8 Young key populations in Southern Africa

An analysis of the social determinants of HIV risk and barriers to sexual and reproductive health services

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Introduction

The health and well-being of young people (10–24 years) is vital to the social and economic development goals of the Africa continent, which is home to a youthful and growing population.¹ Protecting the sexual and reproductive health and rights (SRHR)² of these young people is clearly a fundamental requisite. However, there remain substantial barriers to young people accessing quality health services, and they face a range of serious health challenges, particularly with regard to their sexual and reproductive health (SRH) (Kabiru, 2013; Fatusi, 2016). In sub-Saharan Africa, HIV prevention remains a persistent challenge among young people, where 37% of all new infections are among youth aged 15–24 and where females are disproportionately affected (UNAIDS, 2019). Likewise, there exist high rates of teenage pregnancy, unsafe abortion and maternal mortality and morbidity in the region, all underpinned by pervasive sexual and gender-based violence (SGBV) and harmful cultural and gendered practices (Juma and Klot, 2011; Anderson, 2015).

Adolescence is a life phase in which rapid physical maturation and psychological and cognitive change takes place, with adolescent development fundamentally impacted by their structural and social environments. Differential exposure to these environments has the potential to positively or negatively shape adolescent health and psychological well-being, with strong associations between socio-economic status and health behaviours and concomitant long-term outcomes (Fatusi and Hindin, 2010; Sawyer et al., 2012). Young people who are also members of key populations (KP)³ are one example of young people facing compounded vulnerabilities since they share a number of specific barriers and challenges concerning their SRHR, linked to legal, social and political structures, which undermine their ability to access healthcare (Cornell and Dovel, 2018), and this is reflected

in the poor SRH indicators for this group. Given these overlapping and intersectional challenges, there is need to apply a comprehensive framework of analysis which draws on all aspects of their lifestyles and choices, peer groups and networks as well as broader social, economic and political structures. This comprehensive approach is indispensable to efforts to fully understand the challenges these young people face, and to plan and take action on appropriate policy and programmatic interventions to improve their overall health and well-being.

This chapter presents an overview of what is known about the SRHR of young key populations (YKP) in Southern Africa, using specific examples from five countries, namely Angola, Madagascar, Mozambique, Zambia and Zimbabwe, to anchor the discussion. The discussion draws on the social determinants of health framework to structure an analysis of what is known about the determinants and drivers of sexual and reproductive health (SRH) risk and to highlight the gaps in evidence and understanding of specific vulnerabilities of these groups of youth. The social determinants of health framework allows for an analysis that goes beyond some current approaches which are over-reliant on psychosocial or behavioural factors of risk and vulnerability and which fail to adequately consider the underlying structural and social factors which shape and limit these behaviours and psychological predispositions (Ross, 2010). The discussion is based on a review of academic and grey literature concerning the SRH of YKPs in Southern Africa, together with a series of interviews with key informants from relevant government ministries, international organisations and international and national non-governmental organisations (NGOs) working with key populations in each country. Our initial findings point to the importance of understanding the vulnerabilities and risks faced by young people in these key populations in the context of a wider consideration of the social determinants of health of all young people, as well as in the context of the full range of SRH needs and priorities which include but go beyond HIV alone. Moreover, looking more broadly at the economic situation of young people, educational and employment opportunities, health systems, and peer and family networks will give us a more complete picture that will help us to understand how and why certain young people are more at risk for negative SRH outcomes than others. This more comprehensive approach creates the foundations for the development of equally comprehensive and more inclusive policies and programmes to protect and promote the SRHR of all young people in the region in all of their diversity.

The research informing this chapter is part of an ongoing study being carried out by the Health Economics and HIV and AIDS Research Division (HEARD) as part of a joint four-year project in collaboration with United Nations Development Programme (UNDP) and African Men for Sexual Health and Rights (AMSHer), supported by funding from the government of the Netherlands. The overall project aims to strengthen HIV/SRH-related rights of young key populations in law, policy and strategy in five

Southern African countries (Angola, Madagascar, Mozambique, Zambia and Zimbabwe) and at the SADC regional level. The long-term objective of the project is to improve the SRH outcomes for young key populations in SADC countries.

Why a focus on young key populations?

In the context of the HIV and AIDS response, key populations have been defined as groups who are at increased risk of HIV infection and who are often faced with legal and social barriers and discrimination which increase their vulnerability to HIV and prevent them from accessing the concomitant SRH services.⁴ Young members of key populations are located at a critical juncture of overlapping vulnerability for poor SRH, facing both the challenges associated with adolescence and the stigma and discriminations experienced by key population groups. Despite growing attention to the health of key populations in the Southern African region, there is a paucity of research on SRHR (including HIV) of YKPs, in part because of the methodological difficulties in identifying and reaching these young people, who in most cases have good reason to remain “hidden” because of the discrimination, stigmatisation and possible criminalisation that they may face. There are also important ethical challenges in carrying out research among young people under the age of 18, and while the 15–18-year-old segment of the young key populations is more under-researched than their older counterparts, the reality is that many of these 15–18-year-olds are also sexually active and in need of quality SRH services. Given the above, there are few studies which specifically explore how and why young people from these key populations may face specific challenges regarding their SRHR.

The paucity of reliable data and the lack of in-depth knowledge are sufficient reason for pursuing further research into the situations of YKPs. But what we do know makes this even more urgent, as available data suggest a range of negative SRH indicators for young people in general, and in particular for young people in key populations. An analysis conducted by UNICEF estimates that 9.6 million young people aged 15–24 will be newly infected with HIV in sub-Saharan Africa between 2017 and 2050 (UNICEF, 2018). Other estimates suggest that 50% of new HIV infections worldwide occur among members of young key populations (WHO, 2014). Young people in key populations also experience heightened risk of other STIs, unintended pregnancy, violence and other negative health outcomes. This is indicative of the vulnerable situation in which these young people find themselves, a vulnerability which is heightened in many cases by punitive legal contexts, stigma and discrimination. Restrictive legal contexts which criminalise same-sex activity, sex work or drug use – and the social stigma attached to these – affect all key populations, but for young people there are additional barriers. In some cases, health service providers face legal restrictions in providing SRH services such as HIV testing or provision

of contraception to young people under the age of 18 without parental consent (Mbeba et al., 2012; Chandra-Mouli et al., 2015; Delany-Moretlwe et al., 2015). NGOs and associations working with key populations may also be reluctant to engage with young people for fear of being accused of promoting homosexuality or sex work, for example (Muller et al., 2018). Like other adolescents and young people, YKPs are at a crucial age of social and sexual development where they face pressure from families, peers and community and require support and access to services to ensure positive health for their present and future lives. The combination of being young and being a member of a key population means that many of these YKPs find themselves in a situation of high vulnerability with little or no access to SRH services or to social support groups or networks. Improving the SRHR of these young people is thus a major challenge, and one which requires understanding of the very specific situations in which they find themselves in order to design programmes and interventions which can really make a difference to their health outcomes.

Deconstructing the categories of key populations

For over a decade, key populations have been central in policies and interventions on HIV and AIDS at international levels.⁵ The focus on key populations is justified by these groups' vulnerability and risks of HIV infection as mentioned earlier. However, without detracting from the importance of the attention to key populations – a focus which has been necessary in the more targeted responses to HIV and AIDS – it is important to deconstruct and analyse these categories and to acknowledge that both between and within different key populations there is a wide variety of different situations of risk and vulnerability, and also possibilities for action and resilience. Research studies have shown the diversity within each of the so-called key population groups (Paiva et al., 2015; Parker et al., 2016; Garcia et al., 2016), but the continuing usage of the term in policy and programming masks this diversity and thus erases the impacts of varying social, economic and political inequalities on individual members of the groups. The category of men who have sex with men (MSM), for instance, encompasses men in a wide range of social and economic situations, from those who are living in poverty and engaging in transactional sex for economic survival to others who are in an economically and socially privileged position but who may in turn be marginalised by legal restrictions or stigmatisation by peers. The ways in which MSM identify and experience their sexual orientations and gender identities also varies from one person to another (Alcala-Alezones et al., 2018; Sandfort and Reddy, 2013; Sheehy et al., 2014). Creating generalised categories such as MSM can risk excluding and marginalising those who feel that they cannot or should not be categorised as such (Kaplan et al., 2016). Similarly, the category of “sex workers” will encompass both more professional and visible women who sell sex who may be organised in associations

