ZAMBIA

Baseline report on young key populations and sexual and reproductive health and rights
# Zambia

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EXECUTIVE SUMMARY

This short report details an analysis of the current situation of sexual and reproductive health and rights (SRHR) for adolescent and young key populations in Zambia using the social determinants of health as the organising frame. The main groups included in the discussion are young sex workers of all genders (male, female and transgender); young gay men and other men-having-sex-with men (MSM); young prisoners; and, young people who use drugs. The findings are based on a desk review of the currently very limited sources of information on young key populations in the country as well as a series of key informant interviews with the main stakeholders working in the domain of improving SRHR for these groups.

The report makes the following main findings:

- Although the country’s 7th National Development Plan has identified the health, well-being and economic prosperity of its predominantly young population as a cross-cutting priority, significant challenges are impeding progress, including poor sexual and reproductive health (SRH).

- A number of policies and strategies have recently been put in place to improve health for adolescents and young people, amongst them the National HIV/AIDS Strategic Framework 2017-2021 which, for the first time, recognises the need to address the situation of key populations in order for the country to reach national, regional and global level commitments regarding reducing the burden of HIV and other linked health concerns.

- However, such commitments are being made in the absence of comprehensive evidence about the challenging and complex lived realities of young key populations and what influences their SRH, from individual behavioural elements to broader structural complexities.

- Examining the situation of young key populations in Zambia through the social determinants of health lens has not been done before. Doing so, although on the basis of very limited data, suggests that these groups have much poorer SRH than their non-key-population peers and that a number of such inequities may be at once unfair, avoidable and remediable.

- Poor SRH outcomes for these groups include an elevated prevalence of HIV and other sexually transmitted infections (STIs) for MSM and sex workers, as well as increased levels of sexual violence. These arise from a range of factors, including a general context of discrimination and marginalisation as well as more specific pathways linked to the health effects of punitive laws and policies; negative socio-cultural beliefs and practices; a high degree of social exclusion; and, limited or no access to relevant and acceptable health services.
With support from Global Fund, the United States President’s Emergency Plan for AIDS Relief (PEPFAR), UNDP and others, the situation is changing for young key populations. There are a number of current or recently completed interventions aimed towards improving SRHR for these groups, 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.

While such efforts are important, they are being conceived and implemented on the basis of limited knowledge and understanding of social health determinants. The findings of this analysis suggest, even if only provisionally, 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.

The findings also point to the implications of this gap in the form of a significant ‘blind spot’ that will continue to exist in Zambia’s broader project to improve the health and well-being of the entirety of its young people.

The report concludes by suggesting the following research priorities for moving forward to close this gap:

- **Describe young key populations in Zambia**—There are no comprehensive descriptions of young key populations in Zambia, in all of their diversity. There is a need to evolve a more nuanced way of framing disadvantage or marginalisation for these young people. A ‘ground up’ analysis for Zambia is a critical first step.

- **Describe SRH inequities**—As presented in the analysis, there are some data for HIV and other STIs. However, a much broader spectrum of data is needed that is specific to young key population groupings in the different ways that they emerge in Zambia’s context.

- **Identify the social determinants of the inequities**—The analysis has sketched what some of these determinants may be but more in depth investigation is needed.

- **Describe the contribution of these inequities to broader SRH trends for young people**—The research should probe, for example, the extent to which the current gap in HIV treatment for young people is made up of young people from key population groups without access to such services, or of those that are highly reluctant to use them.

- **Document current programmes and investments and calculate what they achieve**—It is important to understand what works and what does not work for improving SRH for young key populations. It is also important to understand issues of value-for-money, particularly in the context of limited resources and competing priorities.
• Propose laws, policies or programmes, and needed investments, to address the determinants of good SRH and to reduce or remove inequities. A more comprehensive body of evidence will lead to the identification of what is needed, individually and in combination, in the different domains of law, policy and programming, to improve the SRH of young key populations and to contribute to improved health for all adolescents and young people in Zambia.
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<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
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<tr>
<td>CCM</td>
<td>Country Coordinating Mechanism</td>
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<td>CIDRZ</td>
<td>Centre for Infectious Diseases Research Zambia</td>
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<td>CSO</td>
<td>Central Statistical Office</td>
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<td>HIV</td>
<td>Human immuno-deficiency virus</td>
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<td>LGBT</td>
<td>Lesbian, gay, bisexual, transgender</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MSM</td>
<td>Men-having-sex-with-men</td>
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<td>NAC</td>
<td>National HIV/AIDS/STI/TB Council</td>
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<td>NASF</td>
<td>National HIV/AIDS Strategic Framework</td>
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<td>NASTAD</td>
<td>National Alliance of State and Territorial AIDS Directors</td>
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<td>PEPFAR</td>
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<td>SADC</td>
<td>Southern African Development Community</td>
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<td>Southern African Litigation Centre</td>
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<td>SAT</td>
<td>Southern African AIDS Trust</td>
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<td>Swedish International Development Agency</td>
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<td>SRH</td>
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<td>Sexual and reproductive health and rights</td>
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<td>STI</td>
<td>Sexually transmitted infection</td>
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<td>TB</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<td>WSW</td>
<td>Women-having-sex-with-women</td>
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INTRODUCTION

