

NEEDS ASSESSMENT REPORT

for the
PREVENTION and RESEARCH INITIATIVE
for
SEXUAL MINORITIES (PRISM) PROGRAMME

THE BOTSWANA NETWORK ON ETHICS, LAW and HIV/AIDS (BONELA)
and
LESBIANS, GAYS and BISEXUALS of BOTSWANA (LeGaBiBo)

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SUMMARY

During the past decades, remarkable societal changes in regard to HIV/AIDS and human rights have increasingly led to an emerging variety of social, health and legal interventions emerging in different countries at different speeds and intensities. By far the most prominent interventions, fully accepted in many countries are targeting heterosexuals and children. However, it is internationally recognized that even in countries with generalized epidemics, such as in Botswana, special attention needs to be afforded to marginalized groups, such as sexual minorities. It is against this background that, the Prevention and Research Initiative for Sexual Minorities (PRISM) programme was established. PRISM is an STI/HIV prevention programme that is targeted at Lesbians, Gays, Bisexuals, Transgendered and Intersexed (LGBTI) communities in Botswana.

The PRISM needs assessment sample size consisted of 110 respondents drawn from faith based organizations, traditional healers, partner organizations, public health care provision facilities, training institutions and LGBTI communities in five sites of Botswana.

The results emphasized the need to educate the society at large on prevention, human rights and the general well being of people identifying as lesbians or gays, both at individual and organizational levels and to conduct studies on similar issues as well as modification of laws and policies accordingly. The conclusion drawn from the needs assessment is that there is need to have prevention strategies in place for sexual minorities in Botswana for the attainment of one of the pillars of Vision 2016 that enunciates attainment of a healthy nation and zero new HIV infections by the year 2016.

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Definition of terms

HIV	Human Immunodeficiency Virus
STI	Sexually Transmitted Infections
AIDS	Acquired Immunodeficiency Syndrome
WSW	Women Who Have Sex With Women
MSM	Men Who Have Sex With Men
LGBTI	Lesbians, Gays, Bisexuals, Transgendered and Intersexed
LGB	Lesbians, Gays and Bisexuals
HCP	Health Care Providers
PO	Partner Organizations
TI	Training Institution
FBO	Faith-based Organizations
TH	Traditional Healers
PRISM	Prevention and Research Initiative for Sexual Minorities
BONELA	Botswana Network on Ethics, Law and HIV/AIDS
CAL	The Coalition of African Lesbians
FQ	Frequency

CHAPTER ONE

INTRODUCTION

The Prevention and Research Initiative for Sexual Minorities (PRISM) programme was established in January 2007 with the aim of developing and implementing an HIV/STI prevention programme related to sexual minorities in Botswana. It is a partnership programme between the Botswana Network on Ethics, Law and HIV/AIDS (BONELA), Lesbians, Gays and Bisexuals of Botswana (LeGaBiBo) and the Schorer Foundation in the Netherlands.

The programme came as a result of two workshops held by BONELA and LeGaBiBo on 'discrimination and access to care' and 'healthy relationships'. The two workshops were conducted when the partners mentioned noticed a growing de-sexualisation of the HIV epidemic and lack of self esteem or assertiveness of LGBTI communities. This led to unhealthy relationships as a result of HIV/AIDS messages that do not address sexuality issues, especially those relating to same sex relationships. The two workshops demonstrated that many people lacked information or expertise in LGBTI issues and that LGBTI people stigmatized themselves in the process. The workshops strongly recommended that LGBTI communities should be empowered to be more assertive and access services without fear. A needs assessment and/or research on LGBTIs was indicated as a necessity to inform advocacy on human rights and sexual diversity through the media.

The PRISM programme considers that to achieve optimal success in the response to HIV and AIDS and STI prevention, treatment and care, it is essential for communities, particularly high risk groups such as lesbians, gays, bisexuals and transgendered and intersexed (LGBTI) people. Sexual minorities need to be involved in the prevention programme mainly to enable them to engage in decision and policy making processes that will empower and help them to make informed lifestyle choices. In this initiative, the PRISM programme partners with LeGaBiBo.

Significance of the study

HIV and other sexually transmitted infections and the abuse of human rights affects the lives of human beings economically, socially, emotionally, psychologically and physically, both at individual and family levels. A needs assessment of this nature is relevant to policy development in Botswana since it provides information on prevention of STIs/HIV for sexual minorities to the entire society at a critical moment in its development, since the impact of HIV and AIDS in Botswana society has put the spotlight on social, health and legal developmental gaps.

Service providers will find the results of the needs assessment helpful as they work with individual clients or groups. The social, health and legal systems will be enhanced in terms of direct practice, advocacy, policy and legislation amendments.

Needs assessment process

The process started with a needs assessment proposal to Schorer (the funding partner), and the recruitment of a multi-disciplinary brainstorming group to guide the needs assessment process. A series of plenary meetings were held to adopt the needs assessment process, draft questionnaires and terms of reference, as well as to discuss the literature review.

This process was followed by the recruitment and induction of research assistants to aid the fieldwork after which a database was created and data entry, analysis and interpretation were conducted, culminating in the production of a report.

CHAPTER TWO

LITERATURE REVIEW

Introduction: Law, Culture and Homosexuality in Botswana

Homosexual sexual activity in Botswana is illegal according to the penal code, Section 164 (Cap 08:01-67). It states that ‘any person who has carnal knowledge of any person against the order of nature, has carnal knowledge of an animal, or permits any other person to have carnal knowledge of him or her against the order of nature, is guilty of an offence and is liable to imprisonment for a term not exceeding seven years’. In a precedence setting case of *Kanane vs. the State* (2003), Kanane was found guilty of sodomy and ‘unnatural sex’ under section 164 of the penal code, as amended. The matter was taken before the Botswana Court of Appeal, which upheld the guilty verdict, arguing that the ruling was constitutional, non-discriminatory and not in violation of the rights of homosexuals. This case legally endorsed homophobia in Botswana.

Scientifically, until 1973 homosexuality was considered a mental disorder by the American Psychiatric Association. It was only in 1990 that the World Health Organization started to address the challenges to health in the context of homosexuality (ILGA, March 2006). To this day, some sections of the population still believe that gay people are mentally ill. LGBTI have to cope with internalized homophobia and external negative public attitudes. In some cases, homosexuals do not rely on the support of their families and are forced to break up with the mainstream culture and lifestyle of their societies.

African cultures, Botswana included, also stigmatize minority sexual orientations. Although it is often acknowledged that sexual orientation may pose difficulties for some people, sexuality and sexual orientation is often not openly discussed in many societies. Denial on the part of individuals, families and the larger society have also pushed the issue of same-sex HIV/STI transmission in Botswana, and in Africa as a whole, firmly into the closet. Many individuals and community groups demand that it remains so. This is perpetuated by the political and cultural resistance to acknowledging homosexuality as an African phenomenon.

Although Christian leaders often argue that all people were created in the image of God and that there should not be any discrimination on the basis of race, religion, gender or sex,¹ there is also a strong belief that homosexuality threatens to destroy family values. This is in spite of the fact that many gay and lesbian people are a

1 BONELA Training manual (human rights and HIV, 9, sexuality and human rights),

significant emotional and financial resource to their families. Many gay and lesbian couples even adopt children or have children of their own.

In 2003, senior Anglican priests reacted with hostility towards the appointment by the Episcopalian church in the United States of its first openly gay bishop. For example, in Kenya, the Bishop of Eldoret, in Stephen Kewasis, denounced the decision as contrary to scripture and African culture.²

In March 2007, the Botswana Anglican Church Women's Wing held a dialogue on homosexuality that clearly indicated that homophobia exists within the church. The dialogue showed the willingness of the church leaders to change their attitudes towards homosexuality by acknowledging its existence in society and mapping a way forward.³ This could be a beginning of a more open attitude towards LGBTIs in faith based organizations, especially the Anglican Church.

Archbishop Desmond Tutu and the Dutch Reformed Church have publicly apologized for the persecution of lesbian and gay people by the church in southern Africa (Well, 2004). Many religious communities in South Africa accept lesbians and gays as members. However, many gay and lesbian people still experience difficulty in finding a community of faith that accepts them (Well, 2004). In South Africa, the law is increasingly recognizing these diverse family structures. Gay marriages became legal in South Africa at the end of 2006, after a Constitutional Court ruling that the current marriage laws were discriminatory.⁴

The Situation of Sexual Minorities and HIV Prevention in Botswana

The former President of Botswana, Festus Mogae said as far back as 2000, that the people of Botswana needed to change their strongly held views about certain members of the society in order for the nation to effectively stop any future HIV infection. He said this when launching the UNDP Human Development Report in December 2000, urging the nation not to be judgmental of prisoners, homosexuals and commercial sex workers. In addition, if Botswana did not find a way to protect the groups aforementioned, it would ultimately fail to protect the broader society in general. However, several years later, there is still very little information specific to the issues faced by the LGBTI community in Botswana.