to defend their interests, and young men and women engaging in transactional sexual relations in a more informal way, who may not even acknowledge or recognise that they are involved in selling sex. Young women and men engage in transactional sex for a variety of often interconnected reasons including economic necessity, gender norms or cultural practices. Reducing this range of meanings and motivations to one categorisation may lead to misrepresenting or misunderstanding the complex nature of transactional sex (Stoebenau et al., 2016; Wamoyi et al., 2016). Moreover, labelling any member of a key population primarily by function of this identity runs the risk of classifying their risks and vulnerability in unidimensional terms and ignoring other intersectional forms of discrimination and domination which they may face. Women who sell sex have argued that this identification as a “sex worker” ignores their experiences as women affected by norms related to gender and sexuality, and also their social and economic positioning and experiences (Weitzer, 2009). Further, the use of the notion of YKPs to indicate those young people most at risk of HIV infection may risk further stigmatising these young people by casting them in a negative framework which does not create space for the positive and pleasurable aspects of their sexual and gender identities and behaviours.

This diversity of situations is true for all the key populations as currently defined, making any research or policy recommendations complicated. Moreover, there is a lack of research and data on some of the key populations, leading to them being hidden or invisible in policy-related or programmatic discussions. In all of the five countries studied, there is comparatively little data on young transgender people, young people in prison or other forms of detention and young people who inject drugs. In many cases, what evidence does exist seems to indicate a “crossover” between these young people in a situation of complex and intersectional identities with cross-established categorisations. For example, many young transgender people may also be involved in transactional sex or inject drugs. These crossovers render even more problematic any forms of analysis or interventions which attempt to consider YKPs as discrete categories separate from one another.

In order to be able to develop more effective policy and interventions to respond to the needs of all members of key populations, we need to better understand these variations and the multiplicity and complexity of the SRH situations and outcomes that exist in particular social contexts. In order to do this, we need to move beyond unidimensional analyses which focus on only one factor affecting the SRHR of key populations. Whilst any individual factor may be important, examining it in isolation from a wider range of determinants of health will give only a partial picture. Detailing legislative frameworks on sex work, homosexuality or drug use, for example, may help to provide some elements of the context in which members of key populations SRHR are determined, but it will not be able to explain why certain members of these groups have better outcomes than others.

Evidence shows that de-criminalisation of homosexuality, for example, does not necessarily improve the SRHR of MSM or transgender people in these countries (Beyrer et al., 2013). Thus a multi-dimensional approach is vital in understanding the SRHR of young people who are designated as members of key populations. This multi-dimensional approach will also allow us to question the definitions and boundaries of key populations and to unpack the a priori categorisations which might limit the impacts of policies and interventions aimed at improving SRHR for young people.

Using a social determinants of health framework to understand the vulnerability of young key populations

To better understand the HIV and SRHR situation of young people who are designated as members of key populations, we have thus chosen to use a social determinants of health (SDH) framework (Solar and Irwin, 2010; Viner et al., 2012). This framework analyses the complex interactions between different levels of factors in determining the health of individuals within varying groups in a general population. Wider structural and systemic determinants, such as economic inequalities, political or legal systems (e.g. punitive laws) and health systems, interact with more proximate determinants such as family, peer or community networks and micro-level individual and behavioural-level determinants (e.g. substance abuse). This interaction will be mediated by factors related to social constructions of gender identity and sexual orientation. There is thus a complex interplay of factors which shapes risks and vulnerability, with intersecting social, physical, economic and policy factors at both macro and micro levels. Thus each individual, situated at a different point within this matrix, has their own unique situation of risk, vulnerability or possibility in terms of health outcomes. Using this framework will help us to understand how and why certain individuals are more at risk or vulnerable in terms of SRHR, and how policies and interventions could be better designed to target specific determinants and effect a real shift in health outcomes. Whilst the SDH framework has been in use for some time, there are still few empirically based studies which fully consider determinants at all levels of the framework and their interactions. Further, the framework may need to be adapted for considering young people, for whom various determinants, such as peer networks, may be found to play a larger role than for adults.

The research on young people who are members of key populations is central here because of the youthful “demographic bulge” of the countries of the SADC region and also because of the specific sets of determinants which affect young people’s health outcomes particularly. In all five countries studied here, as in the region more generally, the majority of the population is under 25 years old. The health of these young people is thus central for the future health of the country and the region. A focus on young people is also necessary and justified by a life-course approach

to health, which makes it evident that poor sexual and reproductive health during this period of life will have severe ongoing consequences for the whole of an individual's lifespan. The complex physical, psychological, emotional and social changes that take place during adolescence have immediate and long-term implications for individuals. For example, the onset of puberty is linked to the initiation of sexual activity and subsequent exposure to the risk of pregnancy and STIs, including HIV. Awareness of sexual orientation and gender identity may emerge or become clearer during this period. Social determinants of health are also very specific to the period of adolescence and early adulthood, with an increased influence of family and peer networks (Viner et al., 2012).

Researching SRHR of young key populations also necessitates widening the focus beyond the exclusive concentration on HIV and AIDS. Whilst HIV remains a critical issue for most of the countries in the region, the young people with whom we are concerned also face multiple other and often linked SRH challenges which must be considered and which, in fact, can impact the HIV prevention agenda (Crankshaw et al., 2016; Patton et al., 2016). For young women who sell sex, for example, our initial research highlights a predominantly HIV-dominated intervention response with very little attention paid to these young people's reproductive health, including access to contraception, the problem of unintended pregnancy or unsafe abortion. These challenges are inextricably linked with HIV prevention efforts (e.g. elimination of mother-to-child transmission of HIV or safer conception strategies) and share cross-cutting systemic challenges (e.g. SGBV) which render some more vulnerable to poor health outcomes than others.

Applying the social determinants framework to our baseline findings

Global research has shown that the strongest determinants of adolescent health in general are structural factors such as national wealth, income inequality and access to education (Viner et al., 2012). Our findings point to the major impacts of low levels of national wealth and of economic inequalities on the young people in the five countries studied. Poverty and low levels of national wealth affect spending and availability of public services such as health and education. In many of the project countries there is a basic lack of health infrastructure, and populations, particularly in rural areas, have little access to basic health services (Marks et al., 2016; Ray and Masuka, 2017). For young people, and particularly those in key populations who may experience additional discrimination and stigma, finding appropriate and suitable health advice and care for issues related to SRH issues is often an unsurmountable challenge. The lack of educational opportunities for young people is also a component in creating situations of risk and vulnerability for young people and is linked to worse sexual and reproductive health outcomes (Van Stam et al., 2014).

Young people are particularly affected by income inequality. In all five countries, our baseline research showed particularly high levels of poverty among young people and high levels of youth unemployment. In Madagascar, for example, where recent estimates indicate that extreme poverty impacts 56.5% of the population (IMF, 2017), poverty has a “predominantly young face” (World Bank, 2014). There, young aged 15–24 face immense difficulties in entering the labour market and 75% of the unemployed in the country are under 30 years old (ILO Instat, 2014). Similar situations are found in the other countries studied. In Mozambique, the majority of young people have no access to formal employment (ADB, 2012), and the high youth unemployment levels have been described as leaving young people in a “state of waithood . . . a situation of waiting to become full adults” (p. 16). Poverty and economic inequality impact on young people’s SRHR in various ways, including in their abilities to pay for health services and in their survival strategies, which may in the absence of alternatives lead them to sex work, for example. In Madagascar, increasing rates of transactional sex and sex tourism have been noted in recent years (PSI, 2017; Freedman et al., forthcoming). Although reasons for transactional sex and routes into sex work are not by any means straightforward or unidimensional, there is strong evidence that for many girls and young women transactional sex is primarily a means to be able to buy basic necessities for themselves or their families (PSI, 2017). Evidence from our research, particularly in the south of the country, showed the ways in which traditional and customary gender norms have become imbricated with current structural conditions of poverty and lack of employment, to create situations where transactional sex is a “way of life” for young women. Similar patterns are in evidence in Zimbabwe, where increasing poverty has led to sex work becoming less formalised with the emergence of different forms of transactional sex, and interactions between women who sell sex and clients becoming riskier (Elmes et al., 2017). Young women engaged in this less formalised sex work may not view themselves as “commercial sex workers” and so may risk being missed by targeted health interventions yet struggle to access necessary healthcare elsewhere given conservative community norms around youth and sexuality, and barriers posed by age of consent laws in Zimbabwe and the region more broadly. In Zambia, research has shown that the influence of poverty and inequality as “pathways” to sex work is greater for young women than for other members of the population (Butts et al., 2017). Engaging in transactional sex renders young people vulnerable to infection with HIV and other STIs, unwanted pregnancies and SGBV (Stobeanau et al., 2016). This vulnerability is heightened by legal and policy contexts in which sex work is criminalised, as is the case in Zambia and Zimbabwe, where young people selling sex work may fear reporting SGBV and receiving the necessary care for fear of being arrested themselves. These contexts will interact with economic factors (e.g. out-of-pocket costs to access healthcare) to render young women who sell sex even more vulnerable to poor HIV and other SRH outcomes.

As suggested above, legal and political structures also act as determinants on the SRH of young key populations. In Zambia and Zimbabwe, homosexuality is criminalised, meaning that young people are often scared to reveal their sexual orientations or gender identities for fear of arrest, detention or physical abuse (Hachoonda, 2017; Meer et al., 2017). But even in Madagascar and Mozambique, where homosexuality is legal, norms which strongly favour heterosexuality may mean that young people choose to hide or deny their homosexuality for fear of negative reactions, stigmatisation or violence. Gay or transgender people may thus become “invisible,” a status which can prevent them from accessing health services and push them into marginalised positions within society. In Mozambique, for example, while the decriminalisation of homosexuality has been an important structural change for the legal position of young gays and lesbians, the strongly normative stance on gender relations and identities of key opinion leaders has not shifted much, leading to a continuing marginalisation of young MSM and pressure on them to raise a family (Macia et al., 2011). Marginalisation and stigmatisation of young lesbian, gay, bisexual, transgender and intersex (LGBTI) people, sex workers and injecting drug users (IDUs) are often a fundamental barrier to these YKPs accessing health services where attitudes towards them are discriminatory and where the care provided is inappropriate or unresponsive to these young people’s specific SRH needs. Young women who sell sex, for example, have been found not to disclose their work to health professionals or to misrepresent their health problems or even to avoid care entirely because of their fears of discrimination (Scorgie et al., 2011; Lafort et al., 2016; Mwashita, 2017).

Health systems themselves are an intermediate determinant of health through which differences in health vulnerabilities and risks are exacerbated or mitigated. The five country case studies have different organisations of health systems, but a common factor seems to be health systems which suffer from lack of resources and which may be fragmented in their delivery of services, with vertical delivery of services, for example, separating structures dealing with HIV/AIDS from those addressing other SRH needs. In Mozambique, for example, there is only one methadone treatment site in the country, which is situated in the psychiatric hospital in Maputo. Key informants revealed that people who inject drugs who sign up for this programme often leave prematurely, as they are hospitalised together with psychiatric patients and alcoholics and find it difficult to cope in such an environment. Cost of services and distance from health facilities remain major barriers for many people in accessing care (Marks et al., 2016; Garchitorena et al., 2017). For YKPs these problems may be intensified in country contexts where their health needs are marginalised. For example, despite provision for treatment for AIDS, TB and hepatitis in Mozambique’s Prison Policy (2002), the Integrated Biological and Behavioural Survey found that prisoners often faced interruptions and discontinuation of their treatment regimens

(INS, 2013). A serious lack of health provision for prisoners or for IDUs in many countries reinforces the vulnerabilities of these young people to poor SRH outcomes.

Structures of gender inequality and the persistence of traditional attitudes and norms towards gender and sexuality in conjunction with the existing socio-economic and political systems in each country may thus impact on the SRHR and the general health and well-being of persons belonging to gender or sexual minorities. Similarly, traditional gender norms which place an important prime on heterosexuality and “traditional” family structures create a context within which young women have little control over their sexuality and face particular risks to their sexual and reproductive health. Proximal determinants such as family and peer networks mediate the effects of these structural determinants and have a strong impact on young people’s SRHR. Globally research has shown how social networks including family and peers shape sexual behaviour (Marston and King, 2006). Again, our research shows the potential negative impacts on SRH of young people in communities where there is strong peer pressure on young people to have sexual relations at an early age, or where young men feel peer pressure to engage in multiple sexual partnerships. In Madagascar, the research has shown that strong pressure both from family and peers to engage in sexual relations at an early age, in combination with a lack of access to contraception and to SRH services, has led to high rates of pregnancy among young women and also to high rates of illegal abortion (Focus Development, 2007). Young people with weak sex-work peer networks, as our research suggests may be the case for adolescents who sell sex in Zimbabwe, may not benefit from targeted interventions accessed via these referral pathways.

A final piece in the social determinants framework is the individual behavioural-level determinants, which means that two young people who are seemingly in near identical socio-economic conditions, with similar family and peer networks, gender identities and sexual orientations, may still have very different SRH outcomes. These issues are not explored in the baseline literature review and key informant interviews, and thus need further in-depth research and analysis. One of the objectives of our ongoing research will be to aim to capture these individual-level determinants by in-depth biographical interview techniques to understand better young people’s choice and pathways to vulnerability or resilience. This understanding should lead to recommendations on how better to engage young people from key populations to promote behaviours and choices which will improve their SRH.

Conclusion: moving forward

The initial baseline analysis of the sexual and reproductive health of young key populations in these five countries using a social determinants

of health framework has shown the multiple interlocking factors that may lead to poor HIV and SRH outcomes, including infection with HIV and other STIs, unwanted pregnancies, sexual and gender-based violence. This acknowledgement of the multiplicity of pathways into vulnerability for these young people and the intersectional nature of the barriers and risks they face points to the need for more in-depth research to fully understand how policy and programming could address these determinants to improve SRH for young people in key populations. Questions for further research emerge directly from a lack of data on certain young key populations – especially young prisoners, young transgender people and young IDUs – and others push to explore further the ways in which varying constellations of social determinants will lead to individual outcomes of risk or vulnerability for young people’s SRHR and how these may be better addressed in the future.

Further, our baseline studies point to more serious issues with the categorisation of young key populations and the ways in which these categorisations have been employed. Thus issues which need to be considered in future research concern the ways in which a social determinants of health framework might lead to re-consideration of the categories of key populations in the SADC region as applied to young people. We need to better understand who these populations are and how exactly they are rendered vulnerable. Given a certain set of systemic and structural determinants, how and why do certain individuals and groups have more negative health outcomes than others? And which policy interventions would be most effective in transforming the social determinants for YKPs, thus ensuring better sexual and reproductive health outcomes?

Notes

- 1 Approximately two-fifths of Africa’s population are 14 years or younger, and nearly one-fifth (19%) are between the ages of 15 and 24 (African Union, 2015, 2017; UNECA, 2017).
- 2 Sexual and reproductive health and rights (SRHR) is broadly defined as “a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognise the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing. All individuals have a right to make decisions governing their bodies and to access services that support that right” (Gutmacher-Lancet Commission, 2018).
- 3 Key populations are generally defined as men who have sex with men (MSM), people who inject drugs, people in prisons and forms of detention, sex workers and transgender people (UNAIDS, 2014).
- 4 www.unaids.org/en/topic/key-populations.
- 5 It should be noted that the introduction of KP programmes has been varied across this time, with a somewhat later adoption in Africa due to the focus on more generalised epidemics in many countries on the continent and in some cases political resistance to programmes targeting criminalised or otherwise marginalised groups.

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