Support Groups and Networks

Peer support groups could be an effective way of providing information and providing support. Several organisations run support groups for gender non-conforming people and sex workers some of these groups also include their families. It is important to note that a diverse “community” does not necessarily want to be in support groups with others, based only on sexual orientation. Networks must be developed between members of the LGBTI communities. These networks could range from social groups through WhatsApp groups to formal referral systems. Digital support groups might prove to be a workable solution, but needs more evidence. Some success was demonstrated in some models but more research is needed on best practice and scalability.

5.3.5 Stigma and Discrimination

LGBTI populations are often the targets of high levels of stigma and discrimination. Addressing these issues is therefore an important component of a psychosocial support package. The development of support groups for victims of violence and creation of safe spaces for LGBTI community to disclose their HIV status and discuss stigma and discrimination are some ways to combat stigma and discrimination. These efforts must be complemented with competency and sensitisation training for health and social workers to reduce stigma and discrimination. This training should also be expanded to law enforcement officials, other service providers, and the community. The Western Cape police – through advocacy by SWEAT, WLC, gender Dynamix and Triangle project have a Standard Operating Procedure (SOP) for Trans* people in conflict with the law. The SOP makes clear what is acceptable when searching, transporting and holding trans* people. This is particularly relevant for trans* sex workers. It is recommended that this SOP is adopted nationally.

5.3.6 Violence against LGBTI Community

The members of the LGBTI community experience high levels of intimate partner violence, physical violence and, for lesbians, sexual violence including rape (104). Inability to negotiate safer sex practices means higher risk of HIV, STIs and unwanted pregnancy. Violence increases the likelihood of future risky sexual behaviour such as inconsistent condom use or lack of condom use, increased risk of STI and HIV infection(2015). Violence and lack of control over one’s life means that members of the LGBTI community give lower priority to their health needs when facing more immediate concerns such as safety and survival. Prevention of violence in all its forms is therefore a critical component of empowering the LGBTI community.

Efforts to eliminate violence towards LGBTI community will include the review of restrictive criminal laws, and the involvement of sensitised law enforcement agencies, the judiciary and health services. At an individual level, educational strategies can help the LGBTI community reduce violence by providing safety tips and creating awareness of legal protection options and support to access these. At a local level, norms around violence will be addressed. At a community level working with the police services will ensure that they take reports of violence from LGBTI community seriously.

5.3.7 Counselling Support

Psychosocial stress is associated with poor mental health outcomes (e.g., anxiety, depression, substance use etc.). People with mental health problems have been shown to be at greater risk of HIV infection. Counselling will be offered to LGBTI community who experience psychosocial stress as part of this package. Linkages to psychological assistance will be provided to improve coping skills, self-efficacy and self-esteem.

5.3.8 Alcohol and Drugs

High levels of alcohol consumption is associated with higher HIV prevalence, higher exposure to sexual violence, and increased morbidity and mortality (Hahm, 2012 #769). Some members of the LGBTI community develop potentially harmful habits of substance use. Alcohol and drug use in some settings may further exacerbate their vulnerability and risk. In addition to affecting sexual decision-making and judgement, alcohol and drug use also hampers condom negotiation skills, training to health and general health. Informing the LGBTI community about the risks of alcohol and substance use as well as providing brief screening, harm reduction counselling and referral to services for those who need it is an important component of the psychosocial support package.

5.4 HUMAN RIGHTS SERVICES

In terms of legislation South Africa has to a large extent taken account of the issues related to gender identity and sexual orientation:

- The South African Constitution provides explicit protection against discrimination on the basis of sexual orientation. In addition, legal protections are provided by: The Health Act; The Equality Act 4 of 2000; the Domestic Violence Act 116 of 1998; the Rental Housing Act 50 of 1999; the Employment
5.4.1 The Right to Confidentiality

The right to confidentiality is a basic right. The sensitisation of HCW and other officials will stress the importance of confidentiality in working with members of the LGBTI community. This right will also be emphasised in the training of peer educators.