2 [Http://news.bbc.co.uk/2/hi/africa/3130255.stm](http://news.bbc.co.uk/2/hi/africa/3130255.stm), surfed on 3September 2007 at 1532pm

3 BONELA Guardian, Issue 2 of June/July 2007, pg 4 by Prisca Mogapi

4 [Http://news.bbc.co.uk/2/hi/africa/4744376.stm](http://news.bbc.co.uk/2/hi/africa/4744376.stm), accessed on 3September 2007 at 1651pm

The Right to Health and Sexual Minorities in the Era of HIV/AIDS

The right to health is a basic human right. Sexual health is also a fundamental human right and requires a positive, respectful approach.

Botswana as a signatory to the international agreement reached at the 4th World Conference on Women held in Beijing in 1995, subscribes to the rights contained in the Sexual Health Charter and is obliged to ensure that the sexual rights of all persons are respected, protected and fulfilled, including sexuality education, through which information, skills building and values clarification will enable people to make choices and take control of their sexual lives.

The exercise of these sexual rights can only be achieved in the absence of coercion, discrimination and violence. Sexual rights are universal human rights based on the inherent freedom, dignity and equality of all human beings.

Botswana, with an estimated population of 1.8 million people is experiencing the most severe impact of the HIV and AIDS epidemic. The 2006 Botswana Second Generation HIV and AIDS Surveillance Technical Report⁵ states that in Botswana an estimated 258 000 adults [15-49 years] are living with HIV/AIDS. The country's prevalence rate is estimated at 17.1% in the BAIS II report. HIV/AIDS education has focused on heterosexuals, neglecting gay men and lesbian women as a target audience for HIV/AIDS education. It is important that Botswana acknowledges the existence of homosexuality in the country. The current denial of the existence of sexual minorities and the resultant invisibility of this group, is contributing to the widespread abuse of their human rights and increasing vulnerability to STIs or HIV/AIDS. For example, in prisons, condoms are not provided though anecdotal evidence suggests that, men who have sex with other men (MSM) and women who have sex with other women (WSW) also have heterosexual contact, therefore, exacerbating the rate of STIS/HIV infection.

Towards Health Policies that are Specific to Sexual Minorities

In many African countries, access to health services is difficult to the majority of the population and is even worse for socially discriminated people like the LGBTI. It is not easy for gay men and women to openly discuss their health needs with doctors because they fear persecution and this undermines the quality of health care

5 Botswana Second Generation HIV/AIDS Surveillance technical report (2006)

6 ILGA publication, issue 121, March (2006), 'Lesbian and Bisexual: women's health'

they receive. According to an International Lesbians and Gays Association (ILGA) publication entitled *Lesbian and Bisexual: Women's Health*, there are barriers to accessing health care that are specific to the LGBTI community. However, barriers experienced by other populations, for example, lack of resources, geographic and social isolation, lack of information about and/ or fear of medical procedures, may also pertain to LGBTI people. Barriers which are specific to many LGBTIs include the fear of discrimination and stigma, which prevent them from seeking care for themselves or their families. Once accessing health services, LGBTIs may withhold personal information that health care providers need in order to give appropriate care.

In Botswana, health care needs of the LGBTI community are not addressed at all in public hospitals. Existing health structures continue to provide public information and facilities on the basis of a generalized notion of community. Health services are provided free to all members of the public but there are no doctors and nurses providing services specifically to the health needs of this community. However, it is becoming increasingly evident that prevention programmes need to be inclusive of all social groups in both urban and rural areas. Community mobilization strategies need to begin to target different segments of the population and high risk groups (Botswana Surveillance Report, 2006).

Homophobic social policies and those that are silent on the LGBTI issues continue to compromise access by LGBTI to legal, social, economic and health care services. Also, due to limited access to information and information technology, many cannot access information on LGBTI issues available from more progressive countries. Sexual minorities lack information regarding sexual health matters, HIV and STI prevention and modes of transmission that are specific to their needs.

Confidentiality and LGBT communities

A study conducted in Gauteng and Kwa-Zulu Natal in South Africa, demonstrated that not all gay and lesbian people are open about their sexual orientation. Even when someone else knows about their sexual orientation, confidentiality has to be practiced as their family and friends may be unaware of it. 'Coming out' is a life long process and happens frequently as a person's social circumstances change. For example, when getting a new job, LGBTIs have to decide whether to disclose their sexual orientation or not, and the implications of doing so. Research shows that the general age for coming out for boys is 19 and 21 for girls, though it differs from person to person as other people 'come out' after many years in marriage. Different countries or cultures

may also influence when one ‘comes out’, as each person does so in different ways under unique circumstances, depending on the level of self acceptance, self value and support in the social environment, while others never ‘come out’ at all (Croucamp, 2007).

Discrimination by health care providers

Health care providers are not immune to prejudice. Literature shows that there is lack of knowledge and sensitivity of the specific needs of lesbians in particular and LGBTIs in general. Particularly worrying, are some findings related to the interaction between lesbian and bisexual women with gynecologists and psychologists. In those cases where sexual orientation has a clear impact on health, patients do not disclose their sexual orientation, while health providers assume automatically the heterosexuality of their patients (Croucamp, 2007).

There is little research on the transmission of HIV and other sexually transmitted infections between lesbians, as compared to the research available for gay men. This leads to the belief amongst lesbians and bisexual women themselves that they are immune to contracting sexually transmitted infections when having sex with other women. Therefore, it is important to raise awareness and educate the community on the transmission of HIV and other STIs between lesbians.

In addition, if a member of the LGBTI community experiences homophobia and/or discrimination, or feels that their needs are not recognized or addressed, the experience can result in them not going back for needed further care. Research shows that there is a high degree of ignorance on the health needs of the LGBTI community and lack of sensitivity by health care providers when LGBTIs engage with a system they view with fear and suspicion (ILGA, 2006).

Another major concern in relation to health care is the fact that lesbians do not access the health care system in the same way as heterosexual women. Research shows that lesbians and bisexuals do not normally visit a gynecologist (Lesbians, Bisexuals’ Common Issues, 2006). Most may feel that visiting a gynecologist is relevant only in cases of contraception and motherhood, hence family planning services will not be a priority. Fear of homophobic reactions from health care providers and a reluctance to share ‘private matters’ with a stranger also play a role. The publication emphasizes the importance of raising awareness among lesbian and bisexual women of the benefits of seeing a gynecologist, namely for prevention purposes of the types of cancer that also prevail among this community, that is breast cancer and cervical cancer.

This invisibility in health situations can have important consequences on the psychophysical wellbeing of women who have sex with other women (WSW). Consequently, when health professionals systematically underestimate the number of these patients, their specific health risks and problems remain unnoticed. WSW also lose an opportunity to communicate their specific problems and be comfortable in this situation.

In a recent study undertaken in Windhoek, Namibia, on sexual and reproductive health, researchers found that factors such as poverty, social and gender inequality, sexual violence and culture all restrict women's freedom of choice when it comes to matters of sex and reproduction especially amongst WSW (Women's Health: Common Concerns, Local Issues, 2006). This emphasises how the homophobic environment negatively impacts the well-being of LGBTI.

Vulnerability not only applies to WSW, men who have sex with other men are also vulnerable to HIV and other STIs because of the society that has certain expectations on gender roles. According to G.R. Gupta (2000) in a paper presented at the XIII international AIDS conference (UNAIDS 1999, the unequal power balance in gender relations increase men's vulnerability to HIV infection, despite, or rather, because of, their greater power.

Prevailing norms of masculinity imposes an expectation on men to be more knowledgeable and experienced about sex, putting them, particularly young men, at risk of infection. Such norms prevent them from seeking information or admitting their lack of knowledge about sex or protection, and coerce them into experimenting with sex in unsafe ways to prove their manhood. Male characteristics that emphasize sexual domination over women, contribute to homophobia and the stigmatization of MSM. The stigma and fear, force MSM to keep their sexual orientation a secret and deny their sexual risk, thereby increasing their own risk as well as the risk of their partners, female or male.

In the OUT research that was done in Gauteng, South Africa, a quarter of the participants who had not been tested for HIV did not know how to get tested. This indicates that more education is needed on HIV testing. In Botswana, research undertaken by LeGaBiBo recently on the life experiences of lesbian and bisexual women for the Coalition of African Lesbians [CAL], indicates that women do not know anything about protection [sexually] and, therefore engage in unprotected sex which predisposes them to sexually transmitted infections [STIs] like Gonorrhoea, Herpes and Chlamydia. This also shows that more education and sensitization is

needed regarding these issues for this group.