Census data for Zambia for 2010 showed that 56% of the population was under the age of 19 years and 65% under the age of 25. One third (35%) was between 10 and 24 years (Central Statistical Office [CSO], 2010). More recent population-based studies suggest that these proportions have not changed (CSO, 2015; Ministry of Health [MOH], 2017c). Under its recently launched Seventh National Development Plan 2017-2021, Zambia has identified the health, well-being and economic prosperity of its young population as a cross-cutting priority (Ministry of Development Planning, 2017). The plan seeks to address this through, amongst other things, creating, “an enabling environment...that ensures [all] citizens claim their rights to education, health, development, and live free from violence and discrimination,” and, “where no Zambian is marginalised in benefitting from development (ibid).” For Zambia, the pathway towards greater prosperity for its young population is premised, then, on fulfilling the rights of citizenship to equal shares of primary social goods, such as education and health care, by, amongst other things, preventing or eliminating discrimination or marginalisation in all its forms.

Where young people currently find themselves on this pathway is at a far remove from what the plan outlines. Data on core socio-economic indicators, as well as recent analyses of development prospects, illustrate this. For example, 65% of the primarily young population of Zambians live below the nationally defined poverty threshold of US$1.90 per day (UNDP, 2017). While country data show that 80% of 20-24-year-olds are in the labour force, 79% of all Zambians are engaged in ‘vulnerable employment’ which is primarily made up of self-employment in subsistence agriculture in rural areas or unpaid domestic work (CSO, 2016; UNDP, 2017). Within this same age group, only as many as 14% have completed primary school and 13% secondary school, although most, overall, have some level of schooling (CSO, 2015). The development outlook is challenging for all Zambians while its economy is largely centred around foreign-owned extractive industries (copper mining) with minimal levels of investment and growth in other sectors, particularly small and medium size enterprises which are generally a major source of opportunity for young people. On measures of multi-dimensional poverty, the majority of Zambia’s primarily youth-led households fair worse now than in previous periods. The links between poor health, lack of educational attainment, and food insecurity for this group have been well established (UNDP, 2017).

Recently adopted policies and strategies highlight the health dimension of these structural inequalities, particularly the National Youth Policy, the Adolescent Health Strategy 2017-2021, the National Health Strategic Plan 2017-2021, and the National HIV/AIDS Strategic Framework (NASF) 2017-2021 (Ministry of Youth and Sport, 2015; MOH, 2017a; National HIV/AIDS/STI/TB Council [NAC], 2017). A common strand running through all of these is the central priority of achieving sexual and reproductive health (SRH) for older adolescents and young people aged 15-24 years.
The rationale for this is the growing range of poor SRH outcomes for this group that are linked to a host of issues, including elevated levels of risk and vulnerability to HIV and other sexually transmitted infections (STIs); early entry into child-bearing; early and forced marriages; sexual and gender-based violence; sexual exploitation and abuse; low levels of knowledge regarding sexuality and sexual health; and, low uptake of and retention in available SRH services, including HIV treatment (MOH, 2017a, c; NAC, 2017; UNICEF, n. d.).

Moving forward to address this situation for the country requires, then, that those groups of adolescents and young people whose SRH outcomes are the poorest be identified, and that the root causes of this be investigated. Other countries across the Southern African region are beginning to do this work and, as a result, there is growing attention to young people from key populations which are generally identified as sex workers of all genders (male, female and transgender); people who use drugs; people in prisons; men who have sex with men (MSM); and lesbian, gay, bisexual and transgender (LGBT) individuals (Southern African Development Community [SADC], 2017). For Zambia, there is also an emerging focus on young key populations, although mostly in the context of the HIV response and, for the moment, only obliquely as part of other efforts to improve SRH more generally (NAC, 2017; MOH, 2016, 2017a). While this is nevertheless encouraging, such progress is occurring in a context that is challenging and contradictory and where the many aspects of the complex, lived realities of young key populations that influence their SRH are neither fully recognised nor addressed.

This analysis probes this situation using the social determinants of health framework (WHO, 2010). It finds that, although the evidence is currently very limited, there is enough to suggest that young key populations in Zambia have significantly poorer SRH and that this arises as a result of a range of factors, including a general context of marginalisation and disadvantage as well as more specific pathways linked to health effects of punitive laws and policies; negative socio-cultural beliefs and practices; a high degree of social exclusion; and limited or no access to relevant and acceptable health services. However, none of these issues can be understood to any degree of analytical precision unless additional comprehensive and inclusive research is carried out. The analysis concludes that, until this work is done, a significant ‘blind spot’ will remain for health and development planning for young people in the county, and progress for development through the full realisation of this ‘demographic dividend’ may be compromised (African Union, 2017).1

1 Data and other information to support the assessment was collected using desk review and key informant interviews. Peer-reviewed literature on SRH for young key populations in Zambia was very limited. There were some non-peer-reviewed sources as well as unpublished data that provided additional insights. With the endorsement of NAC, a researcher from the University of Zambia conducted key informant interviews with a range of individuals deemed to be knowledgeable about young key populations in the country. This included informants from governmental and non-governmental entities, international organisations, technical partners, and from key-population-led groups themselves. Documents and interviews notes were analysed using content analysis aligned to the components of the social determinants of health framework.
Applying the social determinants of health lens to the situation of young key populations in Zambia has an important value. It is highly useful for illuminating how differences in SRH arise, particularly for population groups who experience multiple forms of marginalisation or exclusion (WHO, 2010). It leads us towards considering these differences as inequities, or lack of equal shares in health and well-being, and to gauge the extent to which they arise from unfair, avoidable, or remediable factors—or, to put it another way, from things that could be changed through corrective measures in the domains of law, policy or programming. However, to arrive at this endpoint, the social determinants framework asks us to examine in depth a number of different elements starting with the social position of individuals or groups that, in itself, has an overall determining influence on levels of better or poor SRH linked to degrees of social advantage or disadvantage. It also asks us to go even deeper to consider how additional factors play a role in individual or group level SRH, including material circumstances (effects of poverty on access to shelter or food, for example); behavioural factors (high risk sexual behaviour, or alcohol or other drug use); psychosocial factors (traumatising effects of verbal or physical violence); social cohesion (impact of isolation from family or from exclusion from social, cultural or religious activities); and, access to and interactions with the health system (experiences of stigma and discrimination from health care workers and their effects on whether or not someone uses health services at all).

The use the social determinants lens, then, can generate a comprehensive and highly nuanced view of what drives SRH outcomes for young key populations, one that goes beyond any single factor such as whether or not individuals use condoms or clean needles. It also allows us to investigate not only differences in health between these groups and their non-key-populations peers, but also differences between and within the groups themselves. Not all gay men or sex workers are the same, evidently. Some will have better SRH than others and it is important to understand why this may be so. Finally, the results of the analysis may point towards a different programme of action than discrete interventions to address SRH risks such as combination prevention for HIV, for example, or harm reduction interventions for drug users, as important as these things are. Rather, it may suggest a broader project of social justice that combines health interventions with other elements, such as changes in law or policy that address material deprivations or other forms of social exclusion, things which may have an equal or greater role in how SRH is experienced by young key populations. It can also suggest ways to empower constituencies themselves to own and transform their health.

Using the social determinants of health lens is not the typical way that the SRH of young key populations has been examined, at least for Zambia. The sections that follow, then, are meant to demonstrate what it can reveal, to the extent that information is available.
They are also meant to show its importance for guiding new efforts to address the current considerable gaps in knowledge and understanding about the SRH of young key populations in the country and what should be done to improve it.

Young key populations in Zambia

Who are young key populations and how are they situated relative to other young people in the country? Some quantitative data on socio-economic status and other social characteristics of young MSM and sex workers give, at least, an indicative picture. For example, there are some data in a 2013 study on issues of HIV prevention for “sexual minority groups,” defined by the researchers as gay men and other MSM, lesbians and other women-having-sex-with-women (WSW), and transgender (Kiefer et al., 2013). In the study, 82% of the 450 respondents were aged 18-to-25 years. With regard to socio-economic characteristics, 72% of study participants had at least some primary or secondary education, and 49.5% of males and 36% of females were currently employed in some form of remunerated work (including being self-employed); 28% of males and 41% of females were students (ibid.). As a comparator across the general population of young people in Zambia, also in 2013, 90% of 20-to-24-year-old males and females had at least some primary or secondary education while 65% of males and 40% of females were currently employed (CSO, 2015). Are there substantive differences here between the groups? These data cannot say but the comparisons suggest how a further analysis could proceed in order to more clearly situate young MSM or WSW within the wider population of young people in Zambia and, moreover, to more clearly know what influence socio-economic characteristics can have, if any, on differences in SRH outcomes.

2 The application of the concept of key populations in Zambia is a once contested and confusing. It is used primarily within the context of its HIV response, which itself is almost exclusively funded by the Global Fund to Fight AIDS, TB and Malaria, and the United States President’s Emergency Plan for AIDS Relief (PEPFAR). These entities generally define key populations as gay, bisexual and other MSM; sex workers of all genders (male, female, transgender); transgender persons; injection drug users; and prison inmates (Global Fund, 2013; PEPFAR, 2016). Only recently, in its guiding documents for the HIV response, has Zambia recognized most of these groups as key populations (male or transgender sex workers, and transgender persons are not yet recognised). At the same time, however, eight other groups have also been so designated but with no explicit reasoning. These are: adolescent girls and young women, young men, migrants, children and pregnant women living with HIV, displaced persons, persons with disabilities, and people aged 50 and over (NAC, 2017).

3 This study has not been formally released in Zambia as the findings were not endorsed by the MOH as they are required to be before dissemination can take place. The study was, however, conducted under an approved research protocol and ethics clearance from the Tropical Diseases Research Centre. The study results are used throughout this analysis for their indicative value even though they do not, as yet, have the status of approved findings for the country.

4 The definition of ‘employment’ in Zambia is broad and includes unpaid work in subsistence farming or domestic settings (CSO, 2015).
With regard to sex workers, there are less data for similar comparisons. In a 2014 study, 41% of the sample was between the ages of 14 and 24 years (Kasongo et al., 2015). Most (89%) of the total study sample indicated that they were not married and lived alone, and 34% earned some form of income outside of sex work. Almost two-thirds (62%) had at least some primary or secondary education. What proportion of the 14-to-24-year-old study participants also shared these characteristics is not known. As a general comparator on marital status, 56% of all young women in Zambia (20-to-24 years) were in some form of union in 2014 and a larger proportion (90%) had some form of education, as noted above (CSO, 2015). What might position young sex workers on the margin of social structures such as marriage, or what might influence lower educational attainment, these data on their own cannot show. As with MSM or WSW, knowing more about these issues is important for understanding more clearly who young sex workers are in Zambia and what they share or don’t share in terms of socio-economic or other characteristics with the broader population of adolescent and young women for the country. Similarly, these may affect or not affect differences in SRH.

There are no similar, quantitative data on other young key populations. There are, however, a range of qualitative sources for all groups that also speak to issues of socio-economic disadvantage. There are many anecdotal accounts of individuals living in poverty as a result of being denied educational opportunities (passed over for educational support within families, for example); of having to leave school because of discrimination and violence; or, of being turned away from employment (Engender Rights Centre for Justice et al., 2017; Hachoonda, 2017; National Alliance of State and Territorial AIDS Directors [NASTAD] Zambia, 2015; Phiri, 2017; Trans Bantu Zambia, 2014). However, whether or not there is more absolute disadvantage for young key populations, given the broader context of poverty and inequality for all young people in Zambia, as noted previously, has yet to be determined. What is important, though, is the extent to which individuals may be pushed to such margins as a result of actions or contexts that are unjust or unfair and to this the analysis turns next.

The drivers of marginalisation and exclusion

Box 1: “An LGBT person was beaten up by some people on suspicion that he was gay. He went to the police to lodge a complaint, and the cops retorted that his type are beaten up because they are men who make themselves women. He left without formally lodging his complaint.”—MSM outreach worker (Hachoonda, 2017)

In all of the accounts of young key populations in Zambia, criminal statues and prevailing socio-cultural beliefs and practices are 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 are only selectively enforced (Hachoonda, 2017; NASTAD Zambia, 2015; Phiri, 2017).
The litany of such effects is long and includes: highly publicised police actions meant to expose perceived criminality and immoral conduct;\(^5\) 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 are deemed to be outside of established (and frequently violently enforced) cultural norms regarding gender (see Box 1); and, bribery and extortion, using the threat of criminal exposure, including between gay or bisexual men themselves, for example (Engender Rights Centre for Justice et al., 2017; Hachoonda, 2017; Meer et al., 2017; NASTAD Zambia, 2015; Phiri, 2017; Scorgie et al., 2012; Trans Bantu Zambia, 2014).

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 (NASTAD Zambia, 2015). ‘Sodomy’ is a major offence in prisons which, while limiting the range of HIV or other SRH interventions that can be implemented for this population, also imposes a heavy institutional silence on the full spectrum of male-male sexual behaviour that occurs in these settings, including sexual coercion and rape (NASTAD Zambia, 2015; Todrys et al., 2011; Telisinghe et al., 2016).

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 (Republic of Zambia, 2016).\(^6\) It continues to be stated by some (if erroneously) that the country’s ethnic traditions are also strongly Christian-based and that homosexuality and other forms of diversity, such as being transgender, are un-Zambian and threaten the integrity and continuity of traditional identity (Phiri, 2017; van Klinken, 2015).

\(^5\) See, for example: https://www.lusakatimes.com/2017/11/23/acts-homosexuality-reported-will-prosecuted-sumaili/

\(^6\) What this aspect of the Constitution means for law, policy and governance is controversial, at least as it is debated in public spaces such as the media. While some Parliamentarians, including Cabinet Ministers, insist that it means that the country is governed by biblical principles, there are more moderate interpretations such as in the Seventh National Development Plan which states that being a Christian nation means that the country will promote and mainstream the values of, “good neighbourliness, honesty, respect for others, accountability, and service to others (Ministry of National Development Planning, 2017).”
Young LGBT individuals, and those adolescents for whom their differences of social identity or sexual practice are still forming, bear the weight of this, particularly in their family and community environments, as well as in their churches, schools and other social institutions (see Box 2) (van Klinken, 2015). Sex workers face similar forms of cultural and social ostracisation, 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 (Butts et al., 2017; McDonald and Aklilu, 2015).

