ZIMBABWE

Baseline report on young key populations and sexual and reproductive health and rights
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EXECUTIVE SUMMARY

- The punitive legislative context of Zimbabwe amplifies vulnerabilities of key population members in very particular ways. In an environment where homosexuality and sex work is criminalised, there is opportunity for impunity from rape, bullying and coercion resulting in unprotected sex, and sexual harassment, with perpetrators shielded by the silence of survivors who fear arrest should they report illegal activities.

- The widespread and deepening levels of poverty in Zimbabwe has catalysed a shift in the shape of the sex trade, with sex work becoming less formalised with the emergence of different forms of transactional sex, and interactions between sex workers and clients becoming more risky. Transactional sex is a phenomenon observed throughout Zimbabwe amongst young men and women situated in a variety of contexts.

- Female sex workers currently receive the most attention in terms of research focus, funding, health services and policy, and indications are that improvements are being seen in levels of harassment and access to services. However, the focus has been predominantly on their sexual health with little known about their reproductive health. Also, the increasing presence of the diverse population of sex workers, including male sex workers, is currently a gap in policy and programme attention in Zimbabwe.

- Sexual orientation is often at odds with sexual practices and gender roles in a context of sexual exchange driven by economic need. In a climate of economic lack, higher payment and higher numbers of sex work clients - and not risk of exposure - are the primary concern. Hegemonic masculinities and submissive femininities characteristic of the traditional ‘spousal’ roles have strongly shaped expectations of conduct in not only heterosexual, but also homosexual, relationships. Needing to fulfil the role of the “male provider” influences sexual risk behaviour.

- Zimbabwe has a generalised HIV epidemic within which concentrated sub-epidemics exist. The high degree of overlap between the traditional ‘concentrated’ YKP sexual networks and those of the general population makes a strong case for focus on the SRH needs of key populations and targeted interventions. The most at risk population sub groups as well as the geographical spaces of risk remains to be determined.

- Unemployment, poverty, lack of recreational facilities/activities and peer pressure are important drivers of alcohol and drug use leading to unprotected sex. Stress related to an occupation with no legal protections and experiences of stigma and violence is also linked to substance abuse resulting in unprotected sex.
Lesbians, gays, bisexuals and transgender people and sex workers continue to face high levels of stigma and discrimination from both family and community members. The social rejection from family members shapes sexual risk dynamics for these groups negatively. High rates of stigma and lack of understanding of the SRH needs of YKP at health service level are key barriers to care.

Vague and contradictory age of consent laws are used as reason to deny health and related services – and a combination of young age, sexual identity and/or orientation and being a sex worker greatly compounded barriers to access and utilisation of SRH services. There are indications that self and/or peer diagnosis and peer prescribed remedies for SRH ailments is common practice amongst YKPs – as a way to avoid prohibitive cost of services, distance to clinics, and health care provider negative attitude.

**Research agenda**

The baseline review has highlighted several research gaps. While there has been focus on the sexual health of female sex workers, very little attention has been paid to their reproductive health. Little is known about the drivers and rates of unintended pregnancy amongst FSWs and unsafe abortion, which were reported anecdotally in the baseline interviews. Given the highly restricted conditions under which an abortion is allowed in Zimbabwe, safe termination of pregnancy services will not be an option for FSWs, who will resort to clandestine and often unsafe services.

**Proposed research questions**

What are the reproductive health needs of young women who sell sex (YWSS) and how are the needs of the group being met?

- What is the extent of unintended pregnancy and abortion amongst young and adult FSWs?
- How do the RH needs of YWSS differ from adult FSWs?
- What are the determinants of unintended pregnancies amongst YWSS and what are the reproductive health consequences for YWSS?
- What is the demand for contraceptive services and commodities amongst YWSS?
- What are the economic, societal and health consequences of unintended pregnancy for YWSS?
- What are the out of pocket costs for contraceptive commodities and services?
- To what extent are the reproductive health needs of YWSS being prioritised in Zimbabwe and why?

The baseline also revealed a number of other research priorities. These include the following: **The characterisation of young key populations is crucial.** Sex work may contribute significantly to onward HIV transmission in regions with high HIV prevalence.
However, the full diversity of individuals engaged in sex for material or economic exchange and their sexual networks, SRH vulnerability and risk behaviours merit further exploration. Further, the binary categories of YKPs are artificial constructs given the clear intersectionality between YKP groupings. The overlapping of these identities and experiences are important to understand because they will fundamentally shape SRH outcomes and service needs.

**There is need to identify the most at risk key population sub groups.** The shifting nature of the most at risk key population sub groups temporally needs to be better understood. The dynamics of age, changes in sexual behaviour (and ‘high risk’ occupation) over time add to the complexity of identifying the most at risk individuals. Further, questions remain around whether the location or features of the environment should carry more weight in terms of determining most at risk populations rather than sexual behaviour or ‘high risk’ occupation.

**Better understanding of YKP support networks is required.** Given the high rates of stigma experienced by many YKP in Zimbabwe and indications of how this shapes risk behaviour, it is important to understand how YKP communication and social support networks positively or negative influence their behaviour and well being with a view to intervention design.

*Additional research questions*

- What is the multiplicity and particularity of SRH risk and vulnerability amongst YKPs in Zimbabwe and what are the implications for their SRH outcomes?
- To what extent does identifying with a sexual or gender minority, profession, or addiction increase vulnerability and what strategies do YKPs employ to mediate this vulnerability?
- To what extent is sex for economic exchange a temporary or long-term occupation amongst young sex workers?
- How different are young SWs from older SWs in terms of sexual practices, risk dynamics and SRH needs?
- What are the forms of sex for economic exchange and what are the associated risk differentials?
- To what extent do local identities and practices align with global agency definitions of YKPs?
- To what extent are sexual and social practices seen as separate or the same as social identity?
- How do gendered relationships within YKPs relationships manifest and how does these gendered roles render some more resilient and others more vulnerable to poor SRH?
- What are the individual, interpersonal and sexual network characteristics, community, health service and policy-level that increase or decrease risk of poor SRH outcomes amongst YKPs?
- What kind of intersectoral action is required to address the complexities of the socio-political, economic and cultural landscape that poses harm to YKPs?
INTRODUCTION

The benefits to protecting the sexual and reproductive health and rights (SRHR) of all individuals extends well beyond individual level health and well-being; it is an economic investment. Better sexual and reproductive health (SRH) has been shown to decrease healthcare expenses, improve productivity, and increase levels of educational attainment – all of which contribute fundamentally to a strong economic workforce. Zimbabwe is a country with significant human and natural resources and strong long-term growth prospects (World Bank 2017)\(^1\) and young people, who make up more than half the population, are key to realising this future. However, Zimbabwe’s SRH indicators are poor (ZIMSTAT 2015), with a maternal mortality ratio estimated to be 651 deaths per 100,000 live births\(^2\). HIV and AIDS remains the greatest health challenge facing the health sector, with young people most affected, and despite progress in the roll out of PMTCT is currently the leading cause of death in the country.