Stress and Mental Health Problems

A study undertaken in Gauteng and Kwa-Zulu Natal in South Africa revealed that, being part of a stigmatized social minority caused all sorts of stress and mental health problems for homosexual communities. Lack of emotional support and poor social integration often lowered self-esteem, leading to other mental health problems, ranging from minor reactions such as headaches, restlessness and sleep disturbances, to more long term reactions such as low self-esteem, depression, post-traumatic disorder, increased alcohol and drug use and suicide. One fifth of the Gauteng participants and 17% of the Kwa-Zulu Natal participants had previously attempted suicide. In many cases, the use of alcohol and drugs as a coping mechanism accentuated the depression.

Violations of Human Rights Specific to Sexual Minorities

There are different types of human rights violations that are related to sexual minorities.

Domestic violence

Although there are similarities between same sex and heterosexual intimate violence, several important differences have been found. Over the past 30 years, women organized and politicized around the issue of domestic violence, defining it as a crime against women. Once a private matter, domestic violence has become a public human rights issue and a recognized legal, social, and psychological problem. Many analyses legitimized domestic violence as “violence against women”, which consequently left behind the parallel issue of partner violence in gay and lesbian relationships as well as heterosexual female-to-male violence. Lesbian and bisexual women face not only the silence and stigma about their sexuality, but also about their experiences of gender-based violence.

The idea that domestic violence is fundamental to men’s power over women in society precluded the possibility that women could be violent or that men could be violated. According to ILGA, the few studies examining the prevalence of same sex intimate violence indicates that intimate violence exists in gay and lesbian relationships. Violence is estimated to be varying from as low as 17% to the highest of 73 percent. The most prevalent is emotional abuse, rating between 65% and 90%, compared to physical abuse, 8% to 60%, and sexual violence 5% to 57 percent.

On the other hand, statistics of heterosexual domestic violence indicate that 25% to 33% of heterosexual women are battered by their male partners. Intimate violence among gay and lesbian partners is shown to be equal or greater in prevalence compared to heterosexual domestic violence.

It is clear, therefore, that same sex intimate violence occurs frequently enough to not be considered an “anomaly” or an exception, to the general pattern of heterosexual male to female violence. Partner abuse is believed to be the third largest health problem facing gay men, second to substance abuse and AIDS according to the ILGA publication. Despite its prevalence and severity, same sex intimate violence remains a largely unrecognized social problem. Social services for victims and survivors of domestic are also geared towards heterosexual women. The legal stance and lack of information on LGBTI in Botswana also makes it difficult to prove the existence of domestic violence among same-sex relationships in the country.

Outing

The most distinct and apparent form of violence in homosexual relationships is the unique form of abuse referred to as ‘outing’ which usually leads to relative social isolation. The threat of outing a partner’s sexual orientation to a family, or community in general can be used as a form of control and makes a partner remain in an abusive relationship. Individual gays and lesbians’ own internalized homophobia also affects the same sex abusive situation, whether homophobia is on the part of the abuser or the abused. Clinical observation shows that the majority of gay males who behave abusively manifest a negative self concept related to internalized feeling of hate and fear over one’s homosexuality.

Hate crimes: Curative rape

“Curative rape” is a crime in which the perpetrator’s conduct is motivated by hatred, bias or prejudice, based on the actual or perceived race, religion, national origin or ethnicity, gender, sexual orientation or the gender identity of another individual or group of individuals. It is motivated by the belief that lesbian women are “pretending” to be the men and is designed to “prove” that they are women. In Botswana, there is no data available for such cases so far. In South Africa, women are abused emotionally and physically if it is discovered that there are lesbians. Recently, two women were brutally murdered for being lesbian (Drum, 26 July 2007: pg 10-11). According to the ILGA publication *Lesbian and Bisexual: Women’s Health; Common Concerns, Local Issues*, hate crimes are committed because of the perpetrator’s prejudices. In

the case of lesbian women, and particularly butch lesbian women, rape is used to demonstrate that as women they are subject to power of men over their lives. The publication further states that, high prevalence of hate crime leads to high levels of fear of victimization which in turn tends to control the behaviors that women feel safe to engage in. This can influence freedom of movement, dress code and sexual interactions. “Curative rape” can force lesbian women into hiding even in their homes, families and communities.

Summary

It has been noted that, one of the primary barriers to accessing services and exercising rights in many countries is knowledge of what those services and rights are. South Africa, for example, has a wonderful constitution which in theory protects LGBTI people from discrimination on the basis of sexual orientation. Unfortunately, in practice, there is still a high prevalence of homophobia as literature has shown above. It is therefore vitally important that people are educated on their rights and where to access what kinds of services as well as educating the public on LGBTI issues. Institutions and or facilities that offer health services must be structured and promoted as non discriminatory and inclusive environments for LGBTI people so as to make easy access for them. In order to eliminate barriers to health care, two steps must be taken. First, at the level of the health care system, it is necessary to build awareness of LGBTI people’s needs and to develop the requisite skills to meet these needs. Secondly at the individual level, it is necessary to encourage self confidence and self esteem as well as to develop advocacy strategies.

LGBTI population is as diverse as the heterosexual or ‘straight’ population in terms of ethnicity, belief, and identity. They need a safe environment in which to freely express themselves. The truth, however, is that many organizations, facilities and families are still not safe for LGBTIs, nor are appropriate counseling services provided for them thus many of them live life in deep depression. Intervention is still very low for many critical populations in many countries including Botswana.

The magnitude of the problem and the current speed of expansion of the HIV pandemic make prevention a primary concern. Interventions like information, education, and communication (IEC) using the participatory approaches are required with linkage to experience. Educational material messages must be clear and easy to comprehend and the community must be involved in identifying the cultural and social practices which increase or decrease the risk of HIV transmission, and in formulating education programmes appropriate for its situation.

Risky sexual behaviors may change over time, when people are able to access information and services for safer sex. According to media resource desk reports from *Mmegi*, a newspaper locally produced in Botswana, MSM, remain among the ‘at risk’ and neglected four key populations in HIV messaging and programming. Education is a useful tool to encourage the LGBTI community to consider their health in terms of human rights. The adoption of a human rights-based approach to health may be especially empowering for lesbian and bisexual women, a group that continues to suffer from double discrimination and whose health concerns are much marginalized. A lot needs to be done with regard to the right to health in the context of poverty and the right to health from the perspective of discrimination and stigma.

Conclusion

Finally, the literature reviewed indicates that because of marginalization, many social and health issues appear not to be addressed for sexual minorities. In addition to external marginalization, LGBTIs often do not accept themselves because they grow up in homophobic societies, resulting in self-stigmatization. Many social issues, such as violence within partnerships and hate crimes are not addressed, leaving the LGBTI community to believe that services are not available for them. In Botswana, criminalization of same sex sexual relationships makes it extra difficult for mainstream service providers to include MSM and WSW in their programmes. All of this calls for a creation of targeted service provision with the full involvement of the LGBTI community.

CHAPTER THREE

METHODOLOGY

Research Design

The needs assessment adopted both descriptive and exploratory research designs. The descriptive design attempts to describe a phenomenon in detail⁶. Identification of gaps in sexually transmitted infections (including HIV) prevention for sexual minorities will thus be described in depth. An exploratory research design was also appropriate for needs assessment of this nature because of the need to explore HIV, human rights and service provision and its impact on lesbians, gays and bisexual communities. It is necessary to know and understand more about lesbians and gays, HIV/STI prevention strategies specific to them and the implications for families and individuals in Botswana before any intervention can be used or discarded to achieve positive results in such situations.

Time Dimension

The study was cross-sectional since it was measuring the variables in a specific period of time.

Research Method

A qualitative research method was most appropriate for understanding HIV/STI intervention gaps for lesbians and gays as well as how to address them. As the source of people's attitudes toward an object is rooted deeply within them, qualitative methods are used in order to obtain a holistic picture of what transpires in particular situations and how it can be addressed. A qualitative method allows the use of questionnaires and face-to-face interviews that enable the researcher to probe and source accurate information towards acquiring an in-depth understanding from the respondents.

Sampling

The study population consisted of health care service providers and partner organizations, training institutions (tertiary), faith based organizations and traditional healers as well as the lesbian and gay communities, making a sample size of 110.

Instrumentation

Both a questionnaire and a face-to-face interview guide with open and close-ended questions were used to collect data which was later given to an agency to create a data base and enter the data.