5.4.2 Supportive Legislation and Policies, Including Law Reform

Although protection to the LGBTI community is enshrined in the Constitution (Constitution of the Republic of South Africa, 1996 #736), this has not always been consistently implemented. Often trans* people are kept waiting for long periods of time before being able to legally change their identity documents. Advocacy and sensitisation is urgently required.

5.4.3 Legal Literacy and Services

Establish a structure to ensure that input is provided by the LGBTI community into all relevant legislative processes. Supportive legislation and policies, including law reform may take time to realise and any changes to legislation or policy will not be effective without supportive activities being run in parallel. Supportive activities within the legal and human rights package will include legal literacy on the human rights of LGBTI community and capacity strengthening to better document, report and prosecute perpetrators of abuse or discrimination against LGBTI community.

5.4.4 Sensitisation of Law Enforcement, HCW, Social Workers

The rights of members of the LGBTI community, and an understanding of the importance of these rights will form an important part of the sensitisation training of HCWs, social workers, law enforcement officials. Trans* people are often subjected to police harassment based on their status as trans* people, sex workers and also because many are homeless. There are also assumptions about their drug use.

5.4.5 Access to Legal Support

Access to legal support will be provided to report situations where the rights of members of the LGBTI community have been violated. A referral network to ensure that LGBTI individuals have access to legal services, will be developed.

5.4.6 Access to gender affirming treatment and surgery

Trans* people have the right to access gender affirming medical treatment from hormones through surgeries.

5.5 EVALUATION

5.5.1 Research

With HIV, a few programmes, mainly from CBOs, are targeted at the MSM and trans* communities but there is a lack of research in general, and specifically regarding WSW and HIV transmission and intersex individuals.

Some research need areas include:• Evidence-based prevention interventions tailored to the needs of each LGBTI sub-population;• Identification of the drivers and impact of HIV on adolescent and adult LGBTI groups.

5.5.2 Operational Research

There is a lack of research in general, and specifically regarding WSW and HIV transmission and intersex individuals.

Table 2. Summary of Psychosocial Services

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Specific activities</th>
<th>Description</th>
<th>Inputs</th>
<th>Implementation considerations</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Psychosocial Package</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stigma and discrimination: National campaign</td>
<td>Design / layout</td>
<td>Funder for National campaign</td>
<td>SANAC Service Providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internalised</td>
<td>Printing</td>
<td>or integrate with DoH</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subject to frightening: Public</td>
<td>Workshops</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCW</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violence: Police</td>
<td>Sensitisation</td>
<td>Trained PE</td>
<td>Ability of PE to cope with burden</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violence: Community</td>
<td>Mass campaigns</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violence: IPV</td>
<td>Negotiation skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMD</td>
<td>Suicide ideation</td>
<td>Counsellor time</td>
<td>Availability of psychologists / social workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harm reduction</td>
<td>Substance use</td>
<td>Referral</td>
<td>Referral networks for rehabilitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risky behaviour</td>
<td>Mass campaigns</td>
<td>Injectable hormones</td>
<td>Needle exchange</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support groups (could be online) and Safe spaces</td>
<td>Curriculum; victims of violence &amp; stigmatisation</td>
<td>Workshops</td>
<td>Creation online face to face forum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual counselling</td>
<td>MH problems</td>
<td>Counsellor time</td>
<td>Travel cost and time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adherence</td>
<td>PEP / UTT</td>
<td>Referral for special care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coping skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disclosure: HIV / coming out</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transitioning trans*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 3. Summary of Psychosocial Services