Given the favourable long term outlook, why then are Zimbabwe’s current health indicators – which are preventable - so poor? The social determinants of health framework conceptualises how the political, economic and social (structural) context can profoundly shape population level health outcomes by situating individuals differentially in terms of socioeconomic position in a given society, which in turn determines an individual’s level of access to education, employment, as well as financial and social resources (Solar and Irwin, 2010). Socioeconomic position bears enormous influence on an individual’s material circumstances, risk exposure and behaviours, and biological and psychosocial vulnerabilities. Based on socioeconomic position, inequities will arise in ability to access appropriate health care and this will be most strongly felt in the context of weak health systems and resource constrained settings (Solar and Irwin, 2010).

The shift in the political context in Zimbabwe has coincided with the increased prioritisation of key populations\(^3\) - and young key populations (YKP) - as part of the HIV response, with multilateral organisations and key funding mechanisms providing impetus and resources\(^4\).


\[^2\] Adult and maternal mortality indicators can be used to assess the health status of a population.

\[^3\] Key populations include sex workers of all genders, men who have sex with men (MSM), women who have sex with women (WSW), people who inject drugs (PWID), intersex and transgender people and prisoners.

\[^4\] This is in a large part due to the impetus of multilateral organisations and key funding mechanisms. A KP-targeted Global Fund grant has recently been awarded to Zimbabwe; PEPFAR Zimbabwe’s COP17 identifies young women who sell sex as a key programmatic priority, the Dutch Ministry has been active with partners like AidsFonds and International HIV/AIDS Alliance in strengthening advocacy skills and promoting evidence based practices (PITCH programme). The Dutch Ministry are also supporting a large multi country project being carried out by UNDP, AMSHeR and HEARD aimed to improve SRHR policy and programming for young key populations and which this baseline responds to. Following the award of the GF grant, multilateral organisations such as UNFPA have been contracted and SSRs have identified organisations who work in the area of KPs. The National
In preparation for the next generation research to inform policy and health services response for young key populations in Zimbabwe, this paper provides a baseline review of the SRHR situation of key populations with a particular focus on YKPs. The review consists of primary and second data emanating from a desktop review of published and grey literature, and relevant policies and plans, as well as qualitative data generated from extensive in-country discussions with high-level stakeholders and key population representatives. Adopting a social determinants of health lens - thereby viewing health as a social phenomenon – this paper offers an analysis of the ways that the structural and intermediary determinants of health are shaping vulnerability to poor SRH outcomes amongst different (young) key population groups. In doing so, the paper presents the rationale for the YKP SRHR research priorities in Zimbabwe.

BASELINE FINDINGS

Structural determinants of health: the socio-economic and political context

According to the social determinants of health framework, the structural context positions different individuals in different ways; for example, law and policy, socioeconomic status, the cultural context and societal values can marginalise some and privilege others by shaping access to education and health, employment opportunity, income and social class and status in their society (Solar and Irwin, 2010). The following section examines the political, economic and social environment for YKPs, and for young people more broadly, in Zimbabwe and the ways that this structural context shapes SRH outcomes.

Together with long standing political challenges, the economy of Zimbabwe has been in decline for nearly two decades, with deepening contexts of poverty for households and with one fifth of the population currently living in extreme poverty (World Bank 2015). Levels of poverty are worse in rural areas of the country and are where 67% of the population are located (World Bank 2017). Socioeconomic position, including social class and gender, can fundamentally shape SRH outcomes. For example, women living in poverty in Zimbabwe have higher numbers of children (5.6 vs 2.4 children) who are more closely spaced together (38.4 vs 51 months) and experience earlier age at first birth (19.2 versus 22.2 years) than women of higher socioeconomic status (Zimbabwe Demographic and Health Survey 2015). They are also likely to be less educated.

AIDS Council (NAC) now has a specific staff member responsible for KP work. However, currently the Ministry of Health and Child Care and the National AIDS Council are the lone State-level drivers of key population issues in Zimbabwe.
Young people are particularly vulnerable to the constrained socioeconomic environment; adolescent girls (15-19 years) in the lowest wealth quintiles in Zimbabwe are almost six times more likely to have started childbearing than their peers living in the highest wealth quintiles (34% versus 6% respectively), with subsequent negative impacts on their schooling trajectory.

Educational qualification is positively associated with a host of good population health and SRH outcomes (Sommer et al., 2015, Chaaban, 2011, Rihani, 2006, Sommer, 2017, UNICEF, 2004). This is, in part, reflected in Zimbabwe’s HIV indicators with higher HIV prevalence amongst those with less than a secondary education versus those with a secondary education or more (ZIMPHIA 2016). However, while long-term investment in education\(^5\) has result in high educational attainment amongst the general population - for both males and females (Zimbabwe Demographic and Health Survey 2015), the expansion of educational attainment has outpaced the growth of formal sector employment opportunities which means unemployment is also high (Osirim, 2003). The high rates of unemployment has resulted in many citizens being informally employed which means they do not benefit from the protections offered through formal employment, such as health insurance or paid leave, and therefore experience inequities in access to quality healthcare.

**Legislative and policy environment**

There are no clear legal frameworks or legal protections for young key populations in Zimbabwe (Meer et al., 2017, Zimbabwe Ministry of Health and Child Care & the National AIDS Council, 2017).\(^6\) Although there has been recent policy attention to including (young) key populations in health planning, the legislative framework for key populations, in general, remains punitive. There are also some inconsistencies and gaps in the age of consent laws in Zimbabwe which makes age of consent laws difficult to interpret and apply. Vague laws are reportedly used as reason to deny health and related services by some health care providers. However, there is also evidence of effort to bridge these gaps in practice through various policy and guideline documents. The following section provides a brief overview of the specific legislative, policy and age of consent laws affecting young key populations.

All people under 18 years are considered ‘minors’ in Zimbabwe (Children’s Act, General Law Amendment Act). Age of consent for sexual activity differs between married minors and unmarried minors. For unmarried minors, age of consent is 16 years for males and females; sex with a child under 12 years is classed as statutory rape and a criminal offence.

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\(^5\) Zimbabwe spends more on education as a share of GDP than any other country in Sub-Saharan Africa.

\(^6\) Section 56 of the Constitution of Zimbabwe states that “all persons are equal before the law and have the right to equal protection and benefit of the law” and that “every person has the right not to be treated in an unfairly discriminatory manner on such grounds as their... sex, gender...or social status” and this is reportedly often cited by advocates of KP rights, in the absence of other protections (Moyo et al 2016).
It is less clear regarding provisions for sexual activity between individuals aged 13-15 years; sex with a person aged 13 and 14 years is regarded as rape unless there is evidence that the participating minor consented and was capable of consenting. No provision exists for sex with a person aged 15 years although it is prohibited under the provisions of Section 70 in The Criminal Law Act (Southern African AIDS Trust). For married people, age of consent for sex is 12 years although there are reportedly plans raise the age to 16 years (Southern African AIDS Trust). Sexual activity between young persons who are both younger than 16 years but older than 12 years is only an offence if a probation officer makes the recommendation for the couple to be charged.

Same sex marriages are prohibited and sex between men is criminalised, but not between women (Section 73 of the Zimbabwean Penal Code). Consensual sex between male adolescents above 16 years is classed as an ‘indecent act’. However, only men over 14 years can be charged with the offence (Southern African AIDS Trust).

Solicitation for the purposes of prostitution is considered a criminal offence in Zimbabwe (Criminal Law (Codification and Reform) Act (Chapter 09:23) 2005). In particular, the ‘loitering for the purpose of prostitution’ provision in the Criminal Law Act has historically been frequently invoked if a non-conforming individual or woman is seen walking alone or in a group. In 2015 the Zimbabwe Lawyers for Human Rights (ZLHR) were instrumental in having the conviction of nine women who were arrested for solicitation overturned resulting in positive changes in police practice and fewer arbitrary arrests of FSWs (Busza et al., 2017). However, it is not known if this has changed the situation for gay sex workers. There are particular protections for youth related to sex work where it is considered an offence “if the owner of a place knowingly induces or allows a young person to enter or be in the place for the purposes of engaging in unlawful sexual conduct with another person or with other persons generally, the owner shall be guilty of permitting a young person to resort to a place for the purpose of engaging in unlawful sexual conduct” (s86). According to section 87, allowing a child (under 18 years of age) to “associate with or to be employed by any prostitute as a prostitute or to reside in a brothel” is also considered an offence. This raises questions around the living arrangements of children of sex workers and the extent that this legislation is enforced.

In terms of legislative and policy environment related to accessing SRH services, all citizens and permanent residents have the right to access basic healthcare services, including reproductive health services (Constitution of Zimbabwe 2013). However, age of consent requirements hamper access to SRH services and commodities for YKPs. Termination of pregnancy is highly restricted and only permitted on the following grounds: to save the life of the woman, to preserve physical health, rape or incest, foetal impairment. There are additional procedural barriers to accessing an abortion; unless the woman’s life is in danger, two clinicians must first certify that the medical condition exists.
There is no legislation that specifies age of minor where parental consent is required for medical treatment (Southern African AIDS Trust). In practice, parental consent to receive medical treatment is required for persons under 16 years and pharmacies require parents/guardians to be present before they will dispense medication to a child under 16 years (Southern African AIDS Trust).

Minors over 16 years can access contraceptives without parental consent and contraceptives are reportedly made available without need for a prescription or parental consent through a public sector initiative for minors between 16 and 18 years of age (Southern African AIDS Trust). Minors under 16 years face difficulty in accessing contraception given that minors under 16 years “cannot consent to sexual intercourse in practice, it is presumed that a child under the age of 16 year does not need contraceptives” (Southern African AIDS Trust). Condoms and other barrier contraceptive methods are available without parental consent. Emergency contraception is viewed as a medical treatment and subject to the Medicines and Allied Substances Control Regulations, 1991 which prohibits the sale of medication to anyone under 16 years unless accompanied by written parental consent (in the case of household remedy or a medicine listed in part I of the Twelfth Schedule) or a written prescription from a medical or dental practitioner. Section 76 of the Children’s Act gives power to a magistrate to consent to medical treatment on the behalf of child in cases that they parents cannot be found or are refusing consent on unreasonable grounds.

Transmission of sexual infection or deliberate transmission of HIV is criminalised under The Criminal Law Code Act Chapter 9:23. The Zimbabwe National Guidelines on HIV Testing and Counselling (2014) and the Guidelines for Antiretroviral Therapy for the Prevention and Treatment of HIV in Zimbabwe (2016) create an enabling environment for access to HIV testing and receipt of antiretroviral treatment. No parental consent is required for HIV testing if a minor is 16 years and above, or married, pregnant or a parent. Parental consent is required if the individuals is below 16 years excepting if they are a mature minor “who can demonstrate that he or she is mature enough to make a decision on their own. The ‘best interests of the child’ principle is endorsed by these guidelines which provides room for medical providers to act in the interest of the child without parental consent.

The increased attention to key populations in Zimbabwe is reflected in a number of recent national documents. Zimbabwe’s extended National HIV and AIDS Strategic Plan 2015-2020 (ZNASP III) now identifies four main key population groups; “gay men and other men who have sex with men, sex workers and their clients, transgender people and people who inject drugs” (Zimbabwe Ministry of Health and Child Care & the National AIDS Council, 2017).
Prisoners and people with disabilities are also acknowledged as being vulnerable to HIV and lacking access to services. Further, the country’s new Adolescent Sexual and Reproductive Health Strategy (2016-2020) (MoHCC and NAC, 2016) expressly aims to target specific vulnerable groups, including adolescents and young girls engaged in sex work as well as adolescent inmates, among others (MoHCC and NAC, 2016). However, the Strategy has come under criticism for being based on culturally acceptable and politically correct sexual reproductive health practices and remains silent on the addressing the SRH issues specific to YKP as well as issues of sexual orientation and choice. There are no laws or policies that provide for hormonal treatment for transgender people and no provision in the Births and Death Registration Act to change gender markers. The diagnosis and treatment of anal STIs is not included in the National Guidelines on STIs.

The following section identifies key pathways arising out of the current political, economic, and social environment for increased risk of exposure to poor SRH, including HIV, for young people, and YKPs in particular.

Punitive legal context

The punitive legislative context of Zimbabwe amplifies vulnerabilities of key population members in very particular ways. Interviews with key informants pointed to harassment and the perpetration of violence against key population groups by those within their own community and those in the broader community. In an environment where homosexuality and sex work is criminalised, there is opportunity for impunity from rape, bullying and coercion resulting in unprotected sex, and sexual harassment, with perpetrators shielded by the silence of survivors who fear arrest should they report illegal activities. Various forms of sexual violence were reported by key informants; rape was reported to be commonly perpetrated by clients of all groups of sex workers. Lesbians, gay and transgender informants reported rape being deployed as a “corrective” tool as well as sexual violence perpetrated by their intimate partners. Other common forms of violence reported across all the groups included physical and verbal attacks by clients, communities, and health providers and law enforcement, including denial of services. The strong influence of political leadership and changes in legislation in preventing rights abuses can be seen in the recent success of the Zimbabwe Lawyers for Human Rights mentioned above.

7 The Domestic Violence Act 14 of 2006 identifies domestic violence as an offence and allows for protection orders for victims. Zimbabwe has recently launched the “Zero Tolerance 365: National Programme on Gender Based Violence (GBV) Prevention and Response” (2016–2020) which is comprises the country’s commitment to eradicate GBV and child marriage and promote gender equality. Despite the formation of a government-NGO Anti-Domestic Violence Council, domestic violence remains high and is rarely prosecuted (ZDHS 2015). A recent report proposing service provision models for sex workers and other key populations also notes that key population members whose behaviour is criminalised cannot draw on the law to protect themselves and cannot be referred to the police by providers for redress from violence (James and Nengoma, 2017).
Key informants attributed the decreasing trend for arbitrary arrests and detentions by the Zimbabwe Republic Police (ZRP) and other state agents to the recent shifts in the political context and the repealed law.

While no specific law or policy restricts access to health services to key populations in Zimbabwe, the lack of enabling legislation and policy was reported during interviews to be used instrumentally against key populations and pose barriers to access to SRH services. One example cited was the negative effect that the illegal status of sex work and homosexuality has in advertising supportive health services. No advertisements in the form of billboards, posters and radio announcements specifically targeting SW and LGBTI community health currently exist and this is understood to be a direct result of the restrictive legal environment. Common sentiment on the ground is that, technically and legally, services cannot be advertised for clients who are acting in contravention to the law. In addition, key informants reported that vague and contradictory age of consent laws were used as reason to deny health and related services – and a combination of young age, sexual orientation and being a sex worker greatly compounded barriers to access and utilisation of SRH services. Donor rules and regulations have also been cited as barriers to providing assistance to female sex workers (Sistahood, 2014).

The Zimbabwe penal code restricts all forms of abortion except when the life of the women or foetus is at risk. In addition to strong social disapproval of childbirth outside marriage, many young girls may resort to clandestine and unsafe abortion. For young female sex workers, most pregnancies are unintended and unwanted with representatives indicating high rates of clandestine abortion amongst their peers.

The ongoing economic crisis has catalysed a shift in the shape of the sex trade, with sex work becoming less formalised with the emergence of different forms of transactional sex (Elmes et al., 2017). The increase in transactional sex has been reported mainly amongst young women situated in a variety of contexts throughout Zimbabwe (Wekwete and Manyeruke, 2012, Mwashita, 2017, Kadzikano et al., 2015) but a silence exists around their mirror male counterparts. Whether previously hidden or a recent phenomenon in response to the pervasive levels of poverty, males engaged in sex for economic exchange are very much part of the Zimbabwean sexual network tapestry. Like their female counterparts, sex for economic exchange can be an overt exchange of cash for sex but also a more nuanced transactional exchange, for example, the sexual partnering of young gay men (blessee) with older, wealthier male benefactors (blesser).

8 A study by Mwashita et al (2017) reported half of young women selling sex not seeking care because age, gender and sex work related stigma made them ashamed to disclose their STI symptoms.
The ‘blesser’/blessee’ phenomenon, which has been documented throughout Southern Africa (again mainly among young female students⁹), is a power-based transactional relationship between a typically younger, poorer, student (or of equivalent status) and an older, and often married, comparatively wealthy, successful/connected man who provides food, accommodation, clothing, student fees, etc in exchange for sex. Power relations linked to expected gender roles and personas define the entire sexual relationship including sexual preferences and ability to negotiate safe sex.

Given their economic muscle, (blesser) are the ones who provide the ground rules on how we should have sex, protected or unprotected, when, where and how often we should have sexual intercourse. (Gay Key Informant, Bulawayo)

While the ZNASPIII identifies “sex workers and their clients” as one of the key population groups, female sex workers currently receive the bulk of attention as reflected in research, funding, health services and policy¹⁰. Male sex workers, on the other hand, receive little policy or programmatic attention although they have been noted in country reports¹¹. The rationale for focussing on FSWs is strong given they are at high risk for HIV infection; in the 2016 ZIMPHIA, HIV prevalence among those who reported paying or receiving money for sexual intercourse in the last 12 months was nearly four times higher for females (47.2%) than for males (12.0%). It is also a pragmatic choice; female sex workers are arguably the least contentious KP group to target in terms of health within a conservative, Christian-based society dominated by male decision-makers and therefore targeting this group in the first wave of SRH interventions in the country may be least likely to face resistance¹².

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⁹ There is indication that tertiary education students in Zimbabwe are struggling to meet with their living expenses and reports of high rates of transactional sex with negative implications for their SRH.

¹⁰ Zimbabwe is currently in the process of developing a national operational plan for sex workers (and other key populations) as part of the HIV response (UNFPA and NAC, 2016). The final draft of the plan identifies young sex workers as a priority for the country and includes discussions around developing eligibility criteria for social transfers for young sex workers (James and Nengoma 2017). PEPFAR Zimbabwe’s COP17 also identifies young women who sell sex as a key programmatic priority (PEPFAR, 2017, PEPFAR, 2017a). Along with the Global Fund and PEPFAR investments, the Partnership to Improve, Transform and Connect the HIV Response (PITCH) in Zimbabwe will also target young sex workers (as well as young LGBT populations) (Partnership to Improve, 2016).

¹¹ The majority of citizens in Zimbabwe are Christian, with the Charismatic Evangelical denominations, primarily Pentecostal and apostolic churches, the fastest growing religious classification.

¹² The majority of citizens in Zimbabwe are Christian, with the Charismatic Evangelical denominations, primarily Pentecostal and apostolic churches, the fastest growing religious classification.
Further, most research on KPs in Zimbabwe has focussed on the FSWs which means the most is understood and known about this group compared to other KP groups. The reality is that young men who sell sex (YMSS) and/or (young) male sex workers (MSW) have a growing presence in the sex work trade in Zimbabwe but little is known about who they are, their sexual orientation and practices and what this means in terms of their SRH services needs and utilisation\textsuperscript{13}.

*We sell sex to earn a living. Our sexual partners include everyone in the population, males and females. The heterosexual community is our major client.* (MSW Key Informant, Bulawayo)

Where the economic need drives business, higher payment will shape greater risk. Key informants indicated different payment terms and high numbers of clients ("100 boys for $100") to earn a living; payment terms depended on residential location and whether a client wished to have unprotected sex. Given the power dynamics and sexual risk implications inherent in sexual relationships based on economic exchange, along with the interplay of gender norms, scholars focussing on female sex workers have started questioning the relevance of making distinction between commercial sex workers and those engaged in transactional sex (Scorgie et al., 2011, Elmes et al., 2017) - and males engaging in sex for economic exchange need to be included in this debate going forward.

In a socially conservative society such as Zimbabwe and where expectations and hopes for marriage are the norm\textsuperscript{14}, the hegemonic masculinities and submissive femininities characteristic of the traditional ‘spousal’ roles have arguably strongly shaped expectations of conduct in not only heterosexual, but also homosexual, relationships. The notion of the “male provider” arose frequently in conversations with key population representatives and, in a context of high unemployment and deep poverty, underpinned discussions around drivers of sexual risk behaviour. Importantly, this included both heterosexual and homosexual male sex workers and male gender identifying LGBT persons who were not sex workers. Young male sex worker representatives spoke about their feelings of responsibility to raise funds to cover personal and family social and health needs. In a context of high unemployment, the need to be the provider can fundamentally heighten exposure to risk.

*Gender roles prescribe that all men should be providers of basic commodities. This is however regardless of one’s sexual orientation. Thus, male sex workers are equally breadwinners who should take care of the entire family.*

\textsuperscript{13} Anecdotal data suggests that female sex workers prefer having dedicated sex worker drop in centres and specialized clinics, whereas MSM prefer to access services through the primary health care system.

\textsuperscript{14} Marriage is almost universal in Zimbabwe, with the median age at marriage among women is 19.8 years.
However, given the economic hardships in Zimbabwe where at least 80% of the population is not employed, male sex workers make use of their genitals and also the mouth to earn a living. (MSW Key Informant, Bulawayo)

Stigma and discrimination is a powerful marginalizing force for key population members and has strong influence over their health and wellbeing. LGBT key population members in Zimbabwe have historically faced strong homophobic sentiment from the highest political level which has permeated throughout the societal structures, from the media and churches to family level (Shoko, 2017, Ricardo, 2015, Youde, 2017). Religious leaders have openly discriminated against LGBT persons and higher education institutions reportedly threatened to expel students based on their sexual orientation (ARASA, 2016). Sex work is similarly stigmatised and sex workers face discrimination based on social, religious and cultural grounds (Maseko, 2015). In a recent study amongst female sex workers living with HIV, sex work-related stigma far outweighed HIV-related stigma (Hargreaves et al., 2017). Sex workers themselves also experience high levels of reported internalised stigma (Hargreaves et al., 2017) which has been shown to influence risk behaviour. Stigma and discrimination against YKPs, and KPs more broadly, means that it is difficult to identify these individuals in population-based samples with the result that population size estimates are unknown. As demonstrated by the example of FSWs, further research characterising all YKPs is critical to informing and mobilising policy and programme response.

Given the high degree of marginalisation experienced by young key population groups in Zimbabwe, questions around power and resistance may reveal key ways in which risk can be shaped. YKP key informants reported widespread social rejection at the family and community level. This has resulted in an expressed “I don’t care” attitude in terms of personal risk in acquiring HIV15. While there is currently significant activity on the ground in terms of representation by KP-led and focussed organisations, high levels of stigma will likely continue to persist for some time. Key informant interviews revealed that a small number of churches and religious groups are showing signs of more tolerance towards the LGBT community. However, the majority of religious organisations discourage engagement with individuals identifying as LGBT. KP representatives shared fears of backlash from the community should they disclose their gender or sexual preferences. According to informants, being verbally insulted by family and community is common and KP-related meetings or activities are generally discouraged by the greater community through public ridicule, reporting to law authorities, and threats of violence. The power of stigma in driving risk behaviour should not be underestimated. Studies have found that internalised homophobia and homophobic abuse amongst MSM is significant associated with unprotected anal intercourse and being HIV-infected, respectively (Vu et al., 2012, Hladik et al., 2012, Muraguri et al., 2012, Ross et al., 2013).

15 MSW Key Informant 2, Bulawayo
**Intermediary Determinants of Health**

It is at the level of the intermediary determinants of health that targeted programmes and interventions can be implemented (Solar and Irwin, 2010). The intermediary determinants include material circumstances, psychosocial factors including stress, trauma and lack of social support, risk behaviours, access and utilisation of health services. Social capital and social cohesion cuts across the structural and intermediary domains and can positively or negatively influence health and wellbeing.

**Risk dynamics and pathways**

Zimbabwe currently has one of the highest HIV prevalences in sub-Saharan Africa (13-14%) and youth are particularly affected. During adolescence, HIV prevalence surges from 4% (15-19 years) to 10.3% (20-24 years) amongst females compared to 2.5% (15-19 years) to 3.7% (20-24 years) amongst males. HIV prevalence is three times higher among females (8.1%) than males (2.7%) aged 20 to 24 years (Ministry of Health and Child Care (MOHCC), 2017). Young women (15-24 years) and young men (15-19 years) are less likely to use condoms with non-marital and non-cohabiting partners than older peers.

While Zimbabwe has a typically generalised HIV epidemic, there are clear variations by geographic region; HIV prevalence is higher in the provinces of Matabeleland North (19.5%), Bulawayo (17.9%), and Matabeleland South (21.7%) than in the other seven provinces, which are all below 15% (ZIMPHIA 2016). There is limited SRH/HIV data for (young) key populations, with most of the available data related to female sex workers, 18 years and above. Adolescent members of KPs have not been included in any of the existing research. What evidence exists, which will be discussed further below, suggests worse SRH indicators than the general population and higher HIV prevalence which points to concentrated sub epidemics within the generalised epidemic setting (Tanser et al., 2014). Key informant interviews suggest a high degree of cross over between the KP sexual networks and general population sexual networks in the country. This is not unique to Zimbabwe. For example, research in other countries in the region have found that male sex workers who sell sex to men also report having female sexual partners (Arnold et al., 2013, Mannava et al., 2013). This creates possibilities for intra and extra routes of HIV transmission within their sexual networks. It also makes a strong case for focus on the SRH needs and targeted interventions for key populations.

Prior to developing targeted interventions, the most at risk population sub groups need to be identified. However the dynamic changes in sexual behaviour (and ‘high risk’ occupation) over time add to the complexity of identifying the most at risk (Fichtenberg and Ellen, 2003). Further, questions remain around whether the location or features of the environment should carry more weight in terms of determining most at risk populations rather than by sexual behaviour or ‘high risk’ occupation (Fichtenberg and Ellen, 2003). For example, transport corridors and borders have been found to be important SRH risk factors independent of individual characteristics and these factors will impact intervention approach.
Further, young people will likely move fluidly in and out the high risk grouping but their material circumstances or living conditions will impact negatively on social relationships and lead to unhealthy behaviours (Cohen et al., 2003). A recent study identified stress due to unemployment, poverty and social disapproval as key drivers of drug use (Zimbabwe Civil Liberties and Drug Network, 2016).

**Social support and social cohesion**

Social cohesion contributes to a wide spectrum of social outcomes including health and economic gains (Stanfield, 2005). Social support and social networks can powerfully influence behaviours – both positively and negatively. For instance, social support can contribute to psychological well-being with potentially protective benefits against partner violence (Jewkes, 2002) but it can also consist of negative interactions, for example peer pressure leading to risky behaviours. In country consultations suggest that unemployment, lack of recreational facilities/activities and peer pressure lead to alcohol and/or drug use and unprotected sex. Amongst LGBT and sex worker key informants, alcohol, drug abuse and peer pressure were commonly cited reasons for unprotected sex with “side dishes” (non steady sexual partners) in the context of low levels of condom use with steady sexual partners. Stress related to an occupation with no legal protections and one marked by stigma and violence is also linked to substance abuse as a coping strategy.

The civil society sector can potentially mitigate some of the stigma experienced by key populations through advocacy and creating safe space for young people to meet and develop social networks and access social support. The organisation, Gays and Lesbians of Zimbabwe (GALZ) is the oldest and historically most visibly active LGBT advocacy institution in Zimbabwe and is also one which was frequently subjected to police raids and state harassment under the previous political regime (Shoko, 2017). Given the negative attention that GALZ had attracted over the years, other LGBT representative organisations and lesbian, bisexual and transgender (LBT) organisations - which have been more recently established - have reportedly strategically limited their visibility (Shoko, 2017). This has resulted in a relatively weak status overall for LGBT organisations in Zimbabwe, bolstered only when working with other human rights organisations such as Zimbabwe Lawyers for Human Rights (Shoko, 2017).