6 .Bailey, C.A (1996) A guide to field search, Thousand Oaks, California

Sources of Data

The primary and secondary sources of data were used. Respondents provided first hand information (primary) and secondary data was obtained from related books and journals.

Limitations of the Study

- The sample size is small and not representative of the entire population. This was mainly due to unavailability of some respondents and resource constraints such as time and funding. Institutional accessibility was not easy as protocols had to be followed.
- Measuring attitude is not always easy and information is not always reliable.
- Translation of some terms relating to sexual minorities to the local language proved to be a problem.

Ethical Considerations

Same sex relationships are not accepted in Botswana. The relationship carries with it a social and legal stigma which makes it a sensitive issue, therefore, the following ethics were considered in safeguarding the rights of those who participated:

- Participation was voluntary and no one was coerced into answering the questionnaire
- Consent was secured and the respondents were informed of the purpose of the research and the implications of their participation
- Confidentiality regarding the information collected was ensured through anonymity
- The respondents were informed about the use and dissemination of information received

CHAPTER FOUR

Data Presentation and Discussion of Results

The needs assessment was conducted to assess and establish factors that influenced HIV and other STIs prevention programmes for sexual minorities in Botswana and establish the ground work for an HIV/STI prevention programme. 110 respondents participated in the interviews which had a questionnaire guide. Data results or findings are presented below with discussions.

Of the 110 respondents interviewed and questionnaires filled, 53 were from health care facilities, partner organizations and training institutions, while 41 were from the lesbian, gay and bisexual communities and 16 were from faith based organizations and traditional healers.

1. LGBTI

41 respondents were interviewed in 5 sites (4 districts) of Botswana.

Table 4.1 Respondents per District

District	Frequency	Percentage (%)
North East	17	41.5
South East	15	36.6
Kgatlang	5	12.2
Ngamiland	15	36.6

The North East district had the highest number of respondents (41.5 %) followed by South East, Kgatleng and then Ngamiland.

Table 4.2 Respondent's Age

Age	Frequency	%
More than 30yrs and less than 40yrs	4	9.8
More than 20yrs and less than 30yrs	30	73.2
Less than 20yrs	7	17

The highest age range of respondents was more than 20 years of age but less than 30 years at 73.2%.

Table 4.3 Respondent’s Gender

Sex (Biological)	Frequency	%
Male	26	63.4
Female	15	36.6

In all the sites, the highest number of respondents interviewed was male (63.4 %) while females stood at 36.6%. From the total number of respondents, 56.1% preferred a different gender identity to that of their biological one.

Table 4.4 Employment Status

Status	Frequency	%
Employed	20	48.8
Unemployed	17	41.5
Schooling	4	9.7

48.8% of the respondents indicated to be employed [including 7.3% who are self employed], while 41.5% was unemployed. 9.5% was still at school. 90.2% of the interviewees were single and 9.8% married. 68.3% of the total number of respondents had tertiary education and 31.7% secondary education. 87.8% of the total was in urban areas and 12.2% in rural areas. As to whether respondents were open and comfortable being interviewed, 95.2% of the respondent were and 4.8% were not. In a follow-up question on being generally open in the society, 78 % were proud to be gay and open about their sexual orientation, whilst 22% of the total respondents had not disclosed their sexual preference to anyone.

29.3% of respondents who had disclosed their sexual orientation to different people said they had disclosed to those particular people because they were more comfortable with them, 24.4% did so to express themselves while 9.7% disclosed because they were close to those particular individuals and felt they had to know. 7.3% of respondents disclosed for transparency and 4.9% because those people were also gay.

Respondents were asked if they considered themselves integrated in the LGBTI community and 68.3% of them said they were integrated because they identified themselves with the LeGaBiBo organization while, those who were not stood at 31.7%. For those integrated, 48.8% stated their attendance in social gatherings as an indicator for integration and 19.5% said they attended LeGaBiBo meetings. For those who are not integrated, 22% cited registration to LeGaBiBo as the main reason they were not, 7.3% said they were friends to LeGaBiBo members and 2.4% said they met or spoke on the phone.

Asked if there were specific places for LGBTIs to access health services, 51.2% of the respondents did not know any, while 24.4% said they knew of such places and 24.4% said there were no such places. Of those who knew of such places, 17% stated that one had to drive to a distant place to access the services, 5% said they can be accessed by public transport and 2.4% said it was a walking distance to those services. On the quality of services, 3.9% of the respondents felt the quality of the services was average, 12.2% said there were good and 7.3% said that the services were poor.

14.6% felt that the services did not meet their basic needs, since there were just regular heterosexual services. 4.9% said the services met their basic needs whilst 4.9% said they did not. As to how the respondents learnt about these services, 13.4% of the respondents indicated word of mouth as the source, 7% said mass media and 4% said printed IEC material.

For LGBTIs needs to be met, 31% of the respondents said there should be more empowerment for the LGBTI community to utilize services. 26.8% felt openness and non-discrimination in the society and service centres was the answer, whilst 24.4% said training on sexuality for service providers would help. 17.1% expressed that there is no need to be treated any different.

As for HIV transmission in same sex relationships, 83% of the respondents said there was transmission, 7.3% said there was no transmission and 9.7% did not know. With regards to HIV transmission risk level in comparison to heterosexuals, 51.2% stated that it is the same, 29.3% felt it was lower, whilst 19.5% said it was high.

Asked whether they use any method of protection, 65.9% of respondents said they did, 26.8% stated that they did not and 7.3% were abstaining.

Table 4.5 Availability of Barrier Methods

Barrier methods	FQ	%
Condoms	19	46.3
Dental Dams	2	4.9
Gloves	2	4.9
Abstinence	3	7.3
Nothing	15	36.6

On the use of barrier methods, 46.3% reported to be using condoms, 36.6% were not, 7.3% were abstaining, 4.9% were using gloves and 4.9% were using dental dams.

On whether respondents faced any challenges with barrier methods, 58.5% said they did not have any problems while 41.5% said they did. Stating the challenges, 17% of the respondents said they were not aware of any barrier methods, 9.8% said they [together with their partners] were not willing to use any barrier methods and 7.3% stated that barrier methods were not available and another 7.3% said the methods were not appropriate.

Of the routine tests or exams at health facilities, 46% knew of HIV tests while 15% knew about STI screening and 12.2% knew about pregnancy tests. 12.2% were aware of TB/Polio exams, 4.9% knew of pap smears, 2.4% of testicular cancer, 2.4% had knowledge of urine/kidney and 4.9% did not know any. 63.4% of the respondents had accessed these routine tests and 36.6% had not. From those who had accessed the services, 51.2% had done an HIV test and 12.2% had accessed STI services.

Out of the total number of respondents, 36.6% felt that to get better services, the constitution or policies need to change. 26.8% felt cultural norms have to change whilst 17.1% said there was need for education or information for all. 12.2% indicated the need to change everything and 7.3% said religion needed to change. 34.1% of the respondents said they liked nightlife entertainment as their pass time activity, 14.6% stated watching TV or movies while another 14.6% said they stayed at home or sleeping and 9.8% said they visited/traveled/met people, 4.9% of the respondents said sex was their recreational activity and the last 22% stated others which included farming and cooking.

Table 4.6 Preferred health care services

Type	FQ	%
Modern	34	83
Spiritual	3	7.3
A mixture of all	1	2.4
None	3	7.3

83% of the respondents prefer modern type of health care services, 7.3% stated spiritual services as their preference while 2.4% preferred a mixture of all and 7.3% do not have any preference.

Table 4.7 Experiences in accessing services

Experience	FQ	%
Good	7	17.1
Very specific to my needs	6	14.6
Just ok, meets basic needs	22	53.6
Very poor	4	9.8
Discriminatory	2	4.9

53.6% of the total respondents said the quality of the services was average and met their basic needs, 17.1% said they were good while 14.6% said the services were specific to their needs, 9.8% said they were poor and 4.9% stated that there were discriminatory. To explain, 41.5% of the respondents said services met their basic health needs and equally 41.5% stated that services being of private doctor/sector and paying for the services as a reason while 17% stated that services were poor in general, that they were untrained personnel and that services were not catering for LGBTIs.

Of the total number of respondents, 41.5% had never experienced discrimination, 31.7% were targets of hurtful comments passed by people. 21.9% of respondents revealed that they had been isolation by society and 4.9% had been verbally attacked.

26.8% felt that specially trained personnel would make an improvement in health care delivery targeted at them. However another 26.8% recommended longer term solutions such as reviewing of the legislation as the answer. 17% said there was need for LGBTIs to be open and proactive in advocating for their issues to make a difference, 9.8% stated that there is need to sensitize health care providers and 4.9% indicated the availability and awareness of barrier methods as the answer inadequate and insensitive health service delivery. As an explanation, 46.4% thought that such improvements would ensure that all health aspects for LGBTIs will be better thereafter, while 34.1% said the improvements would reduce discrimination and 19.5% said they would be more comfortable with their sexual orientation if health care providers were trained to deal with LGBTIs. The level of cooperation, was high at 83%, medium at 14.6% and low at 2.4%.

2. HEALTH CARE PROVIDERS/PARTNER ORGANIZATIONS

A total of 53 respondents were interviewed in all the 5 sites. 73% interviewed were female and 26.4% were males.

Table 4.8 Respondent's Position

Position	FQ	%
Officer –in-charge	7	13.2
Service delivery officer	46	86.8

13.2% of the total interviewed were officers-in-charge of facilities/organizations and 86.8% were direct service delivery officers.

Table 4.9 Facility Type

Type	FQ	%
Public Health facilities	23	43.4
NGOs/Parastatals	13	24.5
Private health facilities	11	20.8
Training institutions	6	11.3

The highest interviewees were from public health facilities and constituted 43.4% followed by 24.5% from NGOs/parastatals, 20.8% from private health facilities and 11.3% from training institutions.

Table 4.10 Location

Location	FQ	%
Francistown	21	39.6
Gaborone	12	22.6
Lobatse	9	17
Maun	6	11.3
Mochudi	5	9.4

Per-site, Francistown had the highest number of interviewees at 39.6%, Gaborone at 22.6% while Lobatse was at 17%, Maun at 11.3% and Mochudi, 9.4%. 62.3% of the interviewees were in cities, 17.1% in towns and 9.4% in villages. 83% of those interviewed were conversant with their operational policies while 17% were not.

Table 4.11 Policy Parts Relating to Service Delivery

Responses	FQ	%
Confidentiality	12	22.6
Client Centred	8	15.1
Treatment’s flowchart/guides	9	17
Non -discriminatory	9	17
Other	15	28.3

Respondents were further asked if their operational policies had parts/clauses relating to how one delivers services to clients. 22.6% of the respondents said confidentiality was one aspect they adhere to in service delivery, while 17% felt the need to be conversant with the treatment charts/guides in some illnesses. Another 17% thought non-discrimination of clients by service providers was important and 15.1% said policies were client centred and 28.3 % had other uncategorised reasons.

Table 4.12 If Policy Caters for All

Answer	FQ	%
Yes	35	66
No	18	34.4

66% of the respondents said their policies catered for everyone in the community and 34.4% said they do not. To explain, 47.2% felt that policies did because services were free and non-discriminatory and 18.9% stated that they were client centred. On the other hand, 17% said that the policies did not cater for all community members at all,, 9.4% said there were unclear guidelines and 7.5% stated that untrained personnel made policies non- inclusive.

62.3% of the total respondents said there was no organization or individual who was catering for LGBTIs, while 20.7% said they knew some and 17% said they not know of any other party that catered for LGBTIs. Of those who said they knew organisations which did,, 11.3% named civil society organizations, 5.6% public facilities, 1.9% local donors and 1.9% the private sector.

A large percentage of the respondents (52.8%) did not have any experience with clients in same sex relationships, 20.7% had few clients who were open about it, while 15.1% could not say they did or did not because they never asked their clients and only 3.8% had experience. The other contributing factor to having experience or not, was that same sex relations were constitutionally not allowed, hence clients

never disclosed their sexual orientation, and this was mentioned by 1.9% respondents in each category.

73.6% felt that they were well trained or equipped to deal with LGBTIs, whilst 26.4% said they were not. In order to make a difference, 56.6% of the respondents said training was necessary, while 39.6% said exposure to such clients would make a difference, and 3.8% said that they were not interested.

Table 4.13 Why Same Sex Relationships

Reasons	FQ	%
I don't have any idea	16	30.2
I think they are lost	4	7.5
I think they are born like that	15	28.3
I think they choose the lifestyle	18	34

34% of the respondents cited that people had same sex relationships because they choose that lifestyle, 30.2% did not know, while 28.3% thought homosexuals were born like that and 7.5% said it was because they were lost.

Table 4.14 What Society Must Do

Responses	FQ	%
Be accommodating	34	62.2
Follow the law	6	11.3
Form discussion membership groups	12	22.6
Punish them	1	1.9

64.2% felt that society should be more accommodating of LGBTIs, 22.6% said that discussion membership groups/support groups should be formed, 11.3% said the law is silent on LGBTI issues, therefore, it should be followed and 1.9% of the respondents said LGBTIs should be punished.

47.2% of the respondents felt that it is important for the Ministry of Health and other health care service providers to gain insight from civil society, 22.6% emphasized that the law must be changed while 15.1% felt that specially trained personnel must be availed to LGBTIs, 11.3% felt the need to understand the behaviors better is a must and 3.8% said nothing should be done.

As to whether LGBTI are at risk of contracting STIs/HIV, 91 % of the respondents said LGBTIs are at risk of contracting STIs while 9% did not know.

Table 4.15 Practice of Safe Sex

Responses	FQ	%
Yes , just the way heterosexuals do	26	49.1
No, they are the cause of many problem and diseases	4	7.5
No, just the way heterosexuals do	17	32.1
Don't know	6	11.3

49.1% of the respondents felt that LGBTIs practiced safe sex just the way heterosexuals did, 32.1% felt they did not in the same way that heterosexuals did not while 7.5% said they did not and that they are the cause of many problems (making a total of 39.6% who felt they did not) and 11.3% did not know.

Table 4.16 Available Barrier Methods

Methods	FQ	%
Condoms	36	68
Gloves	2	3.8
Dildo	1	1.9
Masturbation	4	7.5
Do not Know	10	18.8

As to safe sex methods that LGBTIs can use, 68% of the respondents mentioned condoms, 18.8% said they were not aware of any method while 7.5% stated masturbation. 3.8 % mentioned gloves and 1.9% stated use of a dildo as a preventing method.

52.8% of the respondents said LGBTIs were aware of these methods, while 37.7% said they were not and 9.4% did not know. In terms of using barrier methods, respondents were asked if they thought LGBTIs used barrier methods and 41.5% felt they did, 34% said they did not, 17% said LGBTIs did partly, because it was a yes for men and a no for women and 7.5% of the respondents did not know.

Table 4.17 Reasons for Not Using Barrier Methods

Responses	FQ	%
They are not knowledgeable	9	17
They think it is not necessary	15	28.3
They are embarrassed to seek them	5	9.4
The methods are not widely available	20	37.7

Explaining the contributing factors of not using barrier methods, 37.7% said it was mainly because the methods were not widely available, 28.3% felt that LGBTIs thought it is not necessary while 17% stated lack of knowledge as the main reason and 9.4% thought LGBTIs are embarrassed to seek barrier methods.

56.6% of the total number of respondents felt that cultural norms were the main obstacle in dealing with LGBTIs equally and respectfully, 22.6% stated policy while 11.3% said lack of education and 9.4% mentioned religion.

68% of the respondents said sexual needs of MSM and WSW were completely ignored by HIV policy makers, implementing agencies and community based organizations, while 32% felt they were not. 52.8% of the total number of respondents felt that it was difficult to plan for MSM and WSW because they were very few people in same sex relationships in Botswana and most of them were still in the closet, hence the lack interventions for them in the country. The law which dictates interventions in Botswana regarding LGBTI issues illegal was mentioned by 11.3% of respondents and equally 11.3% felt that the society was homophobic. 7.5% said interventions were available, but LGBTIs stigmatised themselves while 5.6% did not know.

41.5% of the respondents said they had not witnessed anything in relation to service delivery for LGBTIs while 28.3% indicated having witnessed non-discrimination by service providers. Inclusiveness of policies and the existence of LGBTI specific interventions were stated by 13.2% each, while 3.8% of respondents said they had witnessed NGO efforts. To improve the situation of LGBTIs in Botswana, 37.7% of the respondents felt that cultural norms must be changed, 28.3% stated the country's constitution should be amended accordingly, while 22.6% suggested change of policies and 11.3% pointed out the need to educate people.

The level of cooperation was high with 86.8% of the respondents answering the whole questionnaire and medium with 13.2% answering most but not all of the questions.

3 FAITH BASED ORGANIZATIONS AND TRADITIONAL HEALERS

In all the 5 sites, a total of 16 respondents representing faith based organizations and traditional healers were interviewed. 75% of the interviewees were from faith based organizations and 25% represented traditional healers. 50% of the organizations interviewed had been operating for more than 20 years, 31.3% for more than 10 years and 18.7% for less than 10 years.

Table 4.18 Respondent's Gender

Gender	FQ	%
Male	12	75
Female	4	25

75% of the respondents were male and 25% were female. 56.3% of the respondents were pastors (*baruti*) while 25% were traditional healers (*dingaka*) and 18.7% were church counselors.

Table 4.19 Respondents by location

Location	FQ	%
Francistown	2	12.5
Maun	3	18.7
Gaborone	6	37.5
Mochudi	1	6.3
Lobatse	4	2.5

Gaborone was highest in number of respondents per site at 37.5 %, Lobatse 25 % while Maun was at 18.7%, Francistown, 12.5 % and Mochudi was last at 6.3 %. 50 % of interviewees resided in cities, 25 % in towns, 18.7 % in peri urban types of location and 6.3 % in the village. 31.3 % of the respondents said they had organizational policies dealing with all sexual orientations as they assisted everyone, 18.7 % said their policies did not allow other sexual orientations because it is a sin while those who said they did not have any policy and did not know why, as well as those who said they did not have a policy since it was against the Bible, were at 18.7 % each. 6.3 % said they did not have a policy because they have never considered it as they have never been approached or confronted with such issues.

Table 4.20 Organizational position

Responses	FQ	%
Acceptance of all people regardless of other circumstances	9	56.2
Non tolerance of such communities	6	37.5
Invite them guidance and assistance	1	6.3

56.2% of the respondents thought that their organization should accept all people regardless of their circumstances while 37.5% felt their organizations should not tolerate LGBTI communities and 6.3 % said LGBTIs should be invited to their organizations for guidance and assistance.

Table 4.21 Personal Belief or Opinion About LGBTIs

Responses	FQ	%
Yes ,its a bad thing	6	37.5
Yes, bad, transform them	3	18.7
Don't discriminate	4	25
Yes, gay friendly	2	12.5
No belief/opinion	1	6.3

On personal belief or opinion about LGBTIs, 37.5% believed it is a bad thing, 25% said they believed that LGBTIs should not be discriminated while 18.7% stated that it was bad such that LGBTIs needed transformation, 12.5% said they were gay friendly and 6.3% did not have any belief/opinion.

75% of the respondents had never received any cases relating to LGBTIs, while 25% said they had. To substantiate, 18.7% (of the 25%) said they rarely received these cases in a month and 6.3% said they received many in a month. With regard to contributing factors to not receiving referrals, 18.7% said perhaps people who referred them did not know that they can assist LGBTI clients while equally 18.7% stated fear as the main reason. 12.5% said people believed that their organizations would transform LGBTIs to heterosexuals, while another 12.5% said that the society knew they did not condone or tolerate that practice and 12.5% did not know.

Table 4.22 Experience in Same Sex Relationships

Responses	FQ	%
None	11	68.7
Our followers do not behave that way, it is not allowed by this organization	1	6.3
I have plenty followers who are open about their same sex sexual preference	4	25

68.7% of the respondents indicated that they do not have any experience with clients in same sex relationships, while 25% said they had plenty of followers who were open about their same sex sexual preference and 6.3 % stated that their followers did not behave that way as it was not allowed in the organization. 68.7% felt they were well equipped to deal with LGBTIs and 31.3% felt they were not. In comparison, those who stated that they were not well equipped, 18.7% of them said training can make a difference while 6.3% said more exposure to these cases would and 6.3% said they would not be interested in serving LGBTIs.

Table 4.23 Why Engage in Same Sex Relationships?

Responses	FQ	%
I think they are lost	3	18.7
It is because they are sinners	1	6.3
I believe it is their choice	8	50
Illness to destroy lives	1	6.3
To pass time	2	12.5
Identity crisis	1	6.3

When asked why people were in same sex relationships, 50% of the respondents felt that it was a choice, 18.7% thought they were lost and 12.5% said it was to pass time. Others said LGBTIs had an identity crisis (6.3%), another 6.3% said it was an illness meant to destroy lives and yet another 6.3% felt they were sinners. Interventions applied when dealing with LGBTIs varied. 75% of the respondents said they prayed for them while 25% said they assisted them in various ways.

Table 4.24 STI/HIV Risk

Responses	FQ	%
Yes	14	87.4
No	1	6.3
Don't know	1	6.3

87.4% of the respondents said LGBTIs were at risk of contracting STIs, 6.3% did not know and another 6.3% felt they were not at risk.

Table 4.25 Safe Sex Practices

Responses	FQ	%
Yes , I think they are more conscious than heterosexuals	2	12.5
Yes, just the way heterosexuals do	3	18.7
No , they are the cause of many problems and diseases	6	37.5
Don't know	5	31.3

Of the total respondents, 37.5% felt that LGBTIs were not practicing safe sex and were the cause of many problems or diseases while 31.3% did not know. 18.7% said they practiced safe sex just like heterosexuals and 12.5% felt LGBTIs were more conscious of safe sex than heterosexuals.

With regard to safe sex methods available to the LGBTI community, 31.3% mentioned condoms 25% abstinence and 25% said gloves. 12.5% said there were none available and 6.3% did not know.

Table 4.26 Obstacles in Dealing With LGBTI

Responses	FQ	%
Policy	2	12.5
Culture	6	37.5
Lack of Education	5	31.3
Religion	3	18.7

In response to obstacles to dealing with LGBTIs, 37.5% of the respondents indicated culture, 31.3% said lack of education while 18.7% stated religion and 12.5% said policies. 56.3% of the respondents stated that the sexual needs of MSM and WSW were completely ignored by all in the society while 43.7% felt they were not.

Table 4.27 Contributing Factors to STI/HIV Interventions

Responses	FQ	%
They are few people practicing same-sex sexual relations here	5	31.3
Both MSM and WSW are in the closet so it is difficult to plan for them	4	25
The law dictates interventions, in Botswana issues of LGBTI are deemed illegal	3	18.7
I think it is because of our homophobic society	4	25

Of the total number, 31.3% felt that there were few interventions for MSM and WSW in Botswana due to the fact that there were few people in same-sex relationships. 25% said MSM and WSW were in the closet so it was difficult to plan for them. Another 25% felt society was homophobic and 18.7% said the law dictates interventions so in Botswana issues of LGBTI are deemed illegal making it impossible to incorporate MSM and WSW in the intervention strategies.

43.7% of the respondents felt that there was need to change the cultural norms in Botswana to improve the situation of LGBTIs, while 31.3% said it was important to educate the society and 25% stated that the country's constitution needs to be changed.

The level of cooperation or the willingness to assist and/or talk was also assessed with all the respondents, and it was high with 68.7% of the respondents, medium at 25% and low at 6.3%.

Discussion of Results

The main objectives of the needs assessment were to identify gaps in STI/HIV prevention strategies, focusing on sexual minorities and to make recommendations to inform the implementation of the PRISM programme.

1. For the LGBTI data base, findings showed that although most of them were comfortable and open in interviews because they were proud to be gay, 22% of the total respondents had not disclosed their sexual orientation to anyone. This validates the argument in the literature review that alluded to a majority of gay males and females living in social isolation and usually manifesting a negative self concept

related to internalized feelings of hate and fear over one's homosexuality.

Findings also revealed that disclosure of one's sexual orientation depended much on the external factors such as the social and legal environment, because the reasons for disclosure of sexual orientation varied from being comfortable, close and being able to express one self to those people. However, others said they partly disclosed depending on the environment. The ILGA publication of March 2006 validates this argument by stating that fear to disclose can also affect access to quality health care service provision as one might be unable to openly discuss their health needs with service providers.

Most of LGBs interviewed are integrated into the LeGaBiBo community and usually meet in social gatherings. To identify existing intervention gaps, most respondents either did not know any specific places where LGBTIs could access services or were unaware of such places. This is contrary to government reports through publications such as the 2006 Surveillance Report which indicates that health service provision is non-discriminatory and that health services are provided free to all members of the public, yet there are no doctors or nurses providing services specifically the LGBTI community. This is in spite of the fact that it is becoming increasingly evident that prevention programmes need to be inclusive of all social groups in both urban and rural areas.

It was also discovered that few respondents felt that health services met their basic needs. Findings also show that the majority of the respondents felt the need to empower the LGBTI community to utilize services, for society to have a culture of openness and non-discrimination and to provide training for health service providers on sexuality.

The ILGA publication (issue 121, March 2006) maintains that there are barriers to accessing health care that are specific to LGBTI people such as fear of discrimination and stigma and withholding personal information that can determine proper care. However, barriers experienced by other populations, for example, social isolation, lack of information about and/or fear of medical procedures also pertain to LGBTI people.

An overwhelming number of respondents (83%) said there is transmission of STI/HIV in same sex relationships and that the risk level is the same when compared to those in heterosexual relationships. This element was argued by Gupta (July 2000) when she said MSM and WSW were vulnerable to STI/HIV because of certain

societal expectations on gender roles. The argument is also echoed by the study done in Windhoek, Namibia (ILGA, March 2006) which showed that factors such as social inequality and culture restricted women's freedom to choice when it comes to matters of sex. More significantly WSW are vulnerable to HIV, due to the homophobic environment which negatively impacts on the well-being of LGBTIs.

Findings showed that about 36.6 % of the respondents engaging in sexual activities were not using any protection or barrier methods and that the majority felt that the methods were either inappropriate, unavailable or they were unaware of such methods. This is argued by LeGaBiBo's (forthcoming) research for the Coalition of African Lesbians (CAL) which indicated that lesbian and bisexual women did not know anything about prevention methods, therefore engaged in unprotected sex, predisposing them to STIs, hence the need to educate and sensitize the group on these issues.

Respondents knew about some routine exams or tests at health facilities and 63 % had accessed them. The majority of the respondents felt that there is need to change policies and the constitution to minimize violations of human rights specific to sexual minorities. Some felt it was also imperative for cultural norms and religion to change and to provide education to society on LGBTI issues.

The majority of the respondents said night life entertainment was their pass time activity. A study undertaken in Gauteng and Kwa-Zulu Natal in South Africa (Wells, 2004), showed that, being part of a stigmatized social minority can lead to a lack of emotional support, poor social integration and in many cases there is use of alcohol and drugs as a coping mechanism. Most of the respondents had experienced discrimination at one point or another, either through hurtful comments, isolation and/or verbal attacks.

2. Data collected from health care service providers, partner organizations and training institutions, revealed that the majority of respondents (83 %) were conversant with their operational policies and most of them said the policies they were adhering to had clauses or parts that dealt specifically with service delivery. Examples of these were confidentiality, charts or guidelines for the management of certain illnesses, non-discrimination and being client centred. 66% of the respondents felt that policies were catering for everyone in the community, although the majority of the respondents said no one was catering for the LGBTI community. A large percentage of respondents (52.8 %) did not have any experience with same sex relationships but they felt well equipped or trained to deal with LGBTIs, although further training and exposure would enhance those skills.

When asked why people practiced same sex relationships, 34 % of service providers felt that people chose to have same sex relationships, while 28.3% thought people in same sex relationships were born with that sexual orientation. In terms of assisting and dealing with LGBTIs, 64.2 % felt that the society should accommodate them. Findings also showed that a majority of respondents believe insight should be gained from civil society groups and that there is need to change the law.

91 % stated that LGBs were at risk of contracting STIs/HIV and the majority also said LGBs practiced safe sex just the way heterosexuals did, although after further probing, 41.5 % said LGBs do not use barrier methods as the methods were not widely available and that they also lacked knowledge or were embarrassed to seek them. The majority of the respondents felt that the sexual needs of MSM and WSW were completely ignored by society. 52.8 % said it was difficult to plan for them since they were still in the closet, while others felt the laws of Botswana and society in general were homophobic. The majority of the respondents felt a need to change cultural norms, the constitution or policies and educate people in order to cater and improve on LGBTI issues.

3. The third data base of faith based organizations and traditional healers comprised of 75% respondents representing faith based organizations and 25 % representing traditional healers. The majority of the respondents stated that they had policies dealing with individuals in same sex relationships. 31.3 % indicated that their policies catered for all and 18.7% said theirs did not allow other sexual orientations because it is a sin and against the bible.

56.2% of the total respondents felt that their organizations should accept every person regardless of their circumstances and provide guidance and assistance, while 37.5 % felt that LGBTI communities should not be tolerated. 75% of respondents have never received any cases regarding LGBTIs. In terms of skills, 68.7 % of the total felt that they were well equipped or trained to deal with LGBTIs, though training would compensate for those who are not.

50% of the respondents felt that LGBTIs chose to be in same sex relationships and in terms of interventions, 75 % said they pray for them and 25% assisted in any other form. A large percentage, (87.4%) said LGBTIs were at risk of contracting STIs and 37.5% of respondents said LGBTIs were not practicing safe sex.

Culture, lack of education, religion and policies were mentioned as the main obstacles in dealing with LGBTIs equally and respectfully and 56.3% said the sexual needs of

MSM and WSW were completely ignored. It is encouraging to see that more than half of the respondents in this group were of the opinion that their organizations should be open to everybody regardless of their opinion. However, respondents felt that there was need to change cultural norms, educate the society and change the country's constitution to improve LGBTIs situation.

In all the three sets of data, the level of cooperation was high which could be an indicator that people are willing and comfortable to talk through these issues.

Issues/ Problems Identified

Category	Problem identified
Health	Lack of information about health services Under utilization of health care services Unavailability / inappropriateness of barrier methods Lack of knowledge on barrier methods especially for WSW/ LGBTI in general Low self esteem and assertiveness by LGBs Risky behaviors by LGBs [e.g. unprotected sex, nightlife entertainment] Psychosocial support (health services) Emotional and physical abuse/trauma Lack of knowledge by service providers and LGBs on prevention methods
Social	Stigma and discrimination Social isolation Lack of support at family and community level Psychosocial support (social services) Emotional and physical abuse/trauma
Legal	criminalization of same sex sexual relationships makes it extra difficult for mainstream service providers to include MSM and WSW in their programmes

CHAPTER FIVE

Summary, Recommendations and Conclusion

Several findings are of interest in this needs assessment. One of them is that LGBTI communities are in existence in Botswana. This is substantiated by all respondents who identified as lesbians, gays and bisexuals and those who said they had either plenty or few clients who were in same sex relationships and open about it. Furthermore, it shows that there is need to accommodate LGBTIs and change laws and policies to accommodate them by targeting them for empowerment, service provision and leadership in various settings for capacity building and skill enhancement. There is also an overwhelming need to educate the general public on LGBTI issues,

Most respondents were open, comfortable and cooperative in the interviews. The respondents' experience in life played a major role in accepting or rejecting same sex relationships. The major negative effects pointed out were marginalization through the social, health and legal systems as well as societal isolation leading to discrimination and stigma which predisposes LGBTIs to STIs/HIV.

Since same sex relationships are in existence, it is necessary to conduct further studies about them in Botswana. The Government should recognize their existence and promote further research in this area. Relevant policies can be made based on the findings, and, as the LGBTI community is recognized, government agencies will inevitably be called upon to respond to it and modify policies and laws accordingly. Perhaps same sex relationships should be dealt with legally first in Botswana to inform other aspects of initiatives and strategies in service delivery.

The public needs to be educated on LGBTI issues, that is, their social, health and legal needs and the role of families and communities in this regard. This can be done through workshops, public fora, dialogues, production of IEC materials (booklets and pamphlets) and other media modes such as radio talk shows and newspapers. Education is a useful tool to encourage the LGBTI community to consider their health in terms of human rights. The adoption of a human rights-based approach to health may be especially empowering for lesbian and bisexual women, a group that continues to suffer from double discrimination and whose health concerns are marginalized.

Conclusions

Botswana has set a target of zero new infections of HIV by the year 2016. However, the growing de-sexualisation of the HIV epidemic and lack of self esteem or assertiveness of LGBTI communities has led to many problems such as unhealthy relationships. In

Botswana, many of the HIV/AIDS programmes are not addressing sexuality as a fundamental component. Instead, HIV interventions increasingly communicate about HIV as if it has nothing to do with sex, although sexual activity is the main mode of HIV infection. HIV and AIDS interventions also need to take into cognisance the variety of sexual identities existing in all communities in every part of the world. Implementation of a programme such as PRISM will ensure that marginalized social communities also benefit from the health, social and legal strategies or initiatives undertaken in the country to achieve the set goal of zero transmission by 2016.

BONELA and its partners, therefore, appreciate that resistance to all forms of discrimination and advocacy for the rights of people who are vulnerable to HIV or STIs are not only ethical demands but also a contribution to effective prevention. BONELA, in conjunction with various organizations, confronts these issues and disseminates information about the needs of sexual minorities. It also advocates for the inclusion and incorporation of their health as a formal public health concern by recognizing that marginalization intensifies the risk of HIV infection. It is important that public and private health services and facilities cater for the needs of LGBT people through sensitive social structures, and by promoting human rights through prohibiting non-discrimination, to ensure a more effective HIV prevention programme. In this regard, a lot needs to be done to ensure the right to health from the perspective of discrimination and stigma for the LGBTI community.

