terre des hommes schweiz Opportunities for young people

GAY & LESBIAN NETWORK
equality ukulingana | respect inhlonipho | acceptance ukwamukeleka
NPO NO: 026-854 PBO NO: 930006636

Gay and Lesbian Network (GLN)

BASELINE ASSESSMENT:

My Body, My Rights, My Responsibility Project

SRHR Project proposed to terres des hommes schweiz

May 2017

TABLE OF CONTENTS

Tables:

Figures:

ACRONYMS

ARV	Antiretroviral drug
CBO	Community based organisation
CHC	Community health centre
DOH	Department of Health
DOE	Department of Education
DVA	Domestic Violence Act
FBO	Faith based organisation
FGD	Focus group discussion
GBV	Gender Based Violence
GLN	Gay and Lesbian Network
HIV	Human Immunodeficiency Virus
KII	Key informant interview
KZN	KwaZulu-Natal
LAC	Local AIDS Council
LGBTI	Lesbian, gay, bisexual, transgender and intersex people
MSM	Men who have sex with men
NGO	Non government organisation
NHA	National Health Act
NHI	National Health Insurance
NPO	Non-profit organisation
NSP	New Strategic Plan
PAC	Provincial AIDS Council
PrEP	Pre-Exposure Prophylaxis
SA	South Africa
SAPS	South African Police Service
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health rights
TB	Tuberculosis
tdh	terres des hommes
TOP	Termination of pregnancy
VMMC	Voluntary medical male circumcision
WSW	Women who have sex with women

GLOSSARY

(From the 'Stop hate crime targeting LGBTI people' booklet)

Lesbian: The sexual orientation of women whose primary romantic and sexual attraction is towards other women; a women who self- identifies as homosexual.

Gay: The sexual orientation of men whose primary romantic and sexual attraction is towards other men; a man who self identifies as homosexual.

Bisexual: The sexual orientation of people who are romantically and sexually attracted to men and women, not necessarily simultaneously or equally.

Transgender: The gender identity of people whose birth sex does not conform to the gender they are most comfortable expressing, or would express if free to do so without fear of prejudice, discrimination, rejection or hate. A transgender person may or may not want to permanently alter their body in order to conform to their preferred gender. A transgender person's sexual orientation may be heterosexual, bisexual or homosexual.

Intersex: People who are born with full or partial genitalia of both sexes, or with underdeveloped of ambiguous genitalia, and whose chromosomes and reproductive organs are not exclusively male or female.

MSM (men who have sex with men): Men who engage in sexual activity with other men, but who don't necessarily self -identify as gay or bisexual.

WSW (women who have sex with women): Women who engage in sexual activity with other women but who don't necessarily self -identify as lesbian or bisexual.

Sexual orientation: The way in which people's romantic and sexual desires are directed and whether they are attracted to people of the same sex, the opposite sex, or to both sexes.

Biological sex: The biological classification of bodies as female, male or intersex, based on external genitalia, internal sexual and reproductive organs, hormones and chromosomes.

Gender: The attitudes, feelings and behaviours that society associates with a person's biological sex. A person's gender identity is their sense of self as female, male or transgender, regardless of their external genitalia.

Prejudice: Intolerance of a group of people because of their sexual orientation, sex, gender, race, language, culture, religion, age, disability, political or other opinion, national or social origin, property, birth or other status.

Discrimination: Unfair treatment of a person or group of people on the basis of prejudice.

Homophobia: Fear, contempt, hatred or intolerance of homosexual people.

Hate crimes: Extreme expressions of prejudice through violent criminal acts that are committed against people or their property because of the group to which they belong or identify with. Perpetrators seek to demean and dehumanise their victims, because they consider them to be different from themselves.

INTRODUCTION

terres des hommes schweiz is funding a number of organisations implementing sexual and reproductive health rights (SRHR) and gender based violence (GBV) programmes with youth. One organization to be funded is the Gay and Lesbian Network (GLN).

A baseline assessment of the context was undertaken before the project was funded or implemented, for two purposes:

- To gather data to inform the project intervention.
- To measure baseline values of proposed project indicators, against which to measure change in the future

This document reports on the baseline findings.

SEXUAL AND REPRODUCTIVE HEALTH RIGHTS

Sexual and reproductive health and rights are manifest in the extent to which people feel comfortable about their sexual and gender identity and are able to make decisions about their sexual and reproductive lives, including if, when and how to engage in sexual relationships, and if, when and how to have children in a social, cultural and interpersonal context free of coercion, discrimination and violence (Department of Health (DOH) quoted in Braam and Merkel[1], 2016).

TERRES DES HOMMES SRHR AND GBV PROGRAMME

Terre des Hommes Schweiz is an international non-governmental organization supporting local partner organisations working on young people sexual and reproductive health as well as Gender Based Violence (GBV) in Kwa Zulu Natal (KZN) province, South Africa. The province is the epicenter of the country's generalized HIV epidemic, and has high levels of teenage pregnancies. The high level of GBV being experienced throughout South Africa is mirrored in KZN.

Lessons learned have shown that the there is a lack of local level data pertaining to SRHR of adolescents as well as GBV with most data concentrated at national and provincial level in cases where such data exists at all. In other cases, there is a lag in reporting of this data, posing a threat of distorting information about the current status of the youth with regard to key indicators for SRHR and GBV. [2].

Objectives of the tdh SRHR and GBV Youth Programme

The table below lays out the objectives of the tdh SRHR and GBV Youth Programme. The GLN project will contribute to this overall Programme, along with other participating organisations.

[1]Braam and Merkel[1], 2016. Status of sexual and reproductive health rights in KwaZulu- Natal

[2] Terres des hommes schweiz. 2016. Baseline study on youth SRHR indicators in KwaZulu-Natal, South Africa.

Table 1: tdh SRHR lograme

	Impact SRHR	Impact indicators
	Contributes to the reduction of HIV infections of youth and teenage pregnancy in KwaZulu-Natal	Percentage reduction of HIV incidence among the youth in KZN Reduction in new cases of teen pregnancies in KZN
	Outcome	**Outcome indicators and targets**
1	Youths use their competences to prevent and manage HIV and teenage pregnancy	2500 youth involved in peer education activities by 2020.
2	Community gatekeepers (parents, care givers, teachers, community and religious leaders, health staff, etc.) are allowing and providing information and services on HIV, teenage pregnancy and sexuality	60 community actions carried out by gatekeepers to promote comprehensive sexuality education by 2020.
3	Institutions (schools, churches, health centres, police, etc.) providing youth friendly SRH services	75 institutions are allowing sensitization activities within their facilities by 2020.
	Output	**Output indicator**
A	Youths are equipped with capacities regarding HIV and teenage pregnancy prevention and management	Percentage increase in the number of youth trained in regarding HIV and teenage pregnancy prevention and management
B	Community gatekeepers (parents, care givers, teachers, community and religious leaders, health staff, etc.) are sensitized to support prevention of HIV and teenage pregnancy and support HIV-positive youth and teenage parents	Percentage increase of gatekeepers sensitized regarding HIV and teenage pregnancy prevention and management
C	Institutions (Schools, health centres, etc.) are sensitized about youth friendly policies and services	Percentage increase in institutions sensitized on the importance of designing and implementing and providing youth friendly and services

Table 2: tdh GBV logframe

	Impact GBV	Impact indicator and target
	GBV survivors are empowered to cope with their situation	60% of GBV survivors report to be able cope with their situation (Value 2020: Number of GBV survivors accessing appropriate services)
	Outcome	**Outcome indicators and targets**
1	GBV survivors access appropriate services (psychological/medical/legal).	2500 GBV survivors accessing appropriate services by 2020
2	GBV survivors receive support from gatekeepers	60% of GBV survivors report being supported by community members (Value 2020: Number of GBV survivors accessing appropriate services)
3	Public institutions, including health centres, police stations and schools providing services that support GBV survivors	75 institutions allowing sensitization activities within their institutions by 2020
	Output	**Output indicators**
A	Youths up to 35 are equipped with capacities to access appropriate psychological, medical and legal services.	Percentage increase in the number of youth sensitized and trained regarding access appropriate services
B	Communities including family members and intimate partners, teachers, community leaders, religious leaders and staff of public institutions are sensitized regarding power relations, gender orientation and roles as well as GBV	Percentage increase of gatekeepers sensitized
C	Public institutions, including health centres, police stations and schools are sensitised on policies and services regarding in relation to power relations, gender orientation and roles and GBV	Percentage increase in institutions sensitized

VALUES FOR KEY INDICATORS FOR THE TDH OVERALL PROJECT

The values for the high level indicators of the tdh programme for this area in South Africa are as follows:

HIV

- Incidence of HIV among youth aged 15-24 in 2012 was 1.49% (reported in 2014)[3]
- Prevalence of HIV in 15 -24 year olds in KZN in 2012 was 12.0% (reported in 2014)[4]
- Antenatal prevalence among young women aged 15-24 was 19.9% in KZN for 2013 (reported in 2015)[5]

Teenage pregnancy

- Number of teenage pregnancies in KZN was 26730 in 2013 as reported in the General Household statistics survey 2015
- Teenage pregnancy in 2014 for girls aged 15-19 was 7%[6], and in 2015, the teenage pregnancy rate for 14-19 year olds in SA for the year preceding the survey was 5.3%[7].

