Good Practice

Rooting gender-affirming health care within the public health sector

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Aim

In South Africa, health care for transgender and gender diverse persons has generally been provided within HIV programming, addressing key populations and has been limited in its reach. This paper provides commentary on work to root the provision of gender-affirming care within the public health sector by providing insights into two different health system implementation processes, namely, the Southern African HIV Clinicians Society's: Gender-affirming healthcare guideline for South Africa, and the Practice guidelines for psychology professionals working with sexually and gender-diverse people of the Psychological Society of South Africa. A discussion on how health care for transgender and gender-diverse persons has been problematised and represented is also presented to enable health systems learning.

Method

Utilising an established approach to analysing health policy, an exploratory analysis of the two guidelines was employed to understand how policy problems and framing are constructed within them. Specifically, the study interrogated how health care for transgender and gender diverse persons has been problematised and represented.

Findings

The representations and processes that have taken place to develop, equip and enable the health system to provide care are discussed. The assumptions, effects, silences and disruptions in the provision of gender-affirming health care are presented and the similarities with early HIV denialism are noted.

Conclusion

The guidelines and programming efforts for gender-affirming care have been informed by guidance from local and global systematic review processes. Given current geopolitics, some of these services are threatened and have closed owing to changes in foreign donor priorities. There is potential for the National Department of Health to take ownership and provide stewardship of care for transgender and gender diverse persons to address their healthcare needs from primary to tertiary healthcare settings.

Introduction

South Africa can be viewed as a beacon in the current geopolitics of queer health globally, supported by a clear legal and policy framework that has emerged over time. In contrast, the United Kingdom's economically-driven reforms to its health system have led to the unfortunate disorganising of health provision for transgender and gender diverse (TGD) individuals.[1] Other countries have also rolled back the provision of healthcare services, including Australia[2] and the United States.[3] At the same time, services for TGD people have surfaced as an issue in conservative election politics, with parties investing heavily in advertisements that often amplify controversy and misinformation.[4]

The political discussions that inform election processes in the United States are referred to as the cultural wars of the North; within South Africa, we recognise the substance of these debates. These political discussions and imported debates inform local discourse and practice, leaving South Africa vulnerable. On Monday, 20 January 2025, President Trump was inaugurated; on the

same day, he signed executive orders[5] denying transgender identities. In March 2025, US foreign assistance funding to South Africa was withdrawn affecting services including HIV and gender-affirming health care.[6]

These geopolitical processes have diverted attention from the healthcare needs of TGD individuals and weaponised the issue for political gain, creating barriers to compassionate and informed policy discussions. The provision of health care for TGD persons has generally been provided within HIV programming addressing key populations. The National Strategic Plan for HIV, TB and STI 2023–2028[7] (NSP) includes specific recommendations, such as inclusion of a gender affirmation package of services at all levels of care and strengthening policy implementation relating to gender-affirming health care (GAHC). Efforts are underway to provide inclusive GAHC within the public healthcare system in South Africa to foster improved access and equitable care.[8,9] Given the current context, these services are threatened with some having been closed because of changes in foreign donor priorities.[6]

In reviewing access to health care, Zambezi and Viljoen[10] describe inadequacies where transgender participants and healthcare experts report transgender-related inequalities in the healthcare system, including stigma and discrimination, exclusionary and culturally incompetent health services, and limited availability of competent healthcare services. In a cross-sectional survey of TGD people in the Western and Eastern Cape, Bust, et al.[11] found a gap between needed and actual access to legal and medical gender-affirming care services. There is evidence to show that access to GAHC for TGD persons has been undermined by politically motivated attacks that ignore clinical evidence and patient rights.[12]

Naledi, et al.[13] comment that South Africa's history is marked by deep dehumanisation and powerful resistance in relation to the provision of health care. The authors continue that this: "... same spirit calls us to confront a new injustice: the systemic failure to provide TGD people with the health care they need and deserve".[13] Lynch[14] describes an emerging problem in South Africa of anti-gender groups. She refers to a group of doctors, First Do No Harm Southern Africa (FDNHSA), that disseminate disinformation and deny the existence of TGD identities, and frame themselves as opposed to GAHC.[13]