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16 The following legislation has been used instrumentally against CSOs in Zimbabwe: 1) the Censorship Entertainment and Control Act (CECA) of 1967 which has been used to criminalise IEC materials for LGBTI people; 2) the Public Order and Security Act (POSA) of 2002 has been used to restrictions on public gatherings; 3) the Private Voluntary Organisations (PVO) Act of 2004 (ARASA 2016).

17 LBT organisations include Voice of the Voiceless (VOVO), Pakasipiti and the feminist LBT group, Katswe Sistahood. TREAT, a group for transgender people only, has also emerged more recently in Zimbabwe (Shoko 2017)
On the whole, social cohesion between the LGBT subgroups is fraught and complex internal politics exist between perceived ‘mainstream and male dominated’ LGBT organisations and the newer groups that focus on lesbians, female bisexual and transgender people. Members from these LBT organisations have noted that collaboration between LGBT groups is sometimes forced due to donor-driven agendas. Interviews with key informants suggest that there is a well-established communication network and sharing of information amongst key population members – it appears that this is, in part, linked to peer education interventions.

In terms of FSWs, a National Sex Worker programme (Sisters with a Voice) (SWV) was established in 2009 which works in 36 sites in Zimbabwe with clinical services, health education, and community empowerment and mobilisation activities. The programme also focuses on building social cohesion, support networks, and self-efficacy among sex workers but there are indications that the programme is not reaching young FSWs. The median age of entry into the programme is 27 years but programme and survey data suggest that 25-40% of sex workers are less than 23 years old (PEPFAR, 2016b). Young FSWs are more marginalised than adult FSWs in that they are often seen as rivals to clients amongst older sex workers.

*Health delivery system*

The prolonged economic challenges in the country has resulted in a weak public health system characterised by severe understaffing (vacancy rates up to 70%), deteriorating physical infrastructure and inadequate functional equipment and drug supplies (ZANSP III). Government funding for health constitutes 8.7% of total government expenditure and heavily relies on donors to support services. Households currently incur high out of pocket for health expenditure, which is amongst the most expensive in the region (Mugwagwa et al 2017). Only 10% of citizens have health insurance (ZDHS 2015) which means, in reality, that the urban and rural poor cannot access specialist health care unless they pay out of pocket. User fees are a major barrier to care in Zimbabwe with the poor disproportionately affected.

While there has been a recent shift in mobilisation around KP issues, with Ministry of Health and Child Care (MoHCC) and the National AIDS Council (NAC) driving policy, MoHCC has limited capacity with constrained staff numbers and financial resources. The CSO sector currently provides the bulk of targeted HIV prevention and treatment programmes for sex workers and LGBT people in Zimbabwe. However, support and reach of these organisation is mainly focussed and limited to the urban constituencies and the high traffic areas such as trucking corridors and borders. In a mapping of organisations supporting KP needs, as part of the baseline, it was noted that none of the organisations directly operate in rural areas – where two thirds of the population reside - although they did report occasionally providing support to KPs in the rural areas. These organisations indicated the presence of KP communities in the rural areas.
Nonetheless, even in urban areas, there is currently only a small number of CSOs providing services required by KPs. In addition, consultations revealed that CSOs are not able to provide tertiary level clinical services, such as surgical treatment for complex health needs, including cauterisation of anal warts, post abortion care and long term psychosocial support. Young key population representatives described CSO referrals to public health facilities as the “end game”, not only because of prohibitive cost but also due to fears related to discrimination and lack of confidentially in the public health sector setting.

Stigma, both at the level of the self and society, is a fundamental barrier to key populations accessing SRH information and services in the health sector. Government clinics and hospitals in Zimbabwe were reported to be largely hostile to lesbian, gay and transgender people and sex workers and to lack understanding of the range of their specific SRH needs. While accessing HIV and AIDS care did not seem to pose problems given that treatment was not predicated on sexual orientation, accessing STI services for anal warts, for example, was cited as very challenging: “Nurses are always curious to know how you got infected” (Transgender man key informant, Mutare). Many sex workers choose not to disclose their work to health professionals, misrepresent their health problem, pay bribes to be treated or avoid care entirely (Mtetwa et al., 2013, Scorgie et al., 2011, Scorgie et al., 2013b, Mwashita, 2017). Some clinics refuse to treat sex workers for an STI unless they bring their partner along or restrict the number of condoms issued (Scorgie et al., 2011). Injecting drug users and bisexual females similarly cite stigma as barrier to health services (ZCLDN 2017). Women who have sex with women reported that healthcare providers commonly view them as heterosexuals, asking sexual history questions pertaining to male partners. Where providers are aware of sexual orientation, negative attitudes are reported. Importantly, these KP-specific barriers are underpinned by general barriers to access to health care. In addition, sub optimal services and shortage of key drugs such as STI treatment are further challenges.

Since the completion of a nation-wide sensitization program for health-care workers there has been a reported improvement in health service delivery. However, while FSW key informant indicated improvements in access to services, other KP key informant reported many challenges in access and utilisation of SRH services.

*Self /Peer Diagnosis and Self Prescription and Treatment*

There are indications that self and/or peer diagnosis and peer prescribed remedies for SRH ailments is common practice amongst YKPs – as a way to avoid prohibitive cost of services, distance to clinics, and health care provider negative attitude. Consultations with traditional healers and use of traditional medicines and/or visiting religious shrines for treatment and exorcism were also mentioned in consultations.
Young KP representatives shared that visiting a health facility was viewed as the very last option - after the home and self-prescription remedies had failed. This has cost implications given that the delay in seeking services will likely result in more severe SRH complaints amongst YKPs.

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

The above analysis has highlighted the intersectionalities between the traditional key population groupings, with young people moving fluidly amongst these often overlapping intersections over time. However, for the purpose of presentation of the literature, the following section provides a brief summary of the HIV/SRH situation and key indicators for each of the key population groups.

**Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) populations**

There is an “information black hole” (Bourne et al., 2016) regarding the LGBTI population in Zimbabwe. Over the last two decades, very few LGBTI studies received national ethics approvals which means that only a small number of non-representative studies have been conducted on LGBTI populations and the full diversity of these populations and their specific needs is not known. Size estimations or bio-behavioural surveillance of LGBTI populations have not yet been carried out in Zimbabwe.

There are no age-disaggregated SRH data for LGBTI people in Zimbabwe. Most of the available data is related to HIV prevalence, and where data does exist there are reliability issues (i.e. unpublished, sampling issues, not peer reviewed, etc.). In an unpublished study in 2013 by Biomedical Research and Training Institute (BRTI), HIV prevalence among MSM was found to be 23.5% (PEPFAR, 2016b). In another study, 5.8% of WSW in Zimbabwe self-reported being HIV positive (Sandfort et al., 2013). The mean age of WSW in the study was below 30, but based on the judgments of the community-based organizations involved, younger women were likely overrepresented in the study, creating a skewed picture. In a very small non-peer reviewed survey (n=32), 25% of transgender people in Zimbabwe self-reported being HIV positive (Southern Africa Trans Forum (SAFT), 2016).

There is a small transgender movement in Zimbabwe. Few individuals are openly transgender with the criminal laws impacting on visibility of transgender persons who are harassed and intimidated on the basis of gender expression (ARASA, 2016). Even less is known about intersex persons in Zimbabwe with reports of ‘corrective” surgery being performed on infants in Bulawayo (ARASA, 2016). In a qualitative study on LGBTI people and sex workers’ experiences of accessing healthcare in Zimbabwe, Hunt et al. (2017, p.6) found common experiences of stigma and discrimination among young bisexual women (Hunt et al., 2017). A recent baseline study notes that, with the exception of sex workers, it is not known to what extent other KPs access ART (Moyo et al., 2016).
Zimbabwe

Sex Workers

While HIV prevalence amongst female sex workers is not nationally representative, estimates suggest HIV prevalence is high (around 58%) (Zimbabwe Ministry of Health 2015). There is relatively good age disaggregated data for female sex workers (FSW) in Zimbabwe (James and Nengoma, 2017, Cowan et al., 2017, Elmes et al., 2013, Mtetwa et al., 2015, Mwashita, 2017). The age aggregated data\(^\text{18}\) suggests that HIV prevalence rises exponentially in the older the sex worker group, pointing to greater prevention efforts needed in the younger population of sex workers\(^\text{19}\). Young sex workers (age 18-24) are 4.2 times more likely to be living with HIV than young women (20-24) who do not sell sex (36% compared to 8.5%) (Cowan FM et al., 2014, PEPFAR, 2016a). In a 2013 survey in Beitbridge, Zimbabwe – a border town where many long distance truck drivers pass and many sex workers conduct their business – HIV prevalence among young female sex workers age 18-20 was found to be 33.3%, rising to 43.5% among those age 21-25 (WHO AFRO, 2014). In another study, 27-32% of female sex workers reported recent experience of genital sores, ulcers or unusual genital discharge, with about 66% seeking treatment and care for their symptoms (PEPFAR, 2016b).

Young female sex workers report the highest numbers of unprotected sex acts with clients (PEPFAR, 2016b). Younger sex workers also report more frequent HIV testing but are the less likely to know they are HIV positive (PEPFAR, 2016b). This could signal that the most vulnerable young women who sell sex (YWSS) are not the ones who are accessing services.

While HIV prevalence data amongst FSW is available, there exists no data on male sex workers (MSW) or transgender sex workers nor any visibility of male sex workers in research. Further, there are no population size estimates for sex workers of any sex or gender. The limited epidemiological data, globally, suggest a generally high HIV prevalence amongst MSWs with a higher burden of HIV than men having sex with men (MSM) (Baral et al., 2015, Baral et al., 2009, Vu et al., 2013) and a higher STI prevalence than FSWs (Friedman et al., 2011).

Little is known about transgender sex workers in Zimbabwe but global evidence suggests that they are a particularly vulnerable sub group, with a significantly higher HIV prevalence than all the other groups of sex workers and in transgender women not engaging in sex work (Opeiario et al., 2008).

\(^{18}\) In Cowen et al. (2013), 28% (234/836) of sex workers surveyed were below the age of 25. The median age of entry into the National Sex Worker Program (Sisters with a Voice) is 27 years, but program and survey data suggest that 25-40% of sex workers are less than 23 years old (PEPFAR, 2016b, p.31).

\(^{19}\) In the Sisters Antiretroviral therapy Programme for Prevention of HIV – an Integrated Response (SAPPH-Ire) trial in Zimbabwe, 785 of 2722 sex workers surveyed across 14 sites were between the ages of 18 and 24 (26.8% of the sample) (Cowen et al., 2014). HIV prevalence was found to be 36% among sex workers age 18-24, rising to 55% among those 25-29, 69% among those 30-39, and 77% among those older than 40 (Cowen et al., 2014, p.14).
Given the complexities around sexual identity, many transgender sex workers may self-identify as “gay” or “MSM” and be classified as “male” sex workers (Scorgie et al), with the result that their specific needs remain invisible. Because of their specific needs, some scholars have argued that transgender women engaged in sex work should be considered as an entirely separate group from MSW (Baral et al., 2015). While the literature is scant, the evidence suggests heightened human rights violations towards transgender sex workers, with homophobia compounding the illegal status of sex work-related violence (Scorgie et al., 2015). Key informant interviews pointed to added difficulties for male transgender people compared to female transgender people in availability and accessibility of SRH services due to the complexities of explaining their STIs.

Uptake of SRH services are low and HIV testing behaviours and treatment outcomes are reported to be poor amongst young female sex workers (Figure 1)\textsuperscript{20}. A survey among 2722 sex workers in 14 sites in the country found young women who sell sex had significantly lower levels of HIV testing and engagement with care (Napierala Mavedzenge et al., 2015). Treatment cascades for sex workers in Zimbabwe reveal gaps that are particularly pronounced for young sex workers (<25 years of age). Young sex workers are less likely to know their HIV status, be on treatment and be virally suppressed compared to adult sex workers (WHO and MoHCC, 2016). However, it is worth noting that low uptake of SRH services is, to a large extent, similarly reflected in the general population in Zimbabwe\textsuperscript{21}.

\textbf{Figure 1: Treatment Cascade for HIV-positive Sex Workers in Zimbabwe (WHO & MoHCC, 2016)}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{treatment_cascade.png}
\caption{Treatment Cascade for HIV-positive Sex Workers in Zimbabwe (WHO & MoHCC, 2016)}
\end{figure}

\textsuperscript{20} While 69% of HIV positive sex workers age 25 or older know their status, just 39% of sex workers below the age of 25 do. Further, while 48% of older HIV-positive sex workers (≥25 years) are on treatment and 37% are virally suppressed, just 21% of younger sex workers (<25 years) are on treatment and just 13% are virally suppressed. In Cowen et al. (2013), 28% (234/836) of sex workers surveyed were below the age of 25.

\textsuperscript{21} Amongst respondents who reported having an STI or symptoms of an STI, 48% of women and 55% of men sought no advice or treatment. Eighty percent of women and 62% men (15-49) have ever tested for HIV (ZDHS2015).
Prisoners

HIV prevalence in prisons in Zimbabwe is high (estimated at 28% in 2015 (26.8% among male detainees and 39% among female detainees but the evidence suggests that prisoners have access to ART (Tucker and Wallace-Karenga, 2015). The population size estimate of prisoners in 2011 was 14,700. Data from a 2011 survey among prisoners in Zimbabwe (most recent age disaggregated data) reveal that about 10% of the adult prison population is below the age of 24 (Center for Health Strategies (CHEST), 2011). In the survey sample, 1% (161/14,976) were juveniles age 13-17 years. HIV testing data shows that many of these young prisoners – both male and female – are living with HIV. (Figure 2).

![Figure 2: Age Range of Prison Inmates in Zimbabwe (Left) and HIV Test Results among Prisoners in Zimbabwe, by Age and Sex (Right) (CHEST, 2011)](image)

While the survey does not provide age-disaggregated data on knowledge and attitudes or access to services, the risk-perception data is noteworthy. While 80% of prisoners surveyed believed they were at high risk for TB and at some risk for HIV, 70% reported that there was no risk of STI transmission, and 60% said they did not know if they were at risk for Hepatitis B and Hepatitis C (CHEST, 2011). This suggests that there are significant knowledge gaps among these prisoners – of whom 10% are younger than 24 – in terms of risk perception for SRHR issues outside of HIV and TB.