Of all the limiting factors for addressing SRH for young key populations, these are the more difficult to shift. The prominence of religious and cultural leaders at all levels of Zambian society remains strong and strongly endorsed, and their views on key population issues remain firmly negative and punitive. While there are efforts to address this, through peer-led sensitisation interventions, for example, progress is slow and very little substantive change has occurred thus far (Panos Institute for Southern Africa, 2016).

**The sexual and reproductive health of young key populations**

How might the degree of disadvantage, marginalisation or exclusion faced by young key populations be related to their SRH outcomes, both on their own and in comparison with their non-key-population peers? Data on these trends are few but what is available suggests much poorer SRH outcomes. The 2013 study on sexual minorities, noted above, found the following HIV prevalence rates for young MSM and WSW, as shown in Figure 1, on the next page.

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For a recent example, see: See this recent example: https://www.daily-mail.co.zm/clandestine-homosexuality-meetings-worrying/
As the figures indicate, there were substantial differences in HIV prevalence between younger versus older age groups for both males and females. The large jump in prevalence between the age groups is disturbing and is something that the study did not explore. By contrast, population-wide HIV prevalence for similar age groups in 2013 was much lower where it was 4.1% and 7.3% for adolescent (15-19 years) and young (20-24 years) males, respectively, and 4.8% and 11.2% for adolescent and young females (CSO, 2015). While there was a similar jump in prevalence between age groups for all females (a more than 100% increase in both cases), it was more pronounced for MSM than for other males.

In 2014, the burden of HIV amongst young sex workers was substantial (Kasongo et al., 2015). Figure 2, below, shows the distribution of HIV prevalence across the five data collection sites for the study. It also shows rates for other sexually transmitted infections.

**Figure 2: Prevalence of HIV, Syphilis and Trichomonas Vaginalis among Young Female Sex Workers (age 14-24) in Five Hot Spot Towns Zambia, by site (n=491) (Kasongo et al., 2015)**
It is disturbing to note that HIV prevalence reached as high as 53.6%, and prevalence for syphilis 32.8%. 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 speak 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, is almost non-existent. While, for example, the Ministry of Health’s Adolescent Health Strategy 2017-2021 quotes data from the Drug Enforcement Commission regarding increases in the range and quantities of drugs seized in the country, and makes claims that adolescents and young people are increasingly affected by drugs, no data are provided to substantiate them (MOH, 2017a). As for transgender youth and young people in prison, there are no quantitative data on SRH indicators. In their personal accounts, however, transgender youth describe poor SRH, including untreated HIV infection or STIs, and other reproductive health concerns (Trans Bantu Zambia, 2014; Hachoonda, 2017). For young prisoners, while there are no specific data on their SRH, there is some information on their SRH risks which is discussed in the next section.

**Determinants of poor sexual and reproductive health**

What can account for what appear to be substantial differences in SRH outcomes, at least between young LGBT or sex workers and other adolescents or young people? There is some information about a number of factors or determinants and how they may increase vulnerability to poorer SRH outcomes. This includes how they overlap or intersect to increase the magnitude of their negative effects. Amongst younger MSM, for example, exchanging sex for money or other material benefits from older partners is said to be a main feature of their sexual culture (see Box 3) (Kiefer et al., 2013; Population Council, 2017a). Alleviating poverty is one reason for this practice. When this is placed in the context of limited access to information about risk for HIV or other STIs arising from male-male sexual contact (see Box 4);
the fact that older MSM are more likely to be living with HIV; and, the potentially coercive power dynamics inherent in such forms of economic exchange, the potential link becomes clearer between elevated risk for poor SRH, and a range of inter-acting and overlapping determinants. These include material circumstances (poverty), behavioural factors (low condom use), psycho-social factors (the impact of coercion or sexual violence, for example), and limited or no access to important health information.

**Box 5:** “The reason mainly is poor status of living and sometimes, it causes some girls to involve themselves in having many men [sexual partners] so that they can provide them with money. They say ‘Use what you have in order to get what you want’. So they sell themselves in order to survive.”—Young woman, Ndola (Butts et al., 2017)

For young sex workers, a similar analysis can be made but with different intersectional relationships between determinants and elevated SRH risks. Women, particularly young women, are generally poorer than their male peers in Zambia as a result of lower educational attainment, lower labour force participation, and a range of socio-cultural norms and practices that position them as inferior to men in social value, agency and autonomy (Butts et al., 2017; CSO, 2015; UNDP, 2017; UNICEF, n.d.). While for some sex workers these constitute ‘push factors,’ for younger sex workers the influence of poverty and inequality as a pathway to sex work is greater (see **Box 5**) (Butts et al., 2017; Kasongo et al., 2015; Population Council, 2017b; Southern African AIDS Trust [SAT] Zambia, 2015). Such inequalities shape the power dynamics of transactions in sex work and affect whether or not condoms are used, for example (see **Box 6**) (Butts et al., 2017). Socio-cultural norms attached to women and sexuality also shape the dynamics of private relationships for sex workers where, for example, condom use with intimate partners is even lower (Kasongo et al., 2015; Population Council, 2017b). Finally, such inequalities also affect risk for physical and sexual violence and abuse, from clients, intimate partners, men in communities and the police, amongst others, particularly where young women involved in sex work are considered to have little to no moral or social value (Butts et al., 2017; Population Council, 2017a, b; SAT Zambia, 2015).