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Specific activities</th>
<th>Description</th>
<th>Inputs</th>
<th>Implementation considerations</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Psychosocial Package</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stigma and discrimination: National campaign</td>
<td>Design / layout</td>
<td>Funder for National campaign</td>
<td>SANAC Service Providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internalised</td>
<td>Printing</td>
<td>or integrate with DoH</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subject to frightening: Public</td>
<td>Workshops</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCW</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violence: Police</td>
<td>Sensitisation</td>
<td>Trained PE</td>
<td>Ability of PE to cope with burden</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violence: Community</td>
<td>Mass campaigns</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violence: IPV</td>
<td>Negotiation skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMD</td>
<td>Suicide ideation</td>
<td>Counsellor time</td>
<td>Availability of psychologists / social workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harm reduction</td>
<td>Substance use</td>
<td>Referral</td>
<td>Referral networks for rehabilitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risky behaviour</td>
<td>Mass campaigns</td>
<td>Injectable hormones</td>
<td>Needle exchange</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support groups (could be online) and Safe spaces</td>
<td>Curriculum; victims of violence &amp; stigmatisation</td>
<td>Workshops</td>
<td>Creation online face to face forum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual counselling</td>
<td>MH problems</td>
<td>Counsellor time</td>
<td>Travel cost and time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adherence</td>
<td>PEP / UTT</td>
<td>Referral for special care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coping skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disclosure: HIV / coming out</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transitioning trans*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4. Human Rights Services

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Specific activities</th>
<th>Description</th>
<th>Inputs</th>
<th>Implementation considerations</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Human rights Package</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective 4: To ensure the development and implementation of effective mechanisms to deal with human rights abuses and violence from the public, police and health care providers, sensitisation of police and prosecuting authorities, and legal and paralegal support</td>
<td>Protection and prosecution in gender affirming treatment and surgery</td>
<td>Referral to DoH</td>
<td>Overburdened system with long waiting lists</td>
<td>DoH / NGO</td>
<td></td>
</tr>
<tr>
<td>Reporting of violence</td>
<td>Create App</td>
<td>App development</td>
<td>Determine who respond when someone reports an act of violence and what will be the assistance provided to the individual</td>
<td>SAPS</td>
<td></td>
</tr>
<tr>
<td>Confidentiality</td>
<td>Informed consent</td>
<td>Train HCW</td>
<td>DoH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal literacy</td>
<td>Booklet</td>
<td>Developer Design &amp; layout</td>
<td>Distribution to LGBTI members, make available online</td>
<td>SANAC Service providers</td>
<td></td>
</tr>
<tr>
<td>Legal support</td>
<td>Create access and referral</td>
<td>App development Launch</td>
<td>Find partner to provide legal support</td>
<td>SANAC</td>
<td></td>
</tr>
<tr>
<td>Access to gender affirming treatment and surgery</td>
<td>Policy</td>
<td>Resource constraints</td>
<td>DoH</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4. Human Rights Services

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Specific activities</th>
<th>Description</th>
<th>Inputs</th>
<th>Implementation considerations</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Human rights Package</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective 4: To ensure the development and implementation of effective mechanisms to deal with human rights abuses and violence from the public, police and health care providers, sensitisation of police and prosecuting authorities, and legal and paralegal support</td>
<td>Protection and prosecution in gender affirming treatment and surgery</td>
<td>Referral to DoH</td>
<td>Overburdened system with long waiting lists</td>
<td>DoH / NGO</td>
<td></td>
</tr>
<tr>
<td>Reporting of violence</td>
<td>Create App</td>
<td>App development</td>
<td>Determine who respond when someone reports an act of violence and what will be the assistance provided to the individual</td>
<td>SAPS</td>
<td></td>
</tr>
<tr>
<td>Confidentiality</td>
<td>Informed consent</td>
<td>Train HCW</td>
<td>DoH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal literacy</td>
<td>Booklet</td>
<td>Developer Design &amp; layout</td>
<td>Distribution to LGBTI members, make available online</td>
<td>SANAC Service providers</td>
<td></td>
</tr>
<tr>
<td>Legal support</td>
<td>Create access and referral</td>
<td>App development Launch</td>
<td>Find partner to provide legal support</td>
<td>SANAC</td>
<td></td>
</tr>
<tr>
<td>Access to gender affirming treatment and surgery</td>
<td>Policy</td>
<td>Resource constraints</td>
<td>DoH</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Monitoring and Evaluation

The proposed flow of data is from the implementing organisations through to the SANAC Secretariat, which is responsible for the coordination of the Framework. Data will then flow upwards to the South African Government to be used for policy and strategic decisions. This flow mirrors the funding and organisational model of the programme and data flowing in this way will avoid duplication and developing parallel systems.

