Do young key populations in South Africa have access to sexual and reproductive health services?

A participatory youth-led research on the needs of young key populations

TB HIV Care hosts community advisory group meetings in which young key populations receive counselling on HIV, SRHR and harm reduction.

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In 2020, worldwide 65% of people who contracted HIV were sex workers, people who inject drugs, transgender people, gay men and other men who have sex with men, or their sexual partners. These groups are at increased risk of HIV because of criminalisation, stigma, discrimination and violence. If you are young and from a key population, this vulnerability is aggravated by criminalising laws, unfavourable policies, and different social expectations. That is why young people account for a disproportionate number – around one third – of all new HIV infections worldwide in people over 15 years of age.

Young key populations need access to good quality HIV, sexual and reproductive health and rights (SRHR), and harm reduction services, to address this. However, young key populations experience barriers that hamper their access to these services. In 2020, two young researchers from TB HIV Care conducted 59 in-depth interviews and five focus group discussions with 85 young people from key populations in Durban, South Africa, to understand what influences them to access HIV and SRHR services. The research is part of the Young, Wild and… Free? project (2019-2021), which supports young key populations to increase access to and uptake of HIV, SRHR, and harm reduction services in Russia, Kenya, South Africa, and Vietnam. Young researchers were in the lead of the research process and guided this summary report after receiving training in research skills from partners in the Bridging the Gaps programme (2011-2020), which is the parent programme of Young, Wild and… Free?

Some useful definitions

**Harm reduction** refers to policies, programmes and practices that reduce the negative impacts associated with drug use. Harm reduction interventions are proven to improve individual and public health and are cost-effective. Services include needle and syringe programmes, opioid substitution therapy, non-abstinence-based housing and employment schemes, drug checking, drug consumption rooms, overdose prevention and reversal, psychosocial support, and information on safer drug use.

**Opioid substitution therapy (OST)** is a daily dose of a prescribed opiate (normally methadone) that has been proven to decrease heroin use, reduce injecting, improve health and reduce the risk of HIV and hepatitis C transmission. It also enables people to become more socially active and can lead to a decrease in criminal activity.

Setting the context: South Africa’s legal and policy environment

In recent years, South African legislators have been working towards a more holistic approach to drug use, one that addresses individual needs and prioritises public health. The South African government endorses several drug schemes, but these focus on stopping young people from starting drug use and there is a huge gap for young people who are already using drugs. The government has committed to fund harm reduction services, but only NGOs currently provide these services.

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2 When mentioning ‘young people’ in this report, we refer to adolescents (ages 10-19) and youth (ages 15-24).
3 While we use age categories currently employed by the UN and WHO in this report, it is important to acknowledge that the physical and emotional maturity of adolescents varies widely. The UN Convention on the Rights of the Child recognises the concept of evolving capacities, stating in Article 5 that direction and guidance provided by parents or others must take into account the capacities of children to exercise their own rights as they age.
4 The full research report Perspective, the determinants and the needs for access to and utilization of sexual health services among young key populations in Vietnam is available from Lighthouse and was conducted in partnership with the Mainline Foundation and MPact, global partners of the Bridging the Gaps programme.
**KEY FINDINGS**

These findings reveal the level of young key populations’ knowledge about HIV and SRHR and where they get information from, key elements that affect how likely young key populations are to use services.

85 young key populations took part

30 young people who use drugs
29 young sex workers
5 young men who have sex with men
6 young gay men
3 young transgender people
7 young bisexual women
5 young lesbian woman

Some young people identify as more than one key population

**Characteristics:** All 85 participants were aged 18-24 and lived in Durban. They identified as female sex workers, people who use or inject drugs (13 females, 17 males), lesbian, gay, bisexual or transgender (LGBT). Often, participants identified as more than one key population (for example, most sex workers reported using drugs, as did some LGBT people). More than half had engaged in transactional sex in the last 12 months.

**HIV and SRHR**

**Knowledge about HIV and SRHR services:** One in ten participants felt HIV and SRHR information or services were not needed because they felt healthy. Knowledge about HIV and SRHR was generally good; although 7% of the participants said they had been unaware what HIV and SRHR services were available when they were adolescents, and 4% still had limited knowledge.

**HIV and SRHR information sources:** Friends or family (10%), school (7%), and private clinics (7%) were the most important information sources for those who knew about services. According to the participants, public HIV and SRHR information did not meet their needs, could be stigmatising and was not aimed at them. Online HIV and SRHR information was accessed by LGBT participants.

**HIV and SRHR services accessed:** Due to stigma relating to sexual identity, gender identity and expression young LGBT people were less likely to use HIV and SRHR services than young people who use drugs and young sex workers.

“Most people are still homophobic. It’s worse when you get a [health] worker who is not familiar with LGBT people. They will judge the person and not treat them well because of their sexuality.”

– Transgender female, 23

HIV testing was the most common service used, but still only one-third (31%) had ever tested for HIV. Condoms and family planning were the next most common services used; lubricants were harder to access. All participants living with HIV had started treatment, but many had stopped and restarted. Only 17% of young women were using oral contraceptives. Hardly any accessed circumcision services (male), STI tests, or hormone treatment (transgender people). Most were unaware or misinformed about pre-exposure prophylaxis (PrEP).