Dunkle, et al.[12] recall that GAHC has been available in South Africa since the 1970s, yet services remain overstretched, under-resourced, and inaccessible to most persons. In reviewing the problematising of care, some argue about the pace or appropriateness of care, while the far more urgent problem is that many are unable to access care. In gaining an understanding of how these issues are replicated, it is evident that many avoid health services altogether because of adversarial and/or overtly abusive behaviour from providers.[15,16] Ideologically compromised calls to delay or withdraw services do nothing to address this reality, and in fact risk deepening health inequality.[10]

Case description

The Professional Association for Transgender Health South Africa[17] (PATHSA) released a statement in 2024 that outlines the following approach:

> South Africa is a country built on healing from a past which harmed and divided us. We are all called to commit to a future which is rooted in compassion and acts of care and belonging that bring forth the tangible recognition and affirmation of our shared humanity. In this pursuit, transgender and gender diverse young people are not only fully recognised for their inherent worth but are also honoured as indispensable and cherished members of our society, deserving of the opportunity to reach their fullest potential and contribute to our shared future.[18]

These ideas inform the evolving leadership and practice of GAHC in South Africa. Addressing programming processes of implementing GAHC at a primary healthcare level within the public sector in South Africa, Muller, et al.[9] note that GAHC is safe and effective, and suggests that it can be implemented and best practised in a primary health care setting. It is further argued that this will ensure that TGD people can access and receive preventative healthcare services, mental health services, and social support. In making provision for this level of care, it is suggested that health workers, including family physicians and primary health care staff, should be sensitised to the use of gender-affirming care and enabled to provide gender-affirming hormone treatment.[9] It has been demonstrated that a gender-affirming service delivery model at a primary health care level is feasible and can enhance service access in South Africa.[19]

This paper provides commentary on good practices in South Africa in the development of policy to root the provision of GAHC within the public sector by providing insights into two different health systems implementation processes: the Southern African HIV Clinicians Society (SAHCS): Gender-affirming healthcare guideline for South Africa[20] and the Practice guidelines for psychology professionals working with sexually and gender-diverse people[21] of the Psychological Society of South Africa (PsySSA). The two policies were chosen because they directly address gender-diversity. Historically, transgender and gender-diverse care has often been framed within 'key populations' or 'most at risk' approaches; however, this analysis seeks to foreground an affirmative approach to care.

Approach

This study draws on Bacchi's[22,23] exploratory analysis approach which seeks to understand how policy problems and framings are constructed. Specifically, how health care for TGD persons has been problematised and represented is analysed. Instead of tracking the evolution and staging of policy development, Bacchi recommends "a critical analysis of categories and knowledges that shape

current governing practices".[23] The approach is intended to facilitate critical interrogation of public policies. It starts from the premise that what one proposes to do about something reveals what one thinks is problematic (needs to change). Following this thinking, policies and policy proposals contain implicit representations of what is considered to be the 'problem' ('problem representations').[23]

Bacchi[22,23] draws attention to the construction of how problems are constituted in policies and policy proposals. Informed by a post-structural analytic strategy, she offers methodological framings of 'What is the problem represented to be?' (WPR approach). For example, in referring to abortion, she illustrates how it was not always considered a 'social problem' but rather, its perception is context and time dependent. In this case, she argues that while commonly framed as a 'moral problem', context and history inform this. In reviewing early history, Bacchi outlines how bans on contraceptive advice were linked to government interest in population control and suggests that reproduction becomes a focus of surveillance when population is the concern. She suggests a trend over time that policy proposals on abortion reflect the conflation of national/racial interest. These interests dovetail with religious concerns and biological imperatives, and as a result the global medical profession has enabled the criminalising of abortion to gain unquestionable authority, which enabled the ascendency of abortion to being viewed as a moral problem.[23] TGD identities have been constructed as a social/moral problem and this paper seeks to uncover how these representations have been repeated and disrupted.

Bacchi[23] suggests asking six questions:

1. What is the 'problem' (for example: 'problem gamblers', 'drug use/abuse', 'gender inequality', 'domestic violence', 'global warming', 'sexual harassment', etc.) represented to be in a specific policy or policy proposal?
2. What presuppositions or assumptions underpin this representation of the 'problem'?
3. How has this representation of the 'problem' come about?
4. What is left unproblematic in this problem representation? Where are the silences? Can the 'problem' be thought about differently?
5. What effects are produced by this representation of the 'problem'?
6. How/where has this representation of the 'problem' been produced, disseminated and defended? How has it been (or could it be) questioned, disrupted and replaced?