**Box 6:** “Unprotected sex is more expensive than protected sex, hence we resort to have unprotected sex in an effort to acquire more money.”—Young sex worker, Lusaka (Butts et al., 2017)

One final example from prisons is given highlighting the aspect of material conditions, particularly access to food, as a determinant of SRH risk. Although against the law in Zambia, older adolescents are incarcerated with adults (Todrys et al., 2011; Topp et al., 2016).
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 (Kumwenda, Nzala, Zulu, 2017; Telisinghe et al., 2016). **Box 7** gives an indication about what these risks can entail.

**The role of the health system**

Within the social determinants of health framework, the health system plays an important mediating role between elevated risks for poor SRH outcomes and such outcomes themselves (WHO, 2010). Regardless of the complex web of SRH risks and determinants an individual may encounter, for example, access to health services may significantly mitigate against poor SRH. At an overall level for young key population groups, such as MSM, sex workers or drug users, although it may be difficult to control or overcome their circumstances of SRH risk, the provision of pre-exposure prophylaxis, MSM or sex worker ‘friendly’ clinics, targeted outreach programmes, or harm reduction interventions, can still reduce the potential for negative SRH outcomes (Delany-Moretlwe et al., 2015).

![Box 8: “We need ...to build our capacity... on how to counsel and attend to... MSMs... because I’ll share this... immediately somebody walks in and then everybody knows that this is an MSM and because of the laws in the country and the beliefs and the cultures and everything it becomes a big challenge... on how to handle MSMs.”—Nurse (Population Council, 2017a)](image)

As a general feature of the situation in Zambia, the role of the health system to mediate against poor SRH for young key populations is very limited (Hachoonda, 2017; Population Council, 2017a). This arises from the context surrounding these groups and how it affects, on the one hand, what health care providers think and do when a young MSM or sex worker seeks their assistance (see **Box 8**), and, on the other, what these same young people anticipate and frequently avoid in terms of breaches of privacy, or exposure to ridicule or other abuse that deems them (ibid.). For example, health care providers (mainly nurses) have described two factors that affect how they provide or do not provide care to young MSM, transgender, sex workers, or drug users (Population Council, 2017a). The first is a fear of doing harm (which is sometimes legitimate and sometimes not) when they are faced with clinical conditions that they have not treated before (anal STIs, a request for hormones, help managing drug addiction, or the need to assist with injuries arising from sexual assault for lesbian or transgender youth, for example). As a result, individuals do not provide needed care, although in too many instances this is done in highly inappropriate and abusive ways (Hachoonda, 2017; Keifer et al., 2013; Population Council, 2017a; Southern African Litigation Centre [SALC], 2016; ).

The second reason is less straightforward and has to do with what, in the view of health care providers, constitutes professionalism and their broader social roles in regards to young people, particularly for those working in smaller communities (Warenius et al., 2006).
Nurses and other providers, for example, can ascribe to themselves, or have ascribed to them, a moral purpose linked to their social position within communities. Healthy behaviour for young people should arise from allegiance to Christian values and, where this is not the case, health care providers give themselves the role to condemn such things (SALC, 2016; Warenius et al., 2006). Moral correction is considered to be a legitimate part of clinical care, not only for key populations, but for adolescents and young people as a whole (MOH, 2017a). This is a situation of dual loyalties which, in the accounts of some providers, causes conflict and stress (SALC, 2016; Warenius et al., 2006). Another aspect of this divided loyalty is a self-perceived responsibility (if erroneous under the legal and regulatory framework governing health professionals in Zambia) to report instances of suspected criminal behaviour or, again, to act as strong deterrents, particularly for their younger patients (see Box 9) (Population Council, 2017a; SALC, 2016).

It is no wonder, then, that there are numerous accounts of negative experiences for individuals from key population groups about their interactions with health care providers and that the mediating role of the health system to reduce their SRH risk does not function (Hachoonda, 2017; Kasongo et al., 2015; Keiffer et al., 2013; Population Council, 2017a; Trans Bantu Zambia, 2014). The personal impacts of ridicule and abuse are far-reaching in these accounts and are indeed magnified by the inherent nature of the vulnerability of all patients in health care encounters (see Box 10). The injury to self-esteem from public humiliation and abuse in a health facility, and the consequences of breaches of privacy to parents or family members, have deep ramifications for some and result in subsequent avoidance of the health system altogether (Box 11). It is not all health care providers that behave in such ways (there is a preference for private sector providers, for example, who clearly have other incentives to provide the services that their patients request), nor is it all young people from key populations that have such negative experiences (the limited quantitative data suggest this but without offering any deeper analysis as to why this is the case).