GLN'S PROPOSED SRHR AND GBV PROJECT: MY BODY, MY RIGHTS, MY RESPONSIBILITY

The project's aim is to support the creation of an enabling environment for youth and more specifically LGBTI (Lesbian, Gay, Bisexual, Transgender and Intersex) youth in four local municipalities of the uMgungundlovu district. **An enabling environment should include equal and free access to SRH services and provide GBV survivors with sufficient health, security and psychosocial support for youth and more specifically LGBTI youth.** As a long term objective this project will impact the societal acceptance and the rate at which accountability structures advocate for improved and equitable SRH and GBV services for youth and LGBTI youth.

The project will work at various levels, these include; individual, relationship, community and institutional levels.

At individual level the youth will be targeted, especially LGBTI youth between the ages of 18 and 35. SRH, GBV and gender and sexuality related workshops that will provide relevant and in-depth information that is necessary for this target group to be able to access SRH and GBV services without fear. Furthermore, the necessary psychosocial support (PSS) will be provided through support groups, which will give these individuals the confidence to stand up for the SRH and GBV rights and including the ability to make informed decisions around their health and wellbeing.

The relationship level will target peers, parents, guardians and family members by providing information workshops on SRHR, GBV and gender and sexuality in order to better understand and build healthy relationships with the youth and LGBTI youth within their immediate settings. There will be a focus on encouraging these peers and other community members to advocate on behalf of

[3] Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Zungu N, Labadarios D, Onoya D et al. (2014) South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town: HSRC Press

[4] Shisana et al. 2014. South African National HIV prevalence, incidence and behaviour survey, 2012. HSRC.

[5] Department of Health. 2014. The 2012 national antenatal sentinel HIV prevalence survey in South Africa.

[6] STATSSA GHS 2014.

[7] STATSSA GHS 2015.

youth and LGBTI youth's SRH and GBV rights to non-discriminatory services. A similar strategy will be implemented when working at community level targeting nurses, other clinic staff, community members, police officers and community caregivers. The methodology in working with the community level will be advocacy and support driven. Ways in which community members can be strong allies of youth and LGBTI youth when addressing their challenges in accessing SRH and GBV services will be shared. There will be an emphasis on including youth and LGBTI youth in the decision making process around issues that concern them in the various community structures.

At societal level there will be interaction with accountability structures to decrease the high level of discrimination and lack of access of SRH and GBV services to youth and more specifically LGBTI youth. The strategy will be to use the research programme to conduct all the research for the project. They will lead in design, implementation, capturing and dissemination of data that is collected during the project. This will benefit GLN's ability to be a research leader in youth and LGBTI youth work. Furthermore government structures will be engaged at a policy and legislative level with the aim to be inclusive of youth and LGBTI youth needs and issues.

Currently GLN is active through the four programmes that GLN implements, in representing LGBTI youth challenges within the uMgungundlovu district and surrounding areas. Staff members have seats on the AIDS Councils, the Hate Crime Working Group (HCWG), and Task Team against Gender Based Violence (GBV). The organization is well networked within the South African context of representing LGBTI youth and is frequently called upon to assist LGBTI individuals in supporting them through socioeconomic challenges.

FINDINGS FROM STUDY BY GLN/ TDH IN 2016

In 2016, TDH and GLN carried out a study on sexual and reproductive health indicators in Greater Edendale. (The majority of respondents (86.6%) had tertiary education, so were not directly comparable with respondents in the baseline activities described in this report.)

Key findings of the study in 2016 are given in Table 3 below:

Table 3: Key findings of the tdh/ GLN study in 2016

Indicator/ Issue	Findings (most frequent listed here)
Information sources for family planning	Clinic/ hospital (68.4%), Radio (55%) Newspapers/ magazines (39.5%)
Source of contraceptives	Health facilities 56.8%, drug stores/ pharmacies 24.3%, private hospital/ clinic 16.2%
Confidence to visit a reproductive health clinic	Definitely not confident 11.8%, Definitely confident 55.9%
Advantages of using condoms	STI and pregnancy prevention 83.8%, HIV and pregnancy prevention 78.4%, reduce the risk of contracting HIV 62.2%
Uptake of services	76.3% had visited a facility in the last year to get SRH services
Reason for visit to health facility	HIV counselling and testing 69% education and counselling regarding SRH/ HIV 62%, miscarriage/ post abortion care 10.3%, STI

Indicator/ Issue	Findings (most frequent listed here)
	treatment and counselling 10.3%, screening of cancers of the reproductive system 10.3%, encouraged by peer educator 10.3%
Whom respondent confides in about HIV, AIDS, and STIs	Sexual partner 61.1% sisters 52.8%, mother 50.0%,
Forms of GBV known	Sexual abuse (81.3%), Physical abuse (81.3%), Emotional abuse (71.9%)
Support services for GBV survivors	NGOs 40%, pamphlets 33.3%, clinic/ hospital 30.0%, Newspaper/ magazines 30.0%
Experienced GBV as a result of sexual orientation	All types: 72.4% Physical abuse: 71.9%, emotional abuse 62.5%, verbal abuse 62.5%

The conclusions from the GLN study in 2016 were:

- There were high levels of knowledge around family planning and condoms amongst young people/ participants
- High uptake of services among youth aged above 19 years
- The community plays a key role in supporting young people to make safe SRH decisions, especially the immediate family
- The health facilities play a key role, but interventions are needed to forge close relationships
- Traditional , cultural and religious beliefs and practices remain a major constraint to effectiveness of interventions aimed at supporting LGBTI
- Gatekeepers are not generally sensitized to support young people, but may focus on teen pregnancy prevention rather than HIV prevention
- GBV interventions generally have limited effectiveness due to their non availability.

THE BASELINE EVALUATION

FOCUS OF THE BASELINE EVALUATION

The focus of the baseline evaluation was to generate data related to the proposed log frame for the project. This includes aspects of the following topics:

- Knowledge, attitudes and behaviours of youth and LGBTI youth in regard to SRHR, with a focus on HIV, STIs, TB and pregnancy which are the most pressing issues regarding SRH
- Knowledge, attitudes and behaviours of youth and LGBTI in regard to GBV, with a focus on knowledge of how to report GBV, and the various roleplayers who must be involved.
- The focus of the intervention is on a mixed group of heterosexual and LGBTI youth as an integrated group. There is recognition that issues facing heterosexual youth and LGBTI youth in terms of SRH service provision are different.
- Data will be collected from roleplayers in the broader context at relationship level and societal level at a later stage, when the project initiates its intervention.

BASELINE EVALUATION METHODOLOGY

The methodology for the GLN baseline study consisted of a survey conducted with youth (including both LGBTI and heterosexual youth), and interviews with stakeholders, to gather qualitative data about the situation regarding SRHR and GBV for LGBTI and other youth.

SAMPLING, DATA COLLECTION AND DATA ANALYSIS

Sampling

In order to get a sample of people with whom the project would work for this youth project, GLN contact NGOs and people with whom they had built relationships in previous community meetings in the 4 areas where the project will be implemented. They were requested to attend a day's workshop, and data was collected from all who attended. Although all who attended participated in the data collection activities, only data from those falling in the age bracket of the project (18 to 35 years) is included in this report.

Instrument development

Survey: A questionnaire was developed aligned with the indicators in the proposed log frame (see Appendix 2)
Focus Group Discussions: FGD guides were developed for use with a number of stakeholders (see Appendix 2)

Data collection and data capture

The following table lays out the fieldwork/ data collection activities.

Table 4: Fieldwork/ data collection activities

Data collection methods	Date	Number of participants aged 18-35
Greytown		
Youth survey, stakeholder interview	18/04/2017	17
Richmond		
Youth survey, stakeholder interview	19/04/2017	24
Mpophomeni		
Youth survey, stakeholder interview	20/04/2017	16
Pietermaritzburg		
Youth survey, stakeholder interview	21/04/2017	15

People were not willing to write their sexual orientation on the attendance registers, so this data was not collected.

The survey was self-administered by individual respondents, with the survey being paper based, and a facilitator guiding the group during the process. The instruments were translated from English into isiZulu during their administration by a facilitator.

Respondents were free to write their answers or speak in either isiZulu or English, depending on their preference. Where respondents had difficulties with writing answers, a team member took them to a place where their answers could not be heard by the group, and recorded their answers for them.

The FGDs were not recorded, but detailed notes were made of responses to questions during the discussions.

The responses in the survey were captured and anaylsed through had tabulation. The notes from the FGD were used for thematic analysis.

Ethical issues:
All participants had the purpose of the study explained, and what their participation would involve. They were informed that their participation was voluntary, and that they could choose not to answer any questions they didn't wish to answer. Their answers would be kept confidential. A report would be written, and the findings would be shared with participants.

Limitations of the study
Participants may have found the format of the survey (self-administered with guidance from a facilitator), difficult, particularly as the survey was in English, with the facilitator translating into isiZulu. However, respondents were able to complete the surveys using the methods described above.

FINDINGS

DEMOGRAPHICS OF PARTICIPANTS

Youth Survey: The youth survey was completed by 72 young people with the following characteristics:

- Average age 26 years, age range 16-35 years
- Sex: 35 males and 37 females
- 61 out of school and 11 in school participants
- 7 were employed and 65 were not employed at the time of the survey.
- A question was asked about 'gender'. A mix of responses was received, as for some people this is the same as 'sex'. However, some to the following responses indicated that there were members of the LGBTI community present: 4 males who identified themselves as female, 1 female who identified as male, 3 transmen, and 1 transwoman. There may have been more participants who were not willing to identify themselves as LGBTI in the survey

KNOWLEDGE OF SRHR

What is the knowledge of the youth with regard to SRHR? This was broken down into a number of components.

Knowledge of the term SRHR

Amongst the participants from all areas, 86% did not know what the term SRHR meant.

Knowledge of legislation, policies and plans about health rights

Table 5 demonstrates the levels of knowledge of key legislation, policies and plans about health rights.

Table 5: Knowledge of legislation, policies and plans about health rights

Participant had heard of this legislation, policy, plan	Percentage of participants knowing about this
New Strategic Plan	14
National Health Act	39
National Health Insurance	31
Batho Pele Principles	14

Participants were asked to mention any Batho Pele Principles they knew. Some of the responses were: Consultation, courtesy, information, the right to any public facility service, and the right to speak your mind. A few participants mentioned the Batho Pele slogan: 'People first'.

Knowledge of Sexual and Reproductive Health:

This was focused on knowledge of issues around HIV, STIs, TB and VMMC:

Knowledge of how HIV is transmitted, and how to prevent this:

Participants were asked to name as many ways as they could of how HIV is transmitted (Table 6), and how HIV transmission can be prevented (Table 7).

Table 6: Knowledge of ways in which HIV is transmitted

Knowledge of ways in which HIV is transmitted	Percentage of participants
Unprotected sex	86
Through blood	28
Helping people who are bleeding, open wounds etc.	25
Using unclean needles	14
Not using condoms	10

Other ways in which HIV is transmitted which were mentioned are sharing toothbrushes, Mother to child transmission, not using gloves, injections, razor blades, body fluids, and unprotected anal sex.

Table 7: Knowledge of ways of preventing HIV transmission

Knowledge of ways of preventing HIV transmission	Percentage of participants
Use condoms	69
Use gloves	31
Have protected sex	22
Abstain from sex	19
Have one partner, be faithful to one partner	17
Know the status of your partner	7

Other ways of preventing transmission included not using the same needles, don't kiss someone with an open wound and use lubricants.

An indication of stigma which still exists around HIV is seen in the following: *Don't stay close to someone who has HIV.*

Misconceptions about how to prevent transmission still exist. Participants mentioned '*Trust each other'* and *'Bath after sex'.*

There were low numbers of people mentioning circumcision as a way of reducing risk of transmission of HIV, and of prevention of mother to child transmission (PMTCT).

Treatment for HIV: Antiretroviral (ARV) drugs

In answer to the question, 'Do antiretroviral drugs cure HIV?' 64% said no, which is the correct answer, and 24% said they don't know.

HIV testing

An important piece of information in the contest of a generalized HIV epidemic is that people have to repeated test for HIV. The question 'Should a person test for HIV more than once?' was asked, and many people knew the correct answer: 85% knew that testing more than once for HIV is advisable. Only 6% did not know.

Knowledge of symptoms of sexually transmitted infections (STIs)

In response to the question, 'Do you know what STIs are?' 32% of participants replied that they did not know what STIs are. Details of symptoms mentioned most frequently by the 68% who did know about these, are given in the table below.

Table 8: Knowledge of symptoms of STIs

Knowledge of symptoms of STIs	Percentage of participants
Discharge	25
Pain on urination	18
Drop	15
Pimples/ warts/ blisters	13
Pain in private parts/ during sex/ in lower back	11
Itching	11

Thus levels of knowledge about STIs appear to be low.

Knowledge of symptoms of tuberculosis (TB)

Knowledge of symptoms of TB was widespread. Only 18% of participants said they did not know any symptoms of TB. The symptoms most frequently mentioned are shown in the table below.

Table 9: Knowledge of symptoms of TB

Knowledge of symptoms of TB	Percentage of participants
(Persistent) cough	63
Sweating	31
Lose weight	17
Coughing up blood	14

Knowledge of voluntary medical male circumcision (VMMC)

Participants were asked: 'Do you know what VMMC is?' Only 10% of participants knew what VMMC[8] is.

Knowledge of pre-exposure prophylaxis (PrEP)

In answer to the question: 'Do you know what PrEP[9] is?' Only 1 person out of the 72 participants (1%) said they knew: *'PrEP is a table taken by someone who is HIV negative so they can sleep with someone who has HIV without using condoms and not be infected.'*

YOUTH AND LGBTI BEHAVIOURS WITH REGARD TO SRH

The participants were asked whether they were sexually active[10].

- Of the 72 participants, 57 said they were sexually active (79%).
- 33 participants said they had use d a condom the last time they had sex (58% of those sexually active, 46% of total sample)
- 24 said they used a condom every time (42% of those sexually active, 33% of total sample)
- However, 39 said they had been pregnant or had made a girl pregnant (68% of those sexually active, 54% of total sample)
- In answer to a question about how many sexual partner they had, the participants gave responses as follows: 52% said they had 1 partner, 21% said 2 to 3 partners, 7% said 4 or more partners. The remainder were not sexually active or didn't know how many partners they had.

These responses should be interpreted with caution, as they may be underestimates (as in who is sexually active), or overestimates (saying a condom was used every time they had sex, saying they had had a baby or made a girl pregnant, or saying they had many partners).

Nevertheless, the results demonstrate that many of the participants are sexually active, that condom use is not consistent, and that there are many pregnancies among the population, of which many may be unplanned.

HIV testing

Participants were asked a number of questions about HIV testing[11]. The responses indicated the following:

[8] VMMC: The surgical removal of foreskin of the penis, an intervention proven to reduce the risk of HIV transmission.

[9] Pre-exposure prophylaxis (PrEP) is an HIV prevention strategy where HIV negative people take medications daily to prevent them from becoming positive if they are exposed to the virus.

[10] The question 'Are you sexually active?' might have been interpreted by the participants as 'Are you sexually active now? rather than finding out whether the person had ever had sex.

[11] Where there were inconsistencies in the data for a person, the item was scored as not answered.

Table 10: HIV testing

Topic	Reponses	Percentage of participants
Have tested for HIV	Yes	90
	No	10
Test result	HIV positive	13
	HIV negative	68
	Preferred not to say	19
Disclosed status (HIV positive or negative)	Yes	64
	No	19
	No answer	17

Participants were asked who they had disclosed to, as this might give an indication of where people are looking for support.

Table 11: Disclosure of HIV status

Who the participant disclosed their HIV status to	Percentage of participants
Friend	18
Family (includes brother/ sister, excludes mother)	22
Mother/ parents	24
Partner	11

Other people disclosed to include grandmother, and one person said they had disclosed on social media.

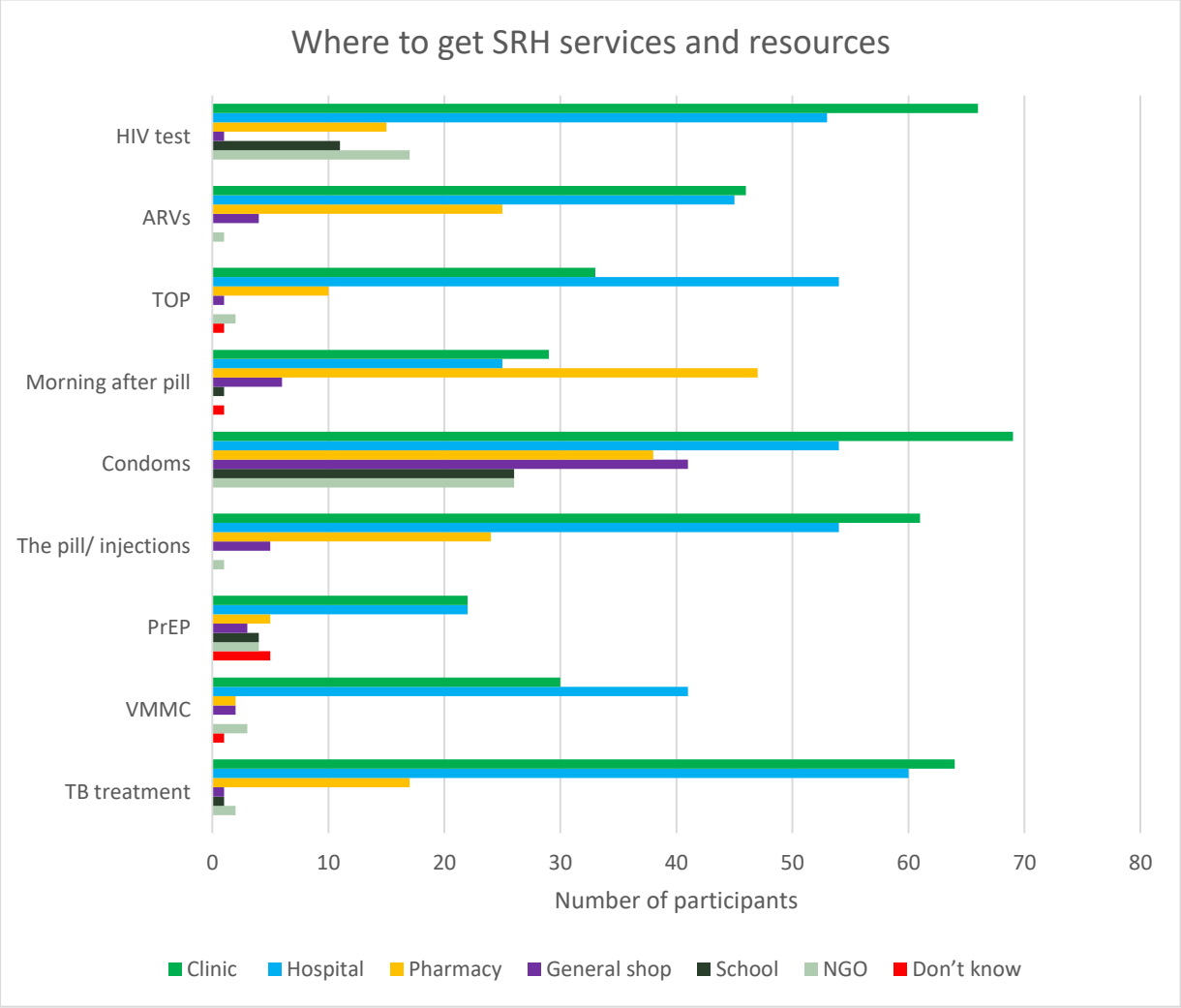
It is of concern that in a group of people who are mostly sexually active, very few have disclosed their status to their partners.

ACCESS TO SERVICES/ RESOURCES

In order to assess access to services, two aspects were examined: Whether the young people knew where to access a number of SRH services, and secondly, what their rating (based on perception) of the services were. Questions were also asked about whether the young people had gone to the health facilities, what they had gone for, and support they had received or desired. There were questions around the youth friendliness of the services.

Knowledge of where to go for services: Participants' knowledge is shown in Figure 1.

Figure 1: Knowledge of where to go for various services



These results demonstrate the following:

- Of all the services/ resources, knowledge of where to access condoms was the most widespread, and participants knew a number of service providers where they could get these. Clinics and hospitals were identified by the most participants as being where they could get these, but general shops, schools and NGOs were also seen as providers.
- Other services for which services providers were well known were HIV tests, the pill/ injections/ contraception, and TB treatment
- Clinics and hospitals were seen as major providers of services and resources.
- Pharmacies were noted as places to obtain pills and treatment.
- Fewer participants knew where to get the morning after pill, PrEP and VMMC than the other services.
- There was some incorrect knowledge in that PrEP, TOP and VMMC were thought by a few participants to be available from places like pharmacies and general shops.

Use of health facilities

Participants were asked a series of questions about use of their local health facility, such as the clinic.

Table 12: Use of local health facility

Topic	Responses	Percentage of participants
Ever been to the local health facility for services	Yes	76
	No	18
	No answer	6
Received the service required	Yes	74
	No	6
	Didn't go/ no answer	21
Service was 'Youth friendly'	Yes	60
	No	15
	Didn't go/ no answer	25
Had support to go to the facility	Yes	60
	No	24
	Didn't go/ no answer	3

Thus three quarters of the participants had been to the local health facility, and all except one had received the service required.

What services were accessed?

In order to ascertain whether participants had been accessing SRH services, they were asked what services they had accessed at the clinics.

Table 13: Services accessed in health facility

What services sought at health facility	Percentage of participants
Check for HIV	24
Check for TB	7
Check for STI	1
Treatment/ medication: ARVs, STIs, TB	18
Family planning/ maternity	8
Flu	13
Illness/ injections/ injuries	17

Thus participants did seek services for SRHR at the clinics; however, the percentages of people doing so was relatively low, for example for testing for HIV.

Youth friendliness: Nearly two thirds of participants perceived the health facility as youth friendly. A number of participants mentioned that they had found the services to be youth friendly. However, there were a large number of suggestions on how to make the facility more youth friendly, as shown in the following table.

The comments about how to make the services more youth friendly can be grouped as follows:

Table 14: Suggestions on how to make the clinics more youth friendly

Theme	Sample of suggestions on how to make health facilities more youth friendly
Staff attitude	Give all patients attention, respect, transform the attitude of clinic staff towards patients Be patient, be polite, make people feel free, do not judge them, don't discriminate about particular illnesses Clinic staff should be taught not to force patients to do an HIV test To be open to patients, mingle with them and ask questions that will not offend them (said by a gender non-conforming person), There should be sensitization workshops (so staff) can be youth friendly Preserve confidentiality Be more accommodating to young people
Staffing	Employ young nurses who are experienced in the things we go through as youth. Get volunteers to help the youth in the clinic We need people who like their jobs Get more staff
Communication	Communicate with youth in a more friendly way rather than blaming us for not using a condom. Speak in a way that people can understand
Systems	Get a quick service Have an area where the youth go and get the help they need They should go to the schools to encourage the youth Avoid long breaks by officials when the patients are unattended Don't use less effective medications
Information and resources to be shared	Tell them about how to love, how to do sex, how to protect themselves when they do sex. Advise about life, what to do if you have a problem like your mother doesn't like you or hates you. Give condoms

Support for going to the clinic:

Table 15 shows that 60% of participants had support in going to the clinics. They were asked who had supported hem in going to the clinic.

Table 15: Who gave support when participants visited the health facilities?

Who had supported them in going to the health facility	Percentage of participants
Family (includes sister cousin, granny)	19

Who had supported them in going to the health facility	Percentage of participants
Friends	17
Parents/ mother	15
Partner/ spouse	14

How did these people show support to the participants? The following were mentioned:

- Psychosocial support: Motivation, hope, encouragement, love
- Counselling and advice
- Reminders: to go to the clinic, to take medication
- Financial support: Money e.g. for transport
- Accompanied the person.

Examples of what the participant said are given below.

- *They gave good advice and made me feel loved and cared for.*
- *My boyfriend supported me when I wanted to test for HIV, and encouraged me (gay person)*
- *They told me the importance of the health facility*
- *They made me feel comfortable to go to the clinic.*

Participants were asked what support they would like. The following are some examples of the support people would like when accessing health services.

The following examples show the trepidation and anxiety which may be experienced when going for example for an HIV test.

- *To support me if anything happens there.*
- *Someone to be there for me and tell me everything will be OK.*
- *To encourage people, to help them to accept whatever results they get*

The need for support and no judgement as an LGBTI person is shown in the following quotes:

- *Since I am a gay person, I need to be helped by a person who understands me.*
- *Those who encourage me, so that I would not be judged according to my sexuality.*

A few participants said they didn't need help and would do things themselves:

- *I don't need help because I am going along; I can take care of myself.*

During the FGDs, a number of points were raised about what could be done to provide support for young people and LGBTI youth.

The difficulties of supporting a group such as LGBTI people who are hidden: A number of participants in the FGDs mentioned how hard it is to help people who are a hidden population:

> *I feel that they should show themselves so that we k now that they are there. Sometimes you would think they are not there……..but they are not even showing themselves to the community. At times you will find them at the tavern and then you will see them come out at night. This is when we will sleep with them and during the day we do not know where they are. They are seen as people that have money and don't even need help. How do you know how to help someone*

when you don't even know that they need help? They should tell us who they are and the needs they have in order for us to help them. FGD Participant, Area 4

Participants felt that it was important start an intervention in the home, before moving out to the community:

We need someone that is calm and understanding that will help me talk to my parents, not someone that will disrespect my parents in telling them about who I am. FGD Participant, Area 3

Support needs to start within the home in order to help you face the community. Then we need sensitization trainings to be done with LGBTI alone with family members, in order to have support when going into the community. This way your family can help you answer questions that the community might have when you are ready to face them. FGD Participant, Area 2

We need this to be discussed among the community in order for them to understand. FGD Participant, Area 2

The difficulties LGBTI people face in having a family was also raised:

If a man is in a relationship with a man or lives with another man then that home is dead, they will not be able to build up that home. We need to be taught on different ways in which we can have children if we are in same sex relationships, that way it will be easy for us to understand how we can build a house. FGD Participant, Area 2

These issues all have a direct impact on the accessing of services by LGBTI youth.

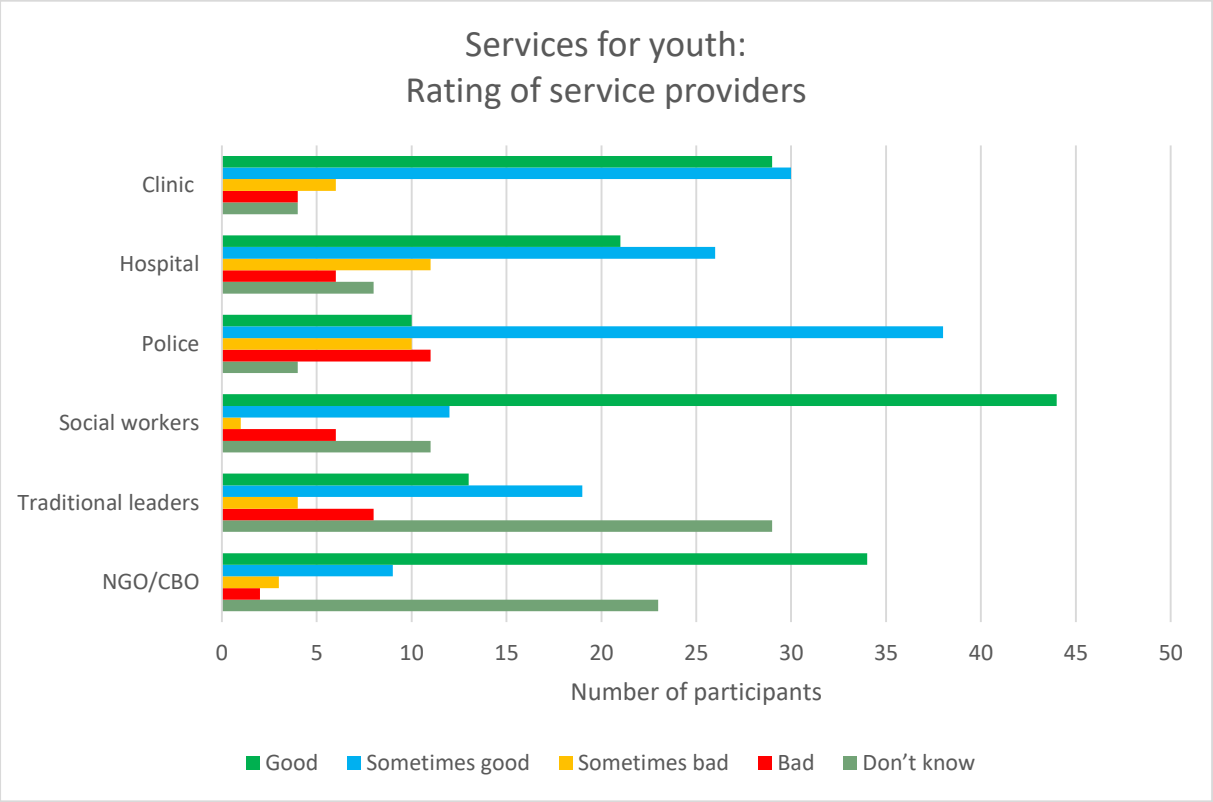
RATING OF SERVICE PROVIDERS

Participants were asked to rate the services provided by a number of key roleplayers. The responses shown in the graphs below are likely to be based on a mix of experience for those who had received services, and of perceptions, for those who had not received services, but had heard about the services from others.

These ratings are key in influencing whether participants would decide to seek services from these providers or not, and are thus very important for the project.

Ratings for services for youth and for LGBTI were given separately, as there are different issues affecting the ratings.

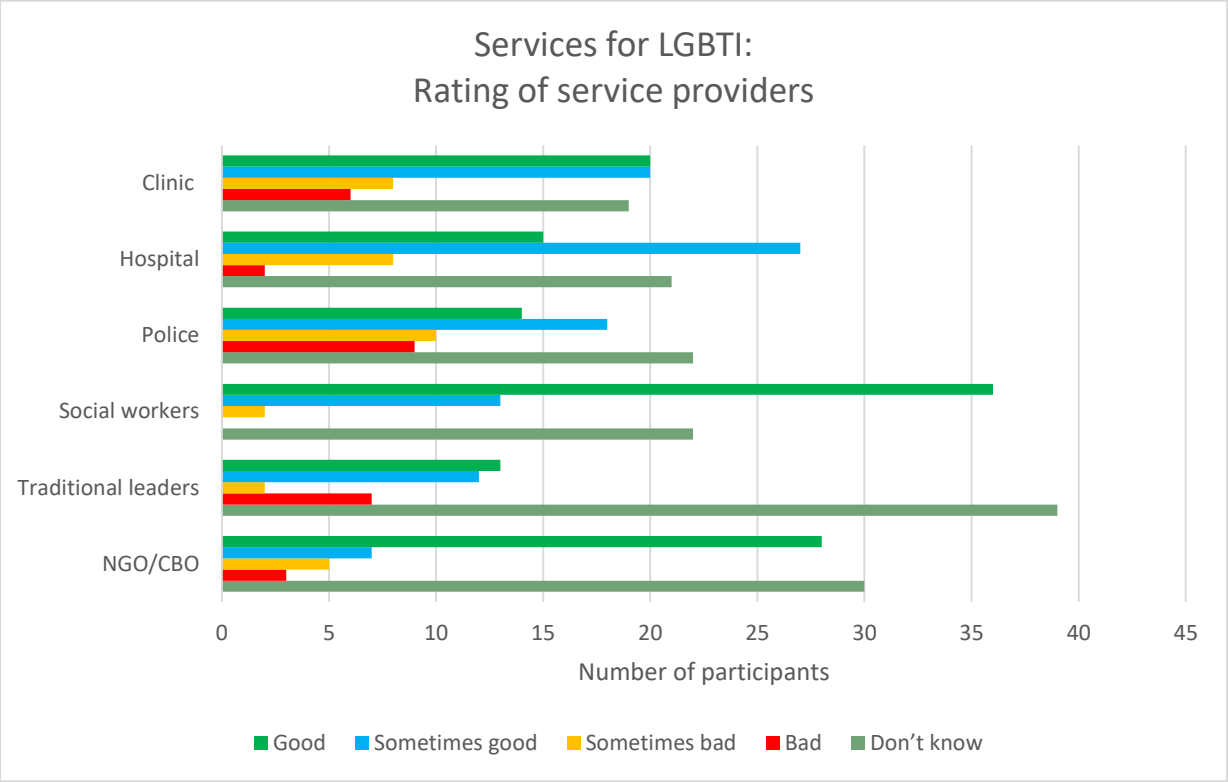
Figure 2: Rating of service providers of services for youth



Services for youth: The graph demonstrates participant's ratings of services provided to youth by various service providers. The following is evident:

- The clinics and hospitals were rated as mostly sometimes good, with followed by good.
- The police were mostly rated as sometimes good
- Most participants rated social workers as offering a good service.
- Participants mostly did not know whether the traditional leaders offer a good service to your or not.
- NGOs and CBOs were rated as offering good services.

Figure 3: Rating of service providers of services for LGBTI



The graph demonstrates the following:

- There is uncertainty about what services are like for LGBTI youth, as shown by the high proportion of 'Don't know' responses.
- Clinics were perceived good and sometimes good by equal numbers of participants
- Hospitals were rated as sometimes good by most participants.
- Police services for LGBTI were rated as mostly good or sometimes good.
- AS with services for youth, services for LGBTI by social workers were rated as good.
- There was uncertainty about rating the role of services from traditional leaders to LGBTI people.
- Services provided by NGOs and CBOs to LGBTI people were mostly rated as good.

The overall picture which emerges about service provision is that services were rated as sometimes good to good by many participants, with social workers having the highest number of participants rating them as good out of all the service provider.

GENDER AND SEXUALITY

If the project is to make changes to the context LGBTI young people currently experience in terms of SRHR, so that there is free accessing of service, there needs to be a growing understanding of gender and sexuality amongst young people, at the relationship level with family and community, and amongst service providers. Thus information was collected about indicators for gender and sexuality.

What is the difference between gender and sexuality?

There is a lack of understanding about what these terms mean, with 43% of the participants saying they did not know, or were not sure, or gave no answer. A further 11% said there was no difference. This might be partially influenced by the fact that translation of these two terms into isiZulu is difficult. The word sex (as in male or female) is translated as umbulili. There is no straightforward translation of gender.

Examples of responses from those who gave correct and incorrect explanations were as follows:

- Gender is the way you feel, sex is the way you are.
- Gender is the way I grow up, sex is my private parts
- Gender is the difference between male and female, sex is when we are enjoying ourselves.

(This notion that sex is only an activity rather than one's physical being in this context was common).

Sexual orientation:

When answering the question 'What different sexual orientations do you know about?' 40% of participants did not mention any. The most commonly known sexual orientations were lesbian and gay.

Representation: the question was asked about whether there were any LGBTI representatives in the communities. The participants answered that there were in 3 of the areas (Mpophomeni 1 person said yes, in Greytown, 4 people, and in Pietermaritzburg 5 people knew a representative).

(One person said: 'We don't have LGBT in the community).

Challenges mentioned by participants which had been raised by the representatives in their communities, were:

- They helped us get roads and houses
- They helped us with our issues, with workshops and campaigns
- They stand up for our rights
- (They said the LGBTI people) were isolated In the community
- LGBTI people were discriminated against and not treated fairly (at school)

Forums where these challenges were raised:

These were the clinic, war room, committee meetings, in the community, at an NGO, a health forum and in school meetings.

Actions taken (mentioned by the participants) included:

- Involving the community to live together and solve the problems
- Saying a lesbian must be loved, accepted and respected, after people went to say that she must pack her bags and leave.
- Teaching everyone about LGBTI
- Taking part in a parade in the streets, as part of an awareness campaign.

Accountability structures with youth and/ or LGBTI on them:

These were committees, NGO committee, clinic committee, and police, on political structures

It was noted that these representatives were often youth members, but not necessarily LGBTI.

GBV

The project will address the reporting of GBV, and thus the survey covered knowledge of procedures and so on for reporting of GBV.

When asked what gender based violence is, the following responses were received:

- 57% said they didn't know or didn't answer

Explanations given included ideas of violence such as rape, hitting, stabbing and partner abuse, but also ideas of discrimination and hate crimes. These were linked to the gender of the person being abused only in some cases, including targeting of LGBTI people and correctional rape.

Some quotes are included below:

- It is violence linked to the gender of the victim
- When a woman experiences abuse from her partner.
- Violence by harassing people who are in love with the same gender.

Knowledge of GBV

In order to deal with GBV, it is important for people to know about certain legislation and protections: The domestic violence act (DVA[12]), a protection order[13], and a J88 form[14]. Participants were asked about these.

Table 16: Knowledge of legislation and protections

Knowledge of …..	Responses	Percentage of participants
Domestic Violence Act	Yes	46
	No/ don't know	53
Protection order	Yes	61
	No/ don't know	29
J88 form	No/ don't know	82

About half of the participants knew about the Domestic Violence Act, nearly two thirds knew about protection orders, but four fifths did not know what J88 is.

[12]The South African Domestic Violence Act 1998 defines domestic violence as: Physical abuse; sexual abuse; emotional, verbal and psychological abuse; economic abuse; intimidation; harassment; stalking; damage to property; entry into the complainant's residence without consent, where the parties do not share the same residence; or any other controlling or abusive behavior towards a complainant, where such conduct harms, or may cause imminent harm to, the safety, health or wellbeing of the complainant.

[13]A protection order aims at preventing the reoccurrence of domestic violence or sexual harassment by stating what conduct the alleged offender must refrain from doing. People such as counsellors, health workers, social workers and police can assist with obtaining an interim protection order.

[14]The J88 is a legal document that is completed by a medical doctor or registered nurse, documenting injuries sustained by the victim in any circumstance where a legal investigation is to follow.

For the protection order, there was some confusion about who can issue this: either the police or the courts were mentioned.

For the J88, participants mentioned that you could get this at the hospital, from a doctor.

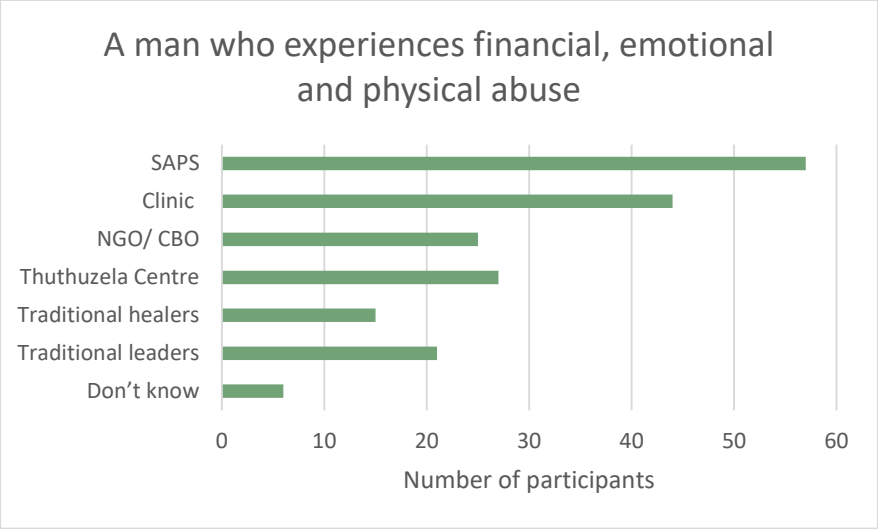
Reporting of GBV: In the sample of 72, 6 mentioned that they had reported cases (8%). Incidents which were reported included being beaten for her sexuality, a person being abusive (the abuser was dismissed from school), being beaten by her fiancé, and fighting.

Scenarios

In order to assess whether participants knew how to report various incidents, 3 scenarios were posed, and people indicated who they would report to in those circumstances. The list contained the following roleplayers:

Police/ SAPS, clinic, NGO/ CBO, Thuthuzela Centre[15], traditional healers and traditional leaders.

Figure 4: Scenario of a man who experiences financial, emotional and physical abuse



[15]Thuthuzela Centre: Thuthuzela Care Centres are one-stop facilities that were introduced as a critical part of South Africa's anti-rape strategy, aiming to reduce secondary trauma for the victim, to improve conviction rates and to reduce the cycle time for finalising cases. Patients don't have to move from one place to another to get help; they are offered the necessary services at one place with all the required resources.

Figure 5: Scenario of an underage girl raped by a family member

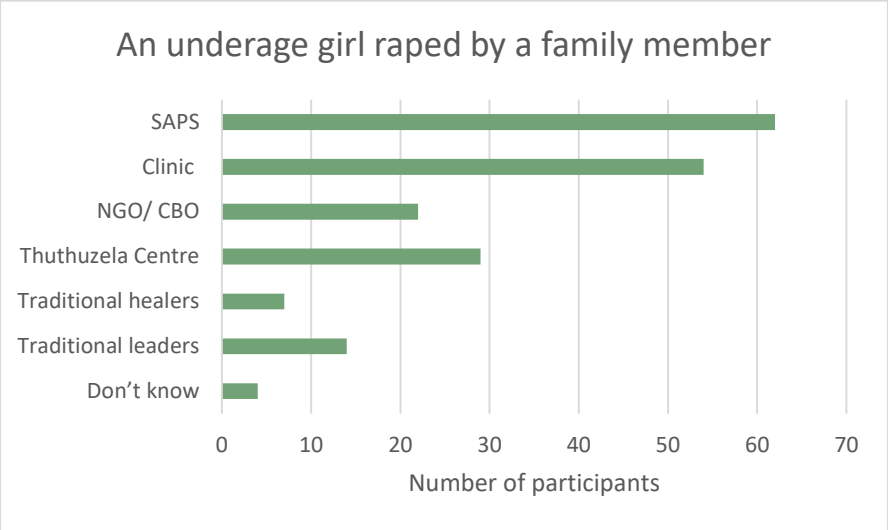
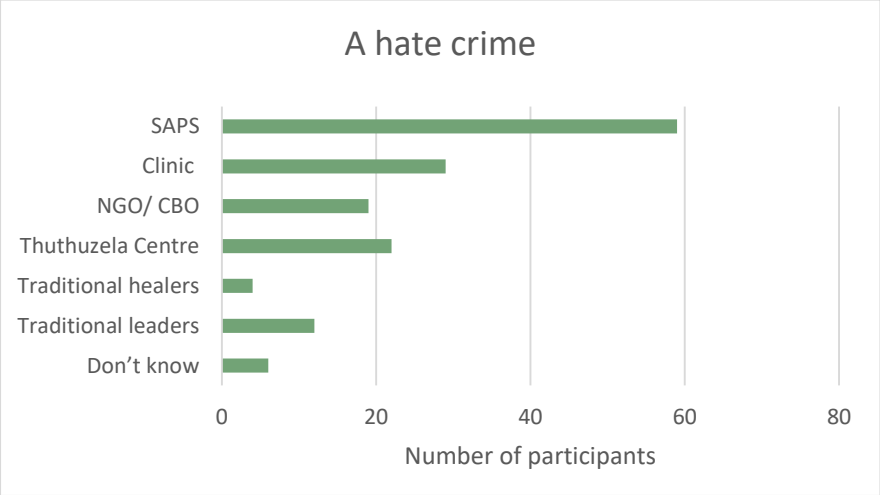


Figure 6: Scenario of a hate crime



The results show that participants knew that these incidents must be reported to the police and the clinic (although the hate crime may not have involved physical violence to the victim). The role of the Thuthuzela centres is possibly not clear to all, and NGOs and CBOs are seen to have a role to play.

It is of concern that in the second and third scenarios, which both involved crimes; some participants did not mention reporting to SAPS.

It is interesting that there is a role for traditional leaders and traditional healers to play, particularly in the scenario of the man experiencing financial, emotional and physical abuse. These are resources to be used to facilitate improving family relationships, but should never take the place of reporting crimes to SAPS.

PROBLEMS ASSOCIATED WITH REPORTING GBV

Underlying the low rates of reporting of GBV are a number of factors, which were discussed in the FGD. Some of these affect all youth, and some are particular to LGBTI youth. One of the difficulties is that an intersectoral response is necessary, with visits to health care providers and the police at a minimum. There are different problems with the various services providers, and these are also sometimes localized (i.e. good service in one area and less good in another).

Health care providers and SAPS: Negative and positive examples:

> *They do not respect us and they make us feel invisible. We feel as though we do not exist to them.* FGD Participant, Area 2

> *There is a lack of confidentiality especially in police stations, which is why a lot of people do not report GBV cases……. There issues at police stations when gays report cases, where they get beaten up by other boys; they do not take them seriously.* FGD Participant, Area 1

> *They humiliate us at the police station.* FGD Participant, Area 2

> *When someone was raped, they were very supportive at the hospital when faced with the issue of GBV and rape within the LGBTI community. At the police station however the officers laughed and told her that she deserved to be raped because of who she is…help came through a female officer that understood the pain she was in and this is the only time she got help.* FGD Participant, Area 2

Other community structures and roleplayers attitudes also affect people's ability to report GBV.

> *We also face humiliation within the church.* FGD Participant, Area 2

> *Intergenerational relationships and abuse by the older women within these communities.* FGD Participant, Area 2

Potentially false accusations of GBV: One person mentioned that there are sometimes false accusations of GBV in order for the so called victim to gain financially.

> *There are women that go to the SAPS and accuse you of GBV and tell you to pay a certain amount of money in order to keep you out of jail. As a man you have to pay this amount because you want to stay out of jail. FGD Participant, Area 4*

Possible interventions to address these problems faced by LGBTI with regard to LGBTI were mentioned, based on the assumption that people do not understand what GBV is:

> *We should call community members from different sexual identities for them to understand when GBV starts.* FGD Participant, Area 3

> *Awareness campaigns could be hosted to make people aware of GBV amongst LGBTI.* FGD Participant, Area 3

KNOWLEDGE, ATTITUDES AND BEHAVIOUR OF THOSE CLOSE TO YOUTH (FAMILY, COMMUNITY)

Attitudes of community members towards youth

Attitudes of the community towards youth as described by participants in FGDs were mainly negative:

> *They look at the youth in a negative way: They see them as drunks, alcoholics; that they are the ones who mostly contribute to high crime rate. They don't take notice of the youth in Mpophomeni, as most of them (the youth) are unemployed.* FGD Participant, Area 1

> *When you try to call youth for programs they ask what they will get and ask if there will be money that they will get. Sometimes you end up giving u on youth because they are not willing to work on things but constantly want things that come to them right now.* FGD Participant, Area 4

Youth themselves have also experienced these negative attitudes, and find this discouraging:

> *Our elders are now looking at us in a demeaning way and don't see hope in us anymore. Some old people do not like the way we are. Where do we start fixing this?* FGD Participant, Area 3

However some community members were more positive, and saw the contribution youth could make:

They attend all meetings and they are active in doing youth projects. (The Department of) Arts and culture looks at visual arts, virginity testing, gathering people, and public speaking is seen as an art. Other activities include sports with different teams, and we go to schools to find talented kids.

These attitudes and perceptions are important, as they will influence the amount of support which families and communities will offer youth in trying to achieve the projects goals of SRH for youth and LGBTI.

Attitudes of community members towards youth having sex:

Older people acknowledge that the youth is having sex, and are concerned, therefore try and warn them about the dangers of unprotected sex, and what to do about this. Dangers include the risk of HIV transmission, and unplanned pregnancy.

> *They are very young and most of them are not yet educated on prevention methods with regards to HIV, STIs and pregnancy. We have children at the age of 12 having unprotected sex.* FGD Participant, Area2

> *They tell you to use condoms and make sure you have ways to protect yourself.* FGD Participant, Area 4

The proliferation of transactional sex in a context of poverty is acknowledged as a reality. This type of sex generally involves the person 'buying' the favours being in a position of power with regard to decision making about have sex which is safe or not.

The government Child Support Grant is perceived as another reason why girls/ women may choose to have a baby, although there is evidence that this perception is not correct.