Injecting Drug Users

Research on people who inject/use drugs (IDU) in Zimbabwe is very limited. In August 2015, local media reported that research conducted by the Anti-drug Abuse Association of Zimbabwe revealed that 50% of injecting drug users who were tested for HIV were found to be positive (Mandizha, 2015). The article states that 70% of them are between 16 and 35 years old, noting that: “These youths are at an elevated risk of contracting HIV for various reasons.
Chief among these is unsafe sex with multiple partners, a combination of indifference to safer sex practices and the demands of commercial sex work, which many addicts turn to in order to support their drug habit” (Mandizha, 2015). Preliminary results from a Zimbabwe Civil Liberties and Drug Network (ZCLDN) study indicate that over 80% of drug users in Zimbabwe are reluctant to seek medical attention and are afraid of the stigma associated with the local primary health care delivery services (Zimbabwe Civil Liberties and Drug Network, 2016).

In conclusion

Female sex workers (and prisoners due to location) are arguably the most easily definable key population groups. Male sex workers include gay, bisexual, transgender, and possibly heterosexual, SWs and, like FSWs are often substance users. Frequently, MSW are grouped as ‘MSM’ which masks the diversity and complexity of the population that makes up young men who sell sex in Zimbabwe. What health services exist are generally orientated towards female sex workers and MSM. Interestingly, some male sex workers or young men who sell sex, themselves, resist being labelled as such which makes it difficult to identify and reach the most at risk YMSS. For young males and females who sell sex, sexual orientation (and safe sex) is very much shaped by economic need. Further, the way that gender is invoked and the gendered relationships both within and outside of the LGBT community are shaped in very particular ways by the constrained economic context. The intersections between age, sexual orientation, gender identity and sexual behaviour, and social context amongst members of these groups and how these shape vulnerability for poor SRH requires further study. Important questions for future research include what kind of social support is needed to mediate stigma and discrimination, the extent that sex workers and young people who engage in transactional sex are the same or different and what this means in terms of their SRH risk and needs, and the ways their sexual networks differ and/or cross over and intersect with the gay and heterosexual community. Inadequate understanding of these issues has direct implications for health sector and policy responses. Currently, no policy or strategy exist that addresses targeted information on risk reduction and HIV education for most KP groups except for FSWs.
CONCLUSIONS AND AREAS FOR FURTHER RESEARCH

There has been recent research interest in the notion of resilience and collective action amongst (mainly female) sex workers as a strategic way to cope with or avoid human rights violations and to increase their uptake to health services (Scorgie et al., 2013a, Mtetwa et al., 2015). Examining the patterns of resilience amongst sex workers in future research may offer important information that reframes young sex workers as agents of change rather than victims and provide clue for how to harness this resilience in meeting their SRH needs. Further, multilevel exploration of the simultaneous forms or intersectionality of violence experienced by different sex workers and how this shapes SRH vulnerability is also currently a gap in understanding and merits further investigation.

It also needs to be noted that during the course of the baseline, it became clear that there is also a marked gap in research understanding of and access to injecting drug users (IDUs) and prisoners in Zimbabwe. At the time of the baseline, there was a Presidential Amnesty for prisoners which saw the release of a number of female prisoners, young people and those with minor misdemeanours into the general population. It was therefore not feasible to be visiting the prisons and interviewing representatives and key stakeholders. However, a CSO working to rehabilitate prisoners strongly emphasized the importance of appreciating the in situ physical environment in the prisons to be able to fully understand how SRH outcomes play out. They indicated expectations of strong bias if the research was limited to only ex-prisoners.

Research agenda

The baseline review has highlighted several research gaps. While there has been focus on the sexual health of female sex workers, very little attention has been paid to their reproductive health. Little is known about the drivers and rates of unintended pregnancy amongst FSWs and unsafe abortion, which were reported anecdotally in the baseline interviews. Given the highly restricted conditions under which an abortion is allowed in Zimbabwe, safe termination of pregnancy services will not be an option for FSWs, who will resort to clandestine and often unsafe services.

Proposed research questions

What are the reproductive health needs of young women who sell sex (YWSS) and how are the needs of the group being met?

- What is the extent of unintended pregnancy and abortion amongst young and adult FSWs?
- How do the RH needs of YWSS differ from adult FSWs?
- What are the determinants of unintended pregnancies amongst YWSS and what are the reproductive health consequences for YWSS?
- What is the demand for contraceptive services and commodities amongst YWSS?
- What are the economic, societal and health consequences of unintended pregnancy for YWSS?
- What are the out of pocket costs for contraceptive commodities and services?
- To what extent are the reproductive health needs of YWSS being prioritised in Zimbabwe and why?

The baseline also revealed a number of other research priorities. These include the following:

**The characterisation of young key populations is crucial.** Sex work may contribute significantly to onward HIV transmission in regions with high HIV prevalence. However, the full diversity of individuals engaged in sex for material or economic exchange and their sexual networks, SRH vulnerability and risk behaviours merit further exploration. Further, the binary categories of YKPs are artificial constructs given the clear intersectionality between YKP groupings. The overlapping of these identities and experiences are important to understand because they will fundamentally shape SRH outcomes and service needs.

**There is need to identify the most at risk key population sub groups.** The shifting nature of the most at risk key population sub groups temporally needs to be better understood. The dynamics of age, changes in sexual behaviour (and ‘high risk’ occupation) over time add to the complexity of identifying the most at risk individuals. Further, questions remain around whether the location or features of the environment should carry more weight in terms of determining most at risk populations rather than sexual behaviour or ‘high risk’ occupation.

**Better understanding of YKP support networks is required.** Given the high rates of stigma experienced by many YKP in Zimbabwe and indications of how this shapes risk behaviour, it is important to understand how YKP communication and social support networks positively or negative influence their behaviour and well being with a view to intervention design.

**Additional research questions**
- What is the multiplicity and particularity of SRH risk and vulnerability amongst YKPs in Zimbabwe and what are the implications for their SRH outcomes?
- To what extent does identifying with a sexual or gender minority, profession, or addiction increase vulnerability and what strategies do YKPs employ to mediate this vulnerability?
- To what extent is sex for economic exchange a temporary or long-term occupation amongst young sex workers?
- How different are young SWs from older SWs in terms of sexual practices, risk dynamics and SRH needs?
- What are the forms of sex for economic exchange and what are the associated risk differentials?
• To what extent do local identities and practices align with global agency definitions of YKPs?
• To what extent are sexual and social practices seen as separate or the same as social identity?
• How do gendered relationships within YKPs relationships manifest and how does these gendered roles render some more resilient and others more vulnerable to poor SRH?
• What are the individual, interpersonal and sexual network characteristics, community, health service and policy-level that increase or decrease risk of poor SRH outcomes amongst YKPs?
• What kind of intersectoral action is required to address the complexities of the socio-political, economic and cultural landscape that poses harm to YKPs?
REFERENCES


