



# HIV PREