



Reaching Key Population Groups with Sexual and Reproductive Health Services

By Ruth Ayisi

The story of a male sex worker

When James¹ told his family that he was gay and living with HIV, he was thrown out of his home. Not only did his family say this went against their religion but gay sex is against the law in his country. To survive James turned to sex work.

Today, James is a strong advocate for people's rights to sexual reproductive health and has been instrumental in reaching out to other male sex workers to test for HIV and access HIV prevention, care and treatment services. He has also sincerely reunited with his family. "*Changing attitudes takes time,*" he says.

Background

Key population groups include sex workers and their clients, men who have sex with men (msm), people who inject drugs, transgender people and people in prisons. Reaching these groups with sexual and reproductive health (SRH) services is a huge challenge, particularly in the eastern and southern African region. Key population groups are also more vulnerable to HIV infection. According to UNAIDS, the risk of acquiring HIV is 35 times higher among people who inject drugs; 34 times higher for transgender women; 26 times higher for sex workers; 25 times higher among gay men and msm. In 2020, people belonging to key population groups and their sexual partners accounted for 65 per cent of HIV infections globally.² Although the percentage of new HIV infections in key population groups in the eastern and southern African region is lower than the percentage in the rest of the world, the overall HIV prevalence in southern and eastern Africa is high compared to the global prevalence, representing 60 per cent of the global total. Furthermore, in the eastern and southern African region, key population groups face higher barriers to their

rights due to prohibitive legislation and extremely high levels of stigma and discrimination in their societies, particularly amongst msm and lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) communities.

Finding ways to reach key populations with quality integrated SRH has been one of the priorities for the joint 2gether 4 SRHR four-year programme which was launched in 2018³. The 2gether 4 SRHR programme has brought together four UN organizations working in partnership with the Swedish International Development Cooperation Agency (SIDA). The programme assists with public policy and programmatic interventions in 10 countries: Botswana, Eswatini, Kenya, Lesotho, Malawi, South Africa, Namibia, Uganda, Zambia and Zimbabwe. This has also involved collaborating with regional bodies including human rights institutions, civil society organizations, networks of people living with HIV, adolescents and young people, msm, LGBTQI people and sex workers.

1. Not his real name to protect his privacy.

2. https://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf

3. 2gether 4 SRHR programme brought together the expertise of four UN agencies – the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO)

Progress

The 2gether 4 SRHR programme has prioritised support towards an enabling environment for key population groups to access their sexual and reproductive health and rights (SRHR). At all levels – global, regional and country – this has involved collecting data, advocating for the rights of key population groups to SRH as well as supporting national and community-based programmes aimed at leaving nobody behind.



Advocacy and strengthening programming

Advocacy and strengthening programming for key population groups has been key. For example, at regional level, the 2gether 4 SRHR programme assisted the Southern African Development Community (SADC) to convene a consultative meeting on strengthening programming among key populations. This provided an opportunity for high-level participants from the region, including officials from the ministries of Health, the National AIDS Councils and UN partners, to discuss the barriers that key population groups face in accessing SRH services, including the barriers associated with discriminatory laws and policies. The participants also developed regional- and country-level SRH plans, policies and frameworks which are inclusive of key population groups.

The programme has also supported the SADC parliamentary forum in its development of a regional package of minimum standards for the protection of SRHR for key populations in the SADC region in line with the Global Coalition Roadmap and SADC Key Population Strategy. This package guides and supports parliamentarians across SADC to promote interventions at parliamentary and constituency level for key populations.

The 2gether 4 SRHR programme has also prioritised high-level advocacy visits with top government officials to raise awareness of the rights of key population groups to SRH. For example, when members of LGBTQI groups were arrested during the COVID-19 pandemic lockdowns, top-level meetings were held between the Government of the country concerned and the Executive Director of UNAIDS. In addition, the 2gether 4 SRHR programme provided emergency legal aid to those who were arrested and, when they were released, medical care and shelter.



Communication

Due to many countries outlawing gay acts and sex work, reaching key population groups in the LGBTQI has had to be done sensitively. An effective way to reach key population groups has been through social media platforms. For example, in 2021, the 2gether 4 SRHR programme supported the development of a regional toolkit in consultation with adolescents and young people from diverse groups in the region. The information is available to everyone through hyperlinks and on social media platforms. Also, interactive messaging tools such as U-Report supported by UNICEF, and Tune me supported by UNFPA, have engaged young people from diverse backgrounds and served as platforms to respond to tens of thousands of messages related to SRHR, HIV and mental health. In addition, the platforms have allowed for rapid assessments of the situation in communities.



Supporting peer educators – a key way to engage key populations

An important way to engage key populations is through peer educators. Peer educators can discuss sensitive issues in ways that their peers are familiar with, without awkwardness. With the support of the 2gether 4 SRHR programme, the Ministries of Health and partners, peer educators in the region have been trained on integrated health service provision including addressing sexual and gender-based violence (SGBV) which is an area that had in the past been side-lined in many countries, especially among key population groups. Many peer educators are also now distributing HIV self-testing kits so that people can test in the privacy of their homes, which can be particularly important for key population groups.

Specifically, UNAIDS took the lead in a community-based project that involved male sex workers which was funded by 2gether 4 SRHR. Health workers were sensitized to inclusive and rights-based public health programming before travelling with peer educators (who belonged to key population groups) to a border district popular with male sex workers. The peer educators mobilised male sex workers through group and one-on-one meetings. In one community, about 18 per cent of the around 120 male sex workers who came forward tested HIV positive. The male sex workers who tested positive received essential information as well as treatment and care, and those who tested negative were counselled on ways to remain negative. The project also documented the barriers experienced by the male sex workers when they had previously tried to access HIV services in public health facilities. In addition, the project supported the initiation of a male sex worker community dialogue so they could later share their knowledge and ideas with stakeholders on how to build a safe environment for this population group, which included reducing new HIV infections.

One of the lead peer educators in the project who is also a male sex worker and works closely with the health authorities and the National AIDS Council, said the project made a significant impact in the community.

“Before, male sex workers were afraid to visit the health facilities because some of them are known (as sex workers), and they know some of the healthcare workers’ attitudes.... they’re afraid of being discriminated against. If you (msm) are caught you can be in prison for 14 years. People are scared. Yet with this intervention, they are open, they trust me, they know I won’t discriminate against them or call the police to arrest them.”

The lead peer educator also helped facilitate the training session with the health workers who were provided by the Ministry of Health. He explains,

“First we take them (the health workers) through sexual and gender orientation and gender expressions so they understand who we are, how we are different. This encourages dialogue. They (the health workers) then might say I have my nephew who looks like you, he does things like you’re doing. Bit by bit people are buying in, they are understanding who we are.”

The lead peer educator then assisted the health workers to take the services to the male sex workers who had gathered in specified areas rather than at health facilities. At the locations, they received pre-counselling for HIV, testing and post-counselling. Those who tested positive were linked to the nearest facilities for ART. Those who tested negative were advised how to protect themselves. The HIV positivity rate amongst the sex workers was high at about 19 per cent. A few weeks later, the lead peer educator accompanied the health workers to check whether those who had tested positive were adhering to the treatment. The lead peer educator said that he would like to have further follow ups and would like to see similar activities scaled up throughout the country. The peer educator sums up his commitment.

“I’ve been trained, I have the knowledge which means I have the power. We need to help those who can’t speak for themselves.”

Challenges and way forward

Despite the progress, one of the major challenges is still the political and legal environments in the region which outlaw sexual practices associated with most of the key population groups. This also contributes to the entrenched discrimination and stigma against key population groups, including amongst some health workers, and also the high levels of fear members of the key population groups experience when they try to access their rights to SRH services. This detrimental environment for key populations and their fear to come out also impedes accurate data collection and the development of evidence-based interventions that will best reach them.

The COVID-19 pandemic further heightened the vulnerability of key population groups. People living with HIV are likely to have poorer outcomes from COVID-19 than people not living with HIV. Studies from England and South Africa have found that the risk of dying from COVID-19 among people with HIV was double that of the general population. COVID-19 lockdowns and other restrictions disrupted HIV testing and led to drops in diagnoses and referrals to HIV treatment.⁴ Also, activities specifically to reach key populations, including orientation sessions for health workers, were limited due to the COVID-19 measures that had to be put in place. However, in response the 2gether 4 SRHR programme worked

to put countermeasures in place. Amongst the first measures was to provide health workers with personal protective equipment (PPE), including masks, and diagnostic and therapeutic supplies. The UN organizations also worked with partners to find different ways to reach groups, for example, using text messaging and social media to offer advice on antiretroviral therapy (ART) adherence counselling, psychosocial support and real-time information on COVID-19.

However, ending discrimination and stigma of key populations, including among health workers, takes continued effort. Even peer educators working on the programme to reach key population groups reported being fearful about coming out into the open as they said that some health workers had not always respected their confidentiality and revealed their sexuality without their consent. More sensitization of health workers is needed to ensure peer educators feel they are in a safe environment to expand their SRH activities. Some peer educators also lacked skills to advocate for their rights and that of key population groups, including the essential public speaking skills. In the future, training of the key population peer educators should precede other interventions.

4. https://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf

Conclusion

New opportunities for engaging key population groups have emerged including the ever-expanding social media platforms and in particular the vital role of peer educators from key populations in reaching their peers.

Advocacy at all levels needs to continue to create an enabling environment for key populations groups to access their SRHR. Support is also needed to strengthen institutional capacity to prevent, report

and monitor abuse of key population groups at points of care, and community-based projects need to be scaled up based on evidence.

The efforts of the 2gether 4 SRHR programme need to be built on and all stakeholders need to assist key population groups to know their rights to SRH and to then assist them in accessing the full package of quality integrated SRH services without discrimination.