> *Some people go looking for someone just because they are in need of a better living situation. So they go out and get a man that is well off financially and trap that man by getting pregnant. This way even though they know the man doesn't love them, they do know that they will be supported financially regardless. FGD Participant Area 4*

> *There are girls that are 18 years old and have 4 children just because they are trying to get child support or aid from government. FGD Participant Area 4*

The 'double standards' for sexual behavior for females and males was also highlighted:

> *We believe that as a woman if you have a lot of children you are seen as a whore, whereas if you are male and have a lot of kids you are seen as someone that is manly. Participant RIchmond*

The interplay between customary practices and constitutional rights may create tension:

I blame older people because they are allowing these things by allowing it in the constitution. We used to respect things as small as time but now it's all individualistic and the community does not care about youth. The child use to belong to the community but now ingane yolowomuzi belongs there. Rights have messed us up. FGD Participant PMB

ATTITUDE TOWARDS YOUTH BY SERVICE PROVIDERS (DOH AND SAPS)

DOH: Attitudes towards youth accessing SRH services

Young people feel that they will be judged and stigmatized at the facilities for being sexually active:

> *They believe they do not get the help they need. They get judged a lot and end up not seeking help.* FGD Participant, Area 1

> *They ask that at such a young age you're already having sex. This makes it difficult for us to access these services because you feel judged.* FGD Participant, Area 4

> *Getting help from clinics will always be an issue and going to the clinic and not being stigmatized is not going to happen.* FGD Participant, Area3

These perceptions held by youth will be barriers to accessing services (even though the majority of youth participating in the survey did not experience judgement).

Some service providers try and assist the youth with services, but the assistance may be misinterpreted:

> *Some people come in looking for commodities and they haven't even had sex. Because they hear things from their peers, they take the precautions before they even start. The nurse sees it as her responsibility to counsel you before you engage in sex or before you get contraception from her in order to make sure that you are well aware of all the consequences. This is interpreted by youth as judgement and then decided not to go for these services.* FGD Participant, Area 4

SAPS: To be ascertained once the project commences.

ATTITUDES TO LGBTI YOUTH

The FGDs demonstrated that there is a high degree of stigmatization towards LGBTI youth, causing them psychosocial distress, and infringing on their ability to access health services and report GBV.

> *People do judge us. It's sad because we do not do any harm to them but they feel the need to discriminate against me*. FGD Participant, Area 3

> *A rapist will be seen as much better than being a gay man because his sexual intercourse is of the norm. Old people that herd cows know what homosexuality is and they know 'ukulalana'. Some people look at being gay as having sex, but if they are not having sex then it's not being gay.* FGD Participant, Area 3

> *When you gay it's hard to find love.* FGD Participant, Area 3

> *There are people that treat us well, but then we have others that discriminate against us. Some people don't have problems with lesbians and gays and sit with us and don't care. There are those that have a problem with us and don't even give reasons as to why they feel disgusted by us.* Participant, Area 2

KNOWLEDGE OF SPECIFIC REQUIREMENTS FOR WORKING WITH LGBTI YOUTH

To be ascertained from service providers once the project commences.

It is helpful if there are members of the LGBTI community working as nurses in facilities, as they understand the specific SRH needs of LGBTI youth:

> *Sometimes they do not believe that we can contract STIs through the type of sex we have. They are judgmental and do not understand that some of us within this community are different and was in which you can contract these things are different. There are people within these health facilities though that are like us and understand our situation and try to educate other nurses.* FGD Participant (lesbian), Area 2

However, all staff need to be trained about the needs of youth and LGBTI youth.

CONCLUSION

The data presented in this study have demonstrated that the proposed GLN activities will address knowledge gaps, and have the potential to change attitudes of youth, LGBTI youth and family and community members, as well as service providers. This would enable youth and LGBTI youth to access SRH services, and to report and follow through on GBV more easily than in the current context. It is likely that the knowledge inputs and the shifts in attitudes will also enable youth to engage in safer sexual practices, leading to a decrease in HIV transmission and in teenage pregnancy.

REFERENCES

Braam, T & Merkel, J. 2016. Status of sexual and reproductive health and rights in KwaZulu-Natal.

Department of Health 2011. Sexual and reproductive health and rights: Reviewing the evidence: Literature review and situational analysis undertaken to inform *Sexual and Reproductive Health: Fulfilling our commitments.*

Department of Health. 2015. The 2013 national antenatal sentinels HIV prevalence survey in South Africa.

Terres des hommes schweiz. 2016. Baseline study on youth SRHR indicators in KwaZulu-Natal, South Africa.

Shisana, O, Rehle, T, Simbayi, LC, Zuma, K, Jooste, S, Zungu, N, Labadarios, D, onoya, D et al. 2014. South African National HIV prevalence, incidence and behaviour survey. 2012. Cape Town, HSRC Press

APPENDIX 1: PROPOSED PROJECT INTERVENTION LOG FRAME

OUTCOMES		OUTCOME INDICATORS
SPO 1:	Youth and LGBTI Youth access SRH, HIV, GBV services and disclose their HIV status	• # of GBV incidents reported by LGBTI • # of LGBTI who report non-discrimination when reporting GBV cases at SAPS and Health SPs • # of LGBTI GBV cases that are followed up by SAPS • # of cases that are resolved • Youth and LGBTI youth attend health facilities • Youth and LGBTI youth report non-discriminatory treatment at health facilities • Youth and LGBTI youth know their HIV status • Youth and LGBTI youth disclose their status (to??)
SPO 2:	Peers, family, guardians support Youth and LGBTI Youth in accessing relevant SRH and GBV services and sharing GBV and SRHR knowledge with other community members. They advocate for Youth and LGBTI Youth SRH and GBV rights to services	• # of youth and LGBTI youth who report being supported in accessing SRH and in reporting GBV • # of community elders/leaders championing acceptance and protection of LGBT relationships and access to SRHR
SPO 3:	Traditional leaders, traditional healers, religious leaders, healthcare providers, police address Youth and LGBTI Youth challenges and accessing SRHR & GBV services and are treat Youth and LGBTI Youth without discrimination	• # of LGBTI SRH challenges raised at meetings • # of LGBT GBV challenges raised at meetings • # and nature of agreed interventions to address LGBTI SRH and GBV challenges • # and nature of successful interventions held •
SPO 4	Accountability structures automatically include Youth and LGBTI Youth on the agendas, policies laws etc. and Gay & Lesbian Network gender and sexuality module is incorporated into the police training colleges curriculum	• # of platforms that are including LGBTI subject matter in their sectors. • # of GLN contributions to GBV and SRH LGBTI policies • # of GLN research contribution in GBV and SRH LGBTI work • # of accountability structure meetings attended by Youth and LGBTI Youth

OUTPUTS		OUTPUT INDICATORS
Result	1.Youth and LGBTI Youth have increased knowledge on: • SRHR • GBV • SRHR & GBV services 2. Youth and LGBTI Youth have increased confidence in accessing SRHR & GBV services and reporting GBV cases	• Youth and LGBTI Youth level of knowledge on SRHR and GBV • Youth and LGBTI Youth level of confidence on SRHR and GBV • Number of reported cases by Youth and LGBTI Youth • # of youth and LGBTI youth who feel confident about accessing services for SRHR and reporting GBV
Result	1. Peers, family, guardians have an increased knowledge and understanding on: • SRHR • GBV • SRHR & GBV services • Gender and sexuality • The need to support youth and LGBTI youth on SRHR	• Peers, family, guardians level of knowledge on SRHR & GBV, services and gender and sexuality • # of LGBTI youth who report feeling supported by peers, family, guardians about SRH and GBV
Result	1 Traditional leaders, traditional healers, religious leaders, healthcare providers and the police have an increase awareness of Youth & LGBTI Youth needs and issues 2 Traditional leaders, traditional healers, religious leaders, healthcare providers, police has an increased acceptance of Youth & LGBTI Youth 3 Traditional leaders, traditional healers, religious leaders, healthcare, police are confident in providing SRHR & GBV services to Youth & LGBTI Youth	• Level of awareness by traditional leaders, traditional healers, religious leaders, healthcare providers and the police on Youth and LGBTI Youth needs and issues • Level of acceptance by traditional leaders, traditional healers, religious leaders, healthcare providers and the police of Youth and LGBTI Youth • Level of acceptance amongst religious, traditional, cultural and healthcare spaces are welcoming to Youth and LGBTI youth and their relationships
Result	1 Youth and LGBTI Youth SRH and GBV challenges raised at accountability structures 2. Increased knowledge of gender and sexuality of police training officers 3. Policies and laws are inclusive of LGBTI Youth acceptance	• Level of awareness on Youth and LGBTI Youth needs and issues within accountability structures • Number of discussions around policy amendments and policy development • Success stories are documented on the implementation of the interventions by the various accountability structures in the uMgungundlovu district • Number of policies and laws amended to include LGBTI Youth issues