A young psychosocial counselor from TB HIV Care conducts individual sessions with young clients who reach out for assistance.
**Harm Reduction**

**Drug use:** Around 20% of the participants used drugs (heroin, crack cocaine, cannabis, alcohol and ecstasy). They used drugs to ‘de-stress’ or escape difficulties such as discrimination, financial worries and sexual trauma. Of the participants who inject drugs 8% shared needles, despite being aware of HIV. Mental health support was wanted by 57% of young people who use drugs but only a minority had received it.

“**I use rock so that I don’t feel anything… If I sleep with someone I don’t concentrate, I just think about other things as a client is busy with me.**”
– Young sex worker, 23

**Access to harm reduction services:** The concept ‘harm reduction’ was unknown to 75% of the participants. Two participants had accessed OST (at private doctors). Clean needles and syringes were mainly accessed from TB HIV Care. Some bought needles in pharmacies, but many avoided this because of the way pharmacists treated them.

“We share needles… No, I am never scared, because during those moments I just want heroin.”
– Young woman who injects drugs, 24

**The Enablers and Barriers to HIV, SRHR, and Harm Reduction Services for Young Key Populations**

In this section, young key populations reveal the main barriers that stop them from accessing HIV, SRHR and harm reduction services, plus the factors that enable them to get the support they need.

**1. Service Providers’ Attitudes**

**Barrier:** Healthcare workers breaching confidentiality and having negative attitudes were the most common reasons participants gave for not accessing SRHR/HIV services. Young sex workers reported being called names, being laughed at and gossiped about. Young people who use drugs who are living with HIV said accessing antiretroviral treatment (ART) could be hard as they may be insulted for how they looked or smelt and even be refused services. Young LGBT people described being mocked due to their sexuality, gender identity or expression.

“The others stigmatise against us, they call us ‘amaphara’ [parasite] and give us a negative attitude.”
– Young woman who injects drugs, 24

**Enabler:** Healthcare workers who “had manners,” “showed interest in their health and wellbeing” and “did not discriminate [against] them because of their choices or practices” were appreciated by participants. Some participants preferred mobile clinics to standard public facilities because they said staff there were more friendly and welcoming.

**2. Fear and Stigma**

**Barrier:** The fear of being judged or treated badly stopped young key populations from using HIV and SRHR services. This is linked to sexuality and family planning being taboos in certain communities, especially for adolescent girls and young women. The fear of not knowing what happened during an HIV test or a sexual health examination stopped some young key populations from using services as did fear of a positive test result. The fear of being physically attacked stopped LGBT people from accessing services.

“They [broader community] still lack knowledge about the [LGBT] community and there are so many incidences where people are being raped and killed because of their sexuality.”
– Young transgender female, 24

**Enabler:** More awareness, about the services that are available and about what these services involve, among young key populations and broader society will increase uptake. For example, by more peer-led HIV and SRHR programmes or events in schools.

**3. Cost**

**Barrier:** Not being able to pay for HIV and SRHR services, or not being able to afford to travel to clinics was a barrier for all young key populations. If they did not have money, they would be assisted last, not assisted at all, or would be marked ‘in debt’ and have to pay double next time.

**Enabler:** Free or subsidised services and nearby facilities (which cost less time and money to get to) are more likely to be used. Just under half (42%) said they were never charged for HIV or SRHR services and this encouraged them to use them.
4. PARENTAL CONSENT

**Barrier:** The need for parental consent stopped 4% of participants from accessing HIV and SRHR services when under the age of 18, despite having a need for them.

**Enabler:** Advocacy to challenge age-of-consent laws and building the skills of young key populations to collect data on the harmful effects of age restrictions are useful strategies.

**WHAT YOUNG KEY POPULATIONS RECOMMEND**

To address the barriers outlined above, young key populations made the following recommendations:

**NGOs and community-based organisations (CBOs) should sensitise and train public healthcare workers to treat young key populations with dignity and respect, particularly in relation to young people living with HIV and young LGBT people.**

**NGOs and governments should support friendly and competent health services** by first mapping the facilities young key populations already access, then meeting with senior healthcare workers there to understand how staff could be better supported and sensitised, and to share best practice with other facilities.

**CBOs and NGOs should use youth-friendly events and social media influencers to educate** and to tackle misinformation (e.g. on PrEP). By focusing on ‘edutainment,’ young key populations learn through fun events involving music, dance or engaging social media content.

**Government and NGOs should provide more family planning services, condoms, lubricants and psychosocial services at drop-in centres and friendly health facilities.** Counselling (one-on-one) from qualified, peer counsellors who can better relate to young key populations, is particularly needed.

**NGOs should invite young key populations to a drop-in centre for harm reduction education led by young people to create awareness.** General awareness drives should be conducted to educate the wider community. Governments should support more peer-led school programmes.

**CBOs and NGOs should employ young community liaison officers** to help tackle stigma in the wider community. The liaison officers should reach out to CBOs working with community gatekeepers such as traditional leaders, churches, religious groups and ward councillors.

**Programmes for young key populations should address the fact that people can belong to more than one key population.** Support for young sex workers should take drug use into consideration, for example, while programmes that support young people who inject drugs should expand to cover all illicit drug use and be inclusive of young LGBT people and sex workers.

**Advocates should campaign for harm reduction approaches towards drug use** in which local governments are provided with evidence on the benefits of harm reduction to encourage them to adopt these practices in their policies and to encourage rehabilitation centres to provide better, age-appropriate services that include harm reduction interventions such as OST.