Further, through the concept of gendering, Bacchi[24] questions the problem of rigid distinctions between male and female biological entities. She says that expressions of gender are longstanding and ingrained in many cultures, asking the question why so much effort is expended in reinforcing these categories noting that TGD identities pose important challenges to conventional gender distinctions.

The analysis in this paper was conducted collaboratively by the authorial team, with initial judgements reviewed and engaged upon collectively until consensus was reached. This process was explicitly informed by the lived experience, disciplinary expertise, and critical perspectives of transgender and gender-diverse co-authors to strengthen rigour in interpretation. We recognise that this positionality shaped how we applied Bacchi's approach.

Results

This section describes the analysis of the two policy documents informed by Bacchi's questions.[23] Results are summarised in Table 1. Both documents respond to the gap of GAHC in health policy from different clinical disciplines. The 'problem' was framed to be the gap in provision of adequate GAHC, rather than a problem with the TGD individual. A key assumption of the study was that gender diversity is a natural part of human experience.[20,21] Regarding whose knowledge is considered valid, the assumption in both guidelines is that the site of knowledge shifts from the clinician being the expert to the TGD person with lived experience. A presupposition is that the marginalisation of TGD persons needs to be addressed within a healthcare response. The health system has a legacy of stigma and pathologisation of TGD identities. In considering Question 3: "How has this representation of the 'problem' come about?", the recent historical shift from viewing gender diversity as a 'disorder' to representation as natural variance is relevant. While earlier editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD) categorised TGD identities as 'mental illness', this representation shifted in 2018 when the World Health Organization (WHO) published the ICD-11. The ICD-11 removed transgender identity from the mental health disorders chapter and reconceptualised it as a 'condition related to sexual health'.[25]

The guidelines that are discussed below address the problem representation of GAHC that has come about given the prior gap of evidence-informed GAHC guidelines.

Southern African HIV Clinicians Society's: Gender-affirming healthcare guideline for South Africa

Historically, health services for TGD persons have been included as part of addressing key populations.[26,27] The SAHCS guideline[20] was represented and produced within an HIV high-transmission framing.

Tomson et al.[20] state that this guideline is specific in its scope and purpose to: "Provide evidence-informed best practice recommendations in order to enable South African healthcare providers, including psychosocial and

allied healthcare professionals, to offer quality, affirming services to TGD clients".[20]

In reviewing Bacchi's[23] fourth and fifth questions that address the different thinking and the effects produced by the representation, the emphasis of the SAHCS guideline in outlining a rights-based approach to GAHC accessible within the public health system with informed consent, is illustrative. The effect is that the discourse shifts from clinicians needing to diagnose a 'disorder' towards facilitating access to care. In addition, the lens includes a multidisciplinary team, including mental health professionals, that is recommended to ensure that GAHC affirms dignity and autonomy and does not impose pathologising frameworks.[20] Gatekeeping (delaying treatment until the healthcare provider feels a particular subjective degree of certainty) is not a neutral act and is potentially harmful.[20]

In reviewing how the problem representation is reproduced, represented and defended in reference to Bacchi's[23] Question 6, it is noteworthy to appreciate the location of GAHC and movement from an HIV response to within a PHC setting. Muller, et al.[9] describe the expanded GAHC guideline in depth, exploring the location of services and implementation at a primary health care level.

In summary, this guideline serves to record the representation of rooted evidence-informed GAHC in the public healthcare system. Key areas produced and questioned in the problem representation include the caveat that withholding care is harmful. In addition, there is a spread of disciplines engaged in GAHC moving from an HIV response to locating it within PHC. The approach also includes a multidisciplinary team that underscores a rights-based approach and a thorough process of informed consent informed by depathologisation.

Psychological Society of South Africa's: Practice guidelines for psychology professionals working with sexually and gender-diverse people

Social transitioning is generally the first part of the journey of GAHC, representing a conundrum for many TGD individuals. The PsySSA guideline[21] is clear in answering Questions 4 and 5 regarding how to think differently and to address the effects of the representation of transitioning persons, given that the orientation is one that encourages the importance of an affirmative stance, self-determination, and intersecting forms of discrimination. The guideline reviewed is the second edition of the document, with the newer edition revising problem presentation. Since science and practice evolve, the PsySSA guideline is an updated consolidation of best practice evidence in South African and international psychology pertaining to understanding sexual and gender diversity.