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ANNEXURES

Transgendered [LGBT] People in Kwa-Zulu Natal, South Africa Pretoria,
OUT LGBT Well-being , 2004

Annex 1: Brainstorm Group members

ORGANISATION	NAME OF PARTICIPANT
BONELA	Felistus Motimedi Prisca Mogapi Yorokee Kapimbua
BONASO	Carolyn Doyle
LeGaBiBo	Selebaleng Segale Caine Youngman Charmaine Olebile
Ministry of Health	Elizabeth Koko
Tebelopele	Thandi Tumelo
UNAIDS	Mona Drage
University of Botswana	Dr. Sethunya Mosime

Annex 2: List of Partner Organizations/Institutions

1. BONASO- Botswana Network of AIDS Service Organizations
2. BONEPWA- Botswana Network of People living with HIV and AIDS
3. CEYOHO-Centre for Youth of Hope
4. BOTUSA- Botswana United States of America Project
5. NACA- National AIDS Coordinating Agency
6. BHP- Botswana-Harvard AIDS Institute Partnership for HIV Research and Education
7. ACHAP- The African Comprehensive HIV/AIDS Partnerships
8. UNAIDS- Joint United Nations Programme on HIV/AIDS
9. UNFPA- United Nations Population Fund (Botswana)
10. UNDP- United Nations Development Programme
11. MISA- Media Institute of Southern Africa
12. YOHO- Youth Health Organization
13. BOCONGO- Botswana Council of Non-Governmental organizations
14. FHI- Family Health International
15. BOFWA- Botswana Family Welfare Association
16. MoH- Ministry of Health
17. MLG- Ministry of Local Government
18. MoE- Ministry of Education

19. UB- University of Botswana

FIELD CASE # : _____

DATA ENTRY REC. #: _____

BONELA PRISM Project

LEGABIBo MEMBER QUESTIONNAIRE

INTRODUCTORY SECTION TSHIMOLOGO YA KAROLO

I would like to start by asking a few background things about yourself that specifically relate to your habits, sexual preferences and your stand in the community.

- (i) Are you open and comfortable right now talking to me about issues related to sex?
- (ii) Are you generally open in the society that you live in about your sexual preference?

[Go to (v)]

- (iii) If Yes, who have you revealed your sexual preference to?

- (iv) Why did you choose this person to disclose to? _____

- (v) Do you consider yourself integrated in the LeGaBiBo community?

(Go to next section)

Is your integration formal/informal. Please elaborate?

KNOWLEDGE

1. Are there places where LEGABIBo specific type services can be accessed?

2. If yes, where are these services?

Demographic & Professional Information

Age of Respondent: _____

Respondents Sex: Male Female [Tick one]

District: _____

Ethnicity of Respondent: _____

Gender role preference: _____

Name of the Respondent: _____

[Tick one] Employed Unemployed Self employed

Marital Status: [S][M][D][W] [Circle one]

Education Level: [Primary] [Sec.] [Tertiary] [Circle one]

Main Domicile, *spend more than 6 months of the year*: [Urban] [Rural]

Date of Interview: _____

[End Time] _____

Annex 3: Questionnaires (the 3 sets of questionnaire attached)

LeGaBiBo Member Questionnaire

3. What is your opinion of the quality of these services? Good [] Average [] Poor []
4. Does the service meet your basic LBGTI need?
5. How did you learn about these services?
6. What do you think needs to be done in order for your specific LBGTI needs to be met?
7. Do you think HIV can be transmitted in same sex relationships?
8. If yes, is the risk Higher [H] Lower [L] or just the Same [S] [Enumerator Circle Only ONE]
9. Are you using protection?
10. What kind of barrier method do you use?

September 15th, 2007.
English Version

2

11. Do you face any challenges in using barrier methods?

12. If yes, what are the challenges?

13. What are the routine screening exams/tests you are aware of at health facilities?

14. What do you think needs to be done for LGBTI to get better services?

EXPERIENCES/**B**EHAVIOURS

15. What are your interests?



*September 15th, 2007.
English Version*

3

16. Which type of health care services to you usually prefer?

17. What has been your experience when accessing these services?

a. Please elaborate why you feel the service has been the way you have described it?

b. [Enumerator Note] Any specific discriminatory occurrences?

18. Have you ever accessed any of the routine screening services at the clinic/hospital?

19. If yes, which in particular?

September 15th, 2007.
English Version

4

LeGaBiBo Member Questionnaire

20. What do you think should be done to improve on LGBTI specific services?
a. Why?

Level of Cooperation

Low (*A ko tlase*)

Medium (*A fa gare*)

High (*A ko godimo*)

HEALTH PROVIDERS INSTRUMENT

Demographic & Professional Information

Field Case Number: _____
 Data Entry Record : _____

Respondents Sex: Male
 Female

Profession: Hospital Superintended
 Matron
 Nurseincharge
 Nurse
 Family Welfare Educator
 Counsellor

Facility Type: Hospital
 Clinic
 Health Post

District: _____ Name of location: _____
 Location type: _____

Date of Interview: _____ [Start Time] _____ [End Time] _____

PERSONAL EXPERIENCES IN SERVICE DELIVERY

1. Are you conversant with policies that are operational in your facility?
2. Are there parts of the policy that directly relate to service delivery?
 - a. [If yes], what are they? Please give me as much detail as you can.
 - b. [If no], what do you think is the reason for service delivery not being catered for in your policy.
3. Do you think your policy caters for all those in the community?
4. Please elaborate on why you think it does/does not cater for all.
5. Have policy makers in particular catered for the needs of LGBTIs?
6. Do other parties cater for the needs of LGBTIs?

If yes, list some that you may recall?

7. What is your experience with clients in same sex relationship?
8. Do you feel well equipped, trained to deal with LGBTIs?
9. If No, what do you think will make a difference?
10. Why do you think people have same sex relationships?
11. What do you think society must do about these people?
12. What do you think the ministry and health care service delivery needs to do about this
13. Are LGBTIs at risk of contracting STIs?

2

ATTITUDES REGARDING LGBTI SEXUAL BEHAVIOURS

Health Care Provider Instrument

14. Do you think LGBTIs practice safe sex?
15. What methods of Safe Sex are available to LGBTIs?
16. Do you think that LGBTIs are aware of these methods?
17. If Yes, do you think they use them?
18. If No, why do you think they don't?
19. What do you think are the main obstacles in dealing with the LGBTIs community equally and respectfully?
20. Do you think sexual needs of WSW, MSM are completely ignored by HIV policy makers, implementing agencies and community based organizations?
21. Drawing from experience, what do you think contributes to fewer interventions for men who have sex with men and Women having sex with Women in Botswana?

3

CONCLUSIONS

Health Care Provider Instrument

22. What are the biggest improvements you have witnessed so far in relation to service delivery in Botswana for the LGBTI community
23. What do you think needs to change to improve the situation of LGBTIs?

Level of Cooperation

Low (*A ko tlase*)

Medium (*A fa gare*)

High (*A ko godimo*)

4

FAITH BASED ORGANISATION INSTRUMENT

Demographic & Professional Information

Organisation Name: _____ Field Case Number: _____

Type of Organisation: FBO [] TH [] Data Entry Record : _____

Respondents Sex: Male
Female

Position: Moruti []
Ngaka []
Counsellor/ mogakolodi []

Date Established: _____ [dd/mmm/yy] Official Registration Date : _____ [dd/mmm/yy]

District: _____ Name of location: _____
Type of Location: City

Date of Interview: _____ [Start Time] _____ [End Time] _____

BACKGROUND & EXPERIENCES

1. Does your organisation have a policy towards individuals with alternative sexual preferences?
2. What do you think your organisation's position should be regarding LGBTIs?
3. Do you have a specific belief or opinion about LGBTIs?
a. [If Yes], what is your belief?
4. Do you receive referral cases related to LGBTIs?
5. If yes, how many cases do you receive in a month?

6. If no, what do you think contributes to your organization not receiving cases of LGBTI clients?

7. What is your experience with clients in same sex relationship?

SKILLS, PRACTICES & BELIEFS

8. Do you feel well equipped, trained to deal with LGBTIs?

9. If No, what do you think will make a difference?

10. Why do you think people have same sex relationships?

11. What interventions do you take when dealing with same sex clients?

12. Are LGBTIs at risk of contracting STIs?

13. Do you think LGBTIs practice safe sex?

14. What methods of Safe Sex are available to LGBTIs?

15. What do you think are the main obstacles in dealing with the LGBTIs community equally and respectfully?

2

CONCLUSIONS

16. Do you think sexual needs of WSW, MSM are completely ignored by HIV policy makers, implementing agencies and community based organizations?
17. Drawing from experience, what do you think contributes to fewer interventions for men who have sex with men and Women who have sex with Women in Botswana?
18. What do you think needs to change to improve the situation for LGBTIs?

3

Level of Cooperation

Low (*A ko tlase*)

Medium (*A fa gare*)

High (*A ko godimo*)

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