**Data use**

Information generated must reach all those who need the information to facilitate decision-making that would strengthen the response and improve the performance of the organisations and institutions. Dissemination is an active and systematic process to ensure that all implementers in all sectors, provinces and stakeholders receive the information that they would need, timeliness and in a practical format for decision making. An annual report on the South African National LGBTI HIV Framework will therefore be produced and disseminated.

### Data flow for routine data collection

The proposed flow of data is from the implementing organisations through to the SANAC Secretariat, which is responsible for the coordination of the Framework. Data will then flow upwards to the South African Government to be used for policy and strategic decisions. This flow mirrors the funding and organisational model of the programme and data flowing in this way will avoid duplication and developing parallel systems.

**Data use**

Information generated must reach all those who need the information to facilitate decision-making that would strengthen the response and improve the performance of the organisations and institutions. Dissemination is an active and systematic process to ensure that all implementers in all sectors, provinces and stakeholders receive the information that they would need, timeliness and in a practical format for decision making. An annual report on the South African National LGBTI HIV Framework will therefore be produced and disseminated.

The National LGBTI Technical Working Group (established by SANAC on the 29th March 2016) will

---

### Table 5. Summary of Research Evaluations

<table>
<thead>
<tr>
<th>Objective</th>
<th>Specific activities</th>
<th>Description</th>
<th>Inputs</th>
<th>Implementation considerations</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.5.2 Monitoring and Evaluation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
monitoring commitment to the framework, and creating a programme within existing systems, sustaining and coordinating structures and implementers supporting government departments, the capacity building of to take place. These include the capacity strengthening of this framework and as such funds should be mobilised for this activity. 6.3 HUMAN AND FINANCIAL REQUIREMENTS

Mobilisation of additional resources is essential if South Africa is to implement the South African National LGBTI HIV Framework at scale to sufficiently reduce HIV prevalence in these populations. The SANAC Secretariat will lead processes to identify potential donors to finance full implementation of the South African National LGBTI HIV Plan. SANAC Secretariat will also facilitate processes for development of multi-agency joint funding proposals.

6.4 COSTING AND FINANCING PLAN

The SANAC Secretariat will commission a costed implementation plan and also estimate the medium to long term costs for the full scale up of the South African National LGBTI HIV Framework. This will inform the prioritisation of the packages for implementation.

provide ongoing technical guidance for the South African National LGBTI HIV Framework. This group includes representatives of South African Government departments (including representation from the DoH High Transmission Area (HTA) programme), the SANAC Secretariat, implementation organisations, development partners, researchers and the LGBTI sector. The role of this group includes maximising synergies between different partners as well as providing the opportunity for LGBTI population input to inform programme design, implementation, adaptation and monitoring.

Provincial, District and Local AIDS Councils including Ward AIDS Councils, where these exist, will be capacitated to ensure the mainstreaming of this framework into local AIDS response strategies. This will decentralise planning, finance full implementation of the South African National LGBTI HIV Framework at scale to sufficiently reduce HIV and STI transmission among LGBTI people.

for TB

8. Screening for TB

LGBTI screened for co-infections

9. STI and SRH programs

Increased demand and uptake of STI, SRH by LGBTI

10. Empowerment programs: skills development and training

ABET and FE trained LGBTI

11. Empowerment programs: community strengthening

LGBTI community meetings

12. Psychosocial and mental health support programs

Increased demand and supply of psychosocial and mental health services among LGBTI people

13. Human Rights programs including advocacy targeted towards law reform

Increased sensitisation on and observation of human rights

14. Human Rights programs including policy improvement

Increased legal literacy

services for LGBTI people in South Africa. Capacity strengthening is an enabler for the implementation of this framework and as such funds should be mobilised for this activity.

REFERENCES


Gender Dynamics; amfAR. (2012). Transgender access to sexual health services in South Africa: findings from a key informant survey.


South African National AIDS Council
2nd Floor, Block E, Hatfield Gardens
333, Grosvenor Street, Hatfield, PRETORIA
For further information contact Kanya Ndaki
Tel: +27 12 748 1002
kanya@sanac.org.za

Draft Plan July 2016 - Subject to Change