With regard to Bacchi's Question 4, that requires those reviewing policy to ask about different thinking, the guideline is explicit in the problem framing and application, it is noted:

> The term 'diversity' includes working with sexual and gender diversity, the specific area of application dealt within the current guidelines. While there is an expanding vocabulary in terms of sexual and gender diversity in academic theorising, empirical research, and from people's lived experiences, these guidelines opt to use the acronym LGBTQIA+ throughout the document, with the plus (+) meant to indicate further complexity, diversity, and possibilities. Quite often, the term 'diversity of sexual orientation, gender identity and/or expression, and sex characteristics' (SOGIESC) is used along with LGBTQIA+. Sexual and gender diversity may also include diverse relationship orientations that challenge, resist, or opt out of the traditional hetero-cisnormative expectations of what a relationship or family ought to look like. The tapestry of sexual and gender diversity is therefore wide and varied, and encompasses a diversity of identities ... These guidelines, therefore, contribute to an improved understanding of sexual and gender diversity competence for psychology professionals working in a multicultural society.[21]

Question 5 requires thinking about the effects of the problem representation, and the authors of this study argue that by rooting these guidelines in programming for mental health professionals, several goals are served. In underscoring the rigour of this edition of the guideline, it is noted that the primary purpose of the document is to consolidate the latest evidence in the areas of LGBTQIA+ psychology and related fields, and to understand the implications for psychology professionals working with sexually and gender-diverse people. The guidelines, therefore, provide a resource for psychology professionals to deal more sensitively, ethically, and effectively with matters of sexual and gender diversity. Moreover, this edition widens the application and adoption of the guideline, it is not limited to psychologists, but extends to all legal categories of psychology professionals registered with the Health Professions Council of South Africa (HPCSA); i.e., registered counsellors, psychometrists, and clinical psychologists, educational psychologists, counselling psychologists, neuropsychologists, industrial psychologists, and research psychologists.

> An additional effect that this guideline represents is its applicability in the public sector. Here, it is suggested that the guideline is a resource for government departments where psychology professionals are frequently employed, especially in the departments of Health, Education, and Correctional Services, and the South African Police Service. Similarly, it is noted that related social service professionals in the Department of Social Development will also benefit from using the guideline, due to its relevance for all mental health professionals, including medical doctors, psychiatrists, occupational therapists, social workers, and nurses. The PsySSA offers an inclusive approach by welcoming attempts by government departments to use the guideline as a resource to develop policies, standardise operating procedures, and other LGBTQIA±friendly interventions that improve service delivery for LGBTQIA+ people.

Table 1. Summary of responses to Bacchi's[23] questions

Question		SAHCS GAHC Guideline	PsySSA Practice Guidelines
1	What is the 'problem' represented to be?	Guideline responds to a gap in GAHC provision.	Guideline responds to a need for affirming care for gender diverse people.
2	What presuppositions and assumptions underlie this representation of the 'problem'?	Gender diversity is natural and a normal feature of human experience. Marginalisation of TGD persons.	Gender diversity is a natural part of human experience. Marginalisation of sexually and TGD people.
3	How has this representation of the 'problem' come about?	Shift from pathologisation of TGD identities: ICD-11.	Support for social transition as an aspect of self-determination.
4	What is left unproblematic in this problem representation? Where are the silences? Can the 'problem' be thought about differently?	Guideline informs GAHC differently and enables a human rights perspective.	Guideline informs care differently and enables an affirming stance.
5	What effects (discursive, subjectification, and lived) are produced by this representation of the 'problem'?	Depathologisation of identity, shift from 'diagnosis' to 'access to care', withholding of treatment is not a 'neutral' clinical act.	Relevance to applicability and rooting in the public sector.
6	How and where has this representation of the 'problem' been produced, disseminated, and defended? How has it been and/or can it be questioned, disrupted, and replaced?	Movement from an HIV response to a PHC setting.	Providers tasked to confront prejudices.

Lastly, in reviewing Question 6 that asks how the representation has been disruptive or enabled questioning, the articulation within the guideline in explicitly calling on providers to confront their own prejudices and to uphold a non-pathologising, affirming stance surfaces.

