Linking Policy to Programming

Situational analysis on young key populations' sexual and reproductive health and rights in Zambia

This brief presents the findings of a situational assessment on young key populations (YKPs)[1] in Zambia, undertaken by HEARD, University of KwaZulu-Natal. The analysis was part of a larger, multi-country project (2017-2020) which seeks to strengthen the legal and policy environments for young key populations and improve their sexual and reproductive health and rights in Southern Africa[2]. The analysis brought together existing and new data in order to capture the political, legislative, socio-economic and socio-cultural issues that affect the sexual and reproductive health rights (SRHR) of young key populations (YKP). Data collection included qualitative and quantitative data from published and grey literature and existing data sets, as well as primary data obtained through key informant interviews with actors from government, international organizations or NGOs working with young people on issues of SRHR.

Key Findings

The Socio-Economic and Legal Context

In all of the accounts of young key populations in Zambia, criminal statutes and prevailing socio-cultural beliefs and practices were said to drive marginalisation and exclusion. On the legal side, punitive criminal laws, most of which date from the pre-Independence period, cast a dark shadow over the lives of young people with same-sex desires or attachments, for example, even if these laws were only selectively enforced [1,2]. On the socio-cultural side, the Constitutional assertion of the primacy of Christianity is reflective of a socio-cultural ethos that remains intolerant to the diversity of social identities and sexual practices that characterise young gay or transgender people, for example. The litany of effects is long and includes; highly publicised police actions meant to expose perceived criminality and immoral conduct; arrests, detention, and physical and sexual abuse of individuals, in violation of Constitutional protections against such abuses; a general culture of impunity within communities for acts of verbal, physical and sexual harassment and abuse, sometimes merely on the basis of appearances that were deemed to be outside of established (and frequently violently enforced) cultural norms regarding gender; and, bribery and extortion, using the threat of criminal exposure, including between gay or bisexual men themselves, for example [1-5].

Sex workers face similar forms of cultural and social ostracization, largely through local beliefs that what they do is not only 'sinful' but also in opposition to what is considered a proper cultural and social role for a Zambian woman. Amongst other things, these factors affect self-esteem and agency, and negatively affect health seeking behaviour for fear of exposure and judgement, not only in health services, but in family and community environments as well [6,7].

Punitive drug laws have a similar effect and, in addition to criminalising specific forms of drug use, also prevent the introduction of harm reduction interventions which are considered under these laws to constitute condoning or promoting illegal drug use [1].

Key issues for young key population groups

How did the degree of disadvantage, marginalisation or exclusion faced by young key populations influence young key populations' SRH outcomes, both on their own, and in comparison with their non-key-population peers? Data on these trends were few but what were available suggested much poorer SRH outcomes. For example, data from a 2013 study for young men who have sex with men (MSM) showed substantial differences in HIV prevalence between this group and the wider population of young men [8]. For young MSM is what 8.7% as compared to 4.1% for other young males [8,9].

In 2014, the burden of HIV amongst young sex workers was substantial [8]. HIV prevalence reached as high as 53.6%, and prevalence for syphilis 32.8% in some locations in the country. Comparable rates in 2014 for all adolescent girls (15-19 years) and young women 20-24 years) were 4.8% and 11.2% for HIV, as already noted, and 4,9% and 9.8% for syphilis. These were substantial differences that spoke to the urgency of understanding more about how these negative outcomes arise for young sex workers, both from a behavioural perspective and from the broader socio-environmental or structural standpoint.

Research on young people who use or inject drugs in Zambia, and the relation between drug use and their SRH, was non-existent. While, for example, the Ministry of Health's A*dolescent Health Strategy 2017-2021* quoted data from the Drug Enforcement Commission regarding increases in the range and quantities of drugs seized in the country, and made claims that adolescents and young people were increasingly affected by drugs, no data were provided to substantiate them [11]. As for transgender youth and young people in prison, there were no quantitative data on SRH indicators. In their personal accounts, however, transgender youth described poor SRH, including untreated HIV infection or STIs, and other reproductive health concerns [5].

For young prisoners, while there were no specific data on their SRH there was some information on their SRH risks. Although against the law in Zambia, older adolescents are incarcerated with adults [12]. In this context, they are at risk of sexual exploitation, amongst other abuses, particularly given prison conditions, which include overcrowding, gang-related activities and chronic under-nourishment [13].

Current efforts to improve SRH

With support from Global Fund, the United States President's Emergency Plan for AIDS Relief (PEPFAR), UNDP and others, the situation was changing for some young key populations at the time of the assessment. There were a number of current or recently completed interventions aimed towards improving SRHR for MSM and sex workers, for instance, including targeted SRH services provision; interventions in communities to shift knowledge, attitudes and practices; and, early efforts at law and policy reform. Adolescent key populations below 18-years-of-age remain excluded from these efforts, however [14]. While such efforts were important, however, they were being designed and implemented on the basis of limited knowledge and understanding of social health determinants. The findings of this situational analysis suggested that until this gap is addressed such efforts may be limited in their ability to mitigate or resolve the main SRHR inequities young key populations in Zambia continue to endure.

Conclusion

Why are additional efforts necessary? As an illustration of this imperative, in 2017 in Zambia, complications arising from advanced HIV infection was the leading cause of death for all adolescents and young people aged 10-24 years [15,16]. To the extent that young key populations continue to bear a high burden of HIV, and have least access to HIV treatment for the kinds of unjust and remediable reasons that this assessment has explored, the disease burden remains high overall for the country and the lives of young people, the erstwhile engine of sustainable development for Zambia, continue to be lost. Addressing this gap in HIV programming is not the only reason to act to improve the SRH for young key populations—but it is surely one of the more urgent.

1 Groups of young people considered 'key populations' in the HIV response include sex workers, lesbians, gays, bisexuals, transgender and intersex people, people who inject drugs and prisoners
2 HEARD collaborates in this project with the United Nations Development Programme (UNDP) and African Men for Sexual Health and Rights (AMSHeR).

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Further information:

Further details on this multi-country research project can be found on https://www.heard.org.za/research-post/linking-policy-to-programming-2/ and on https://www.africa.undp.org/content/rba/en/home/about-us/projects/linking-policy-to-programming.html

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