**Box 9:** “So some of the laws I think they really need to look at them... because they are really affecting our organization.....we might be ... misunderstood by the law makers... because we are seen helping these people they'll think we are promoting, we are encouraging [the behavior].”-- Nurse (Population Council, 2017a)

**Box 10:** “That is the front page of my most recent file. He [the doctor] wasn't supposed to write stuff about my sexual orientation because he knew very well that the file was going to be checked out by everyone including student nurses as I was in the emergency medical ward at this time.”—Young MSM (Hachoonda, 2017)

**Box 11:** “We shun those places [health centres]. You are afraid of telling them ‘Okay look excuse me I took drugs. Please help me I'm dying....’ They would actually call the cops, because that patient and doctor confidentiality isn't there.”—Young female drug user (Population Council, 2017a)
Nevertheless, such challenges for the fulfilment of the role of the health system in mediating SRH risk and in influencing SRH outcomes for young key populations call out for further analysis if not for overall redress.

What does the analysis tell us about what we should do?

As already noted, an important feature of the social determinants of health lens is its ability to clarify the complex aetiology of inequities in health outcomes, especially for disadvantaged or marginalised groups. It positions such inequities as more than just technical issues, lack of appropriate understanding or diagnosis of health needs, for example, or lack of access or availability of needed services. Rather, they become issues of social justice in that they constitute lack of equal shares of health or well-being in comparison to others, a situation that arises because of unfair or unjust factors. As the analysis has attempted to show, such is the case for young key populations in Zambia, at least to the extent that some form of evidence is available.

The point of such analysis, however, is also to indicate what might be done in relation to these determinants to alleviate or remove these inequities. The approach gives us options in terms of the type of instrument or modality of intervention (a change in law, a new policy, a new health or social programme) as well as for the level of intervention (individual, community, institutional, or national, for example) (WHO, 2010). In this regard, it is encouraging to note that things are changing for some young key population groups in Zambia in that there are activities either underway or planned that are addressing some of the determinants of poor SRH.

Examples of efforts in the domains of law and policy include:

- The NASF 2017-2021 which, in addition to naming key populations in the guiding policy document for the HIV response, places an emphasis on the principles of human rights, non-discrimination and inclusion, and lays out a range of strategies to address stigma, discrimination and violence against key population groups; to improve the law and policy context; and, to extend competent service provision through targeted interventions, and through efforts across the health sector as a whole (NAC, 2017).

- The undertaking of an HIV-related legal environmental assessment, jointly led by UNDP and NAC, with a specific component on adolescent and young key populations. The process is led by a National Key Populations Steering Committee and has the aim of identifying law and policy-related barriers to HIV programming as well as opportunities for change.
It is a participatory process and the consultations held in different parts of the country have been important opportunities to table challenges for key population groups in local settings, including, for example, police harassment and abuse (Mushota-Nkata, 2016a, b).

- The implementation of the Zambia component of the UNDP-led Sexual Orientation and Gender Identity and Rights (SOGIR) project. Amongst other activities, the project supported stakeholder dialogues, both within LGBT constituencies and amongst a broader stakeholder group (including senior government representatives), regarding sexual orientation and gender identity issues in Zambia and how to shift the law and policy context towards greater recognition and protection for individuals on these grounds. The project has closed with the issuing of a comprehensive report and recommendations (HachoonDA, 2017). However, it is not clear who now takes up this agenda for change.

- The participation of government representatives in the process to develop the SADC regional key populations strategy and its subsequent endorsement by the Minister of Health (SADC, 2017).

Some examples of efforts in the domains of programmes include:

- The Zambia Open Doors project, funded through PEPFAR, which, in partnership with local entities such as the Planned Parenthood Association of Zambia, is working to increase access to HIV services for key populations, including young key populations, in five locations country-wide. A component of the project is the launch of key-population-focused SRH services through two weekend clinics located in Lusaka and Livingstone. The Lusaka clinic operates from the University Teaching Hospital, a Ministry of Health facility, an encouraging sign of growing, if tacit, government support for this type of service provision (PEPFAR, 2017).

- The Centre for Infectious Diseases Research Zambia (CIDRZ) has begun a two-year project funded by the Elton John Foundation to implement interventions for young prisoners. The project will support youth-friendly health and social services, access to legal services, and advocacy for judicial reform to reduce time in detention without trial, amongst other priorities.⁹

⁹ See: http://www.cidrz.org/new-grant-elton-john-aids-foundation-awards-cidrz-a-750000-grant/
Under the recently concluded Global Fund grant for the 2015-2017 period, a number of LGBT entities received funds to undertake community level interventions on HIV prevention which primarily targeted young key populations. Under the new Global Fund grant, for the 2018-2020 period, sex workers, MSM and prisoners are prioritised under the key population component (Zambia CCM, 2017).

ICAP, with support from PEPFAR, has recently announced its intention to conduct a series country-wide integrated bio-behavioural and sero-prevalence (IBBS) surveys for key populations, beginning with MSM in 2018 pending ethics approval, and the endorsements of the MOH and the National Health Research Authority.