In short, this section reviewing the PsySSA updated and evidence-informed guideline, has provided a problem representation that underscores the first step of social transitioning in GAHC with a commitment to highlighting an affirmative stance, self-determination, and intersecting forms of discrimination. The guideline replicates a framing that contributes to an improved understanding of sexual and gender diversity competence for psychology professionals working in a multicultural society. Being a resource for psychologists and allied professionals, including different departmental service providers in the public sector, the guideline enables a large cadre of providers to question and address their own prejudices and biases.

Discussion

This exploratory policy analysis reveals that despite their different origins and audiences, the two documents share a common refusal to pathologise TGD identities. They also show commitment to rooting affirming, evidence-informed care within the public health system.

By foregrounding how policy framing constrains or enables provider learning, training and capacity building, this study offers insights into how programme guidelines, a form of policy, impact on provider behaviour and so on learning within health systems. Learning health systems improve by listening to those closest to the problem and tolerating uncertainty.[28] A framework that refuses to pathologise TGD identities does both: it treats TGD people as a source of insight rather than a population to be managed, and it allows the system room to hold genuine complexity while evidence is still emerging, as it did during the early era of HIV. Through such processes, policy commitments can be translated into responsive and reflective practice.[28]

The exploratory policy analysis approach of Bacchi[23] differs from other health policy analysis frameworks.[29, 30] Its unique problem representation and questioning method enabled a range of insights including, for example, assumptions, presuppositions, silences, effects, questions and disruptions to be identified. Bacchi's[24] approach also enables contemplation of the effects of gendering on reinforcing rigid categories. The problem constructions revealed that GAHC guidelines are emerging in different disciplines and specialities in health sciences as

a process over time, with the content being refined and informed by the best available evidence. The 'who' in the problem representation is illustrative to unpack as there are a range of actors who are engaged, including academics, government, researchers, health providers, experts, and TGD persons who are part of the development processes.

The Bacchi[23] policy analysis framing approach has been used in South Africa to review policy representation in adolescent health,[31] mental health,[32] and population and sexual and reproductive justice.[33] These analyses inevitably differ from that presented here given the particular contestation on TGD identities, and as they do not engage with gendering[24] representations.

Reviewing these policy problem constructions, including the assumptions that underpin the framing and how this is represented in TGD history, has been informative. An important example is the uneven legacy of injustices that impacted on TGD identity. The harmful (and problematic) practice of conversion therapy in the apartheid military[34] served to redirect, change, suppress or divert one's sexual orientation, gender identity or gender expression, due to religious, family, or cultural problematisations and pressures. Outright International conducted research in South Africa[35] and documented practices revealing that "49% of 303 respondents stated that they were forced into conversion practices, while 30% made a personal decision to seek out and undergo conversion practices due to external influences".[35] These harmful and unethical practices have filtered into healthcare spaces with new languages and approaches calling it 'reparative care'. In disrupting this problem representation, individuals should have access to affirming, evidence-informed care that supports their sexual orientation and gender identity. This includes trauma-informed therapy, peer support groups, and counselling that fosters self-acceptance and wellbeing. Health services should offer gender-affirming care, sexual health education, and create safe, inclusive spaces, where people can explore their identity without judgment.[36] These approaches empower TGD individuals to live authentically and thrive.

The representation of GAHC resonates with the construction of South Africa's painful history with AIDS denialism. Naledi, et al.[13] recall the contestation when the science of the efficacy of antiretrovirals was challenged along with misinformation, stigma, poor governance and bureaucratic inertia in implementing life-saving treatment. In disrupting the representation of the problem, activists and clinicians pushed back, curating and collating the best available evidence to inform care, not fear or ideology.[13] The parallels to GAHC are noteworthy. Just as in the early period of HIV, when care was blocked by calls for more evidence, there are concerted efforts to derail and deny health care to TGD persons under the guise of caution. What is problematic is new forms of disinformation that mirror tactics used by HIV denialist, and anti-vaccine and anti-abortion movements to provoke moral panic.[13]

In reviewing the rooting of GAHC in the public sector, services have been provided over time, but are limited given South Africa's inequitable health system. The two policy guidelines have been crafted in an unfolding path to improve evidence-informed accessible health care. Given contestations undermining TGD diverse identities, stakeholders have had to defend care to avoid further alienating TGD persons when entering and accessing health services. There is a need for further African-centred research to inform understandings of the problem representation informing context so as to be responsive to, and work with, greater clarity in the implementation of equitable public health care.

These two documents have served to question, disrupt and replace the current imposition of questions in relation to the legitimacy of GAHC. Indeed, GAHC has been represented and constructed as a problem, though there have been efforts in dismantling obstacles and implementing GAHC. Operationalising the recommendations of the NSP relating to GAHC will assist with rooting GAHC in the public sector.[7] Provincial and national government departments have the potential to take ownership and provide stewardship of care for TGD persons, thus addressing their healthcare needs from primary to tertiary health care settings.

It is noteworthy that this analysis has been shaped by TGD co-authors whose lived experience and expertise have informed the framing and interpretation throughout. However, given that GAHC is evolving in South Africa, there are gaps of knowledge and limitations with an introductory overview of the problem representation. This analysis is limited to two purposively selected documents. It does not constitute a comprehensive review of all GAHC policy texts in South Africa. The analysis also does not track implementation fidelity nor speak to the gap between what documents represent and what is experienced in public health facilities.

Recommendations

First, given the demonstrated vulnerability of existing provision, national and provincial departments of health should translate existing policy commitments into an implementation plan for GAHC across levels of care. This should include dedicated budget lines, clearly defined referral pathways between primary, secondary and tertiary services, and measurable accountability mechanisms. Locating GAHC within primary health care, while retaining access to specialist multidisciplinary support, would help shift provision away from fragmented donor-dependent services towards sustainable public sector ownership.

Second, health worker education should be strengthened through structured, competency-based training informed by the SAHCS and PsySSA guidelines. Training should not be limited to clinical protocols, but should also address stigma, gatekeeping, informed consent, depathologisation, trauma-informed practice, and the ethical obligation to provide affirming care. This training

should be embedded in pre-service education, continuing professional development, and facility-level mentorship so that implementation is not dependent on individual champions alone.

Third, South Africa should invest in African-centred research, monitoring, and learning processes that are led with meaningful participation from TGD communities. Such work should document service availability, implementation barriers, patient experiences and outcomes across provinces, while also tracking how disinformation and anti-gender mobilisation affect access to care. A learning health systems approach would enable policy, training and service delivery to be refined iteratively, grounded in evidence, lived experience, and the Constitutional commitment to dignity and equality.

Conclusion

This paper sought to understand how GAHC has been constructed as a problem in South Africa. Applying Bacchi's[23] analytic framework to two purposively selected documents illuminated not only what these documents say, but what they assume and what they disrupt. The parallel with South Africa's AIDS denialism history is not incidental as it also illustrates what happens when ideology overrides evidence and care is withheld from marginalised persons.

In terms of GAHC, the contestations undermining TGD identities have forced stakeholders into a defensive position. Energy spent defending the legitimacy of care is energy diverted from the delivery of care. The work of building evidence-informed, affirming care for TGD persons continues. It needs to be grounded in African-centred research that deepens understanding of how the problem is represented in the local context and anchored in the rights that TGD persons are entitled to.

To strengthen GAHC provision, what is needed now is action. National and provincial government departments must operationalise the GAHC recommendations contained in the NSP, with dedicated budget lines and clear accountability mechanisms.[7] Health providers require structured sensitisation and training informed by the two guidelines reviewed. These documents are imperfect, but they exist. The rights exist. What is needed is adequate political leadership to make care a reality.

Abbreviations

Abbreviation	Description
AIDS	acquired immunodeficiency syndrome
DSM	Diagnostic and Statistical Manual of Mental Disorders
FDNHSA	First Do No Harm Southern Africa
GAHC	gender-affirming health care
HIV	human immunodeficiency virus
HPCSA	Health Professions Council of South Africa
ICD	International Classification of Diseases
LGBTQIA+	lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual and other diverse identities
NSP	National Strategic Plan for HIV, TB and STIs 2023–2028
PATHSA	Professional Association for Transgender Health South Africa
PHC	primary health care
PsySSA	Psychological Society of South Africa
SAHCS	Southern African HIV Clinicians Society
SOGIESC	sexual orientation, gender identity and/or expression, and sex characteristics
STI	sexually transmitted infection
TB	tuberculosis
TGD	transgender and gender diverse
UK	United Kingdom
US	United States of America
WHO	World Health Organization
WPR	What is the problem represented to be?

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