Finally, although not a current or planned intervention, the SIDA-funded “Emerging Voices” project, implemented through the SAT Zambia in Chapata District between 2012-2015, supported tailored packages for young sex workers that were implemented through district health facilities and bolstered by important sensitisation work with local officials, the police, health care workers and others (Zulu et al., 2015). The service package was designed to address SRH needs and the numerous barriers for young sex workers to access these services, including stigma and discrimination, police harassment, and gender-based violence. The project is now closed but demonstrated the feasibility and acceptability of integrating services for young sex workers within local public health facilities.

Clearly things are on the move for young key populations in Zambia. With facilitation from NAC, key population constituencies are becoming more active and visible. While there has for some time been a growing and increasingly well-structured LGBT constituency in Zambia, which has stayed away from public notice for evident reasons, this is now beginning to change (Phiri, 2017). Some gaps still remain, however. Programmes are expanding faster than substantive law or policy change. All are externally funded and are operating mostly as stand-alone programmes outside of the public health sector. Some groups are not yet included in these efforts, such as drug users, young transgender men or women, or lesbians and bisexual women. There is very little attention to social health determinants, such as poverty reduction, reducing discrimination in education or employment, or reducing physical or sexual violence, for example. Aside from the CIDRZ project, no other efforts specifically include the needs of older adolescents aged 15-17 years.10

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10 Muller and colleagues (2018) have mapped how adolescents from key populations, in Zambia and elsewhere, are excluded in multiple ways from SRH programmes targeting their older peers, including those programmes that are key-population-led themselves.
There may be other challenges moving forward. Without changes to the larger context, which remains heavily negative in Zambia, uptake and retention in new programmes may be low as individuals will still anticipate too much risk to them in coming forward.

Lack of understanding or recognition of social health determinants may also limit their effectiveness. Individual motivation to use services, and to remain in them (HIV treatment, for example) may be affected by lack of self-esteem or self-stigma, a consequence of traumatic experience or of the difficult daily burden of social isolation (Delany-Moretliwe et al., 2015).

What may occur, then, is the development and implementation of needed programmes that have limited ability to mitigate SRH inequities because they do not take account of, or are not sufficiently complemented by, programme components addressing these other health determinants.

CONCLUSIONS AND AREAS FOR FURTHER RESEARCH

The growing attention to the SRH of young key populations in Zambia is both appropriate and necessary. However, for this work to unfold on firmer ground a deeper analysis is needed, one that is derived from a more comprehensive body of evidence. The social determinants of health can provide an organising framework for this work in terms of pointing out what the priorities for further analysis should be and, subsequently, what actions should be taken once the extent of SRH inequities for young key population is more clearly known. If even some of the tentative conclusions of this analysis are confirmed through this additional work, for example, more will be needed to achieve SRH equity than SRH services, as well designed and as well intentioned as these current efforts may be.

These are some research priorities than can move this work forward:

- **Describe young key populations in Zambia**—There are no comprehensive descriptions of young key populations in Zambia, in all of their diversity. There is a growing continental literature to show that identities are layered and more continuous than the current key populations categories would suggest (Poku, Esom, Armstrong, 2017). There is a need to evolve a more nuanced way of framing disadvantage or marginalisation for young people. A ‘ground up’ analysis for Zambia is a critical first step.

- **Describe SRH inequities**—As presented in the analysis, there are some data for HIV and other STIs. However, a much broader spectrum of data is needed that is specific to young key population groupings however these are subsequently defined for Zambia.

- **Identify the social determinants of the inequities**—The analysis has sketched what some of these determinants may be but more in depth investigation is needed.
- **Describe the contribution of these inequities to broader SRH trends for young people**—The analysis should probe, for example, the extent to which the current gap in HIV treatment for young people is made up of young people from key population groups without access to such services, or of those that are highly reluctant to use them (MOH, 2017c).

- **Document current programmes and investments and calculate what they achieve**—It is important to understand what works and what does not work. It is also important to understand issues of value-for-money.

- **Propose laws, policies or programmes, and needed investments, to address the determinants and to reduce or resolve the inequities.** A more comprehensive body of evidence will lead to the identification of what is needed, individually and in combination, in the different domains of law, policy and programming, to improve the SRH of young key populations and to contribute to improved SRH for all adolescents or young people.

Why should these additional efforts matter? It is important to keep in mind the rationale for the social determinants of health approach and the importance of understanding and resolving health inequities:

*The reduction of inequity is a common goal, not only desirable from an ethical standpoint, but also from a practical standpoint. If certain population subgroups continue to be underserved by the health system and suffer a disproportionate burden of morbidity, this endangers the well-being of a society at large and, in some situations, even holds back health progress for the most advantaged* (WHO, 2010).

As an illustration of this imperative, currently, in Zambia, complications arising from advanced HIV infection is the leading cause of death for all adolescents and young people aged 10-24 years (Patton et al., 2016). 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 analysis 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; however, it is surely one of the more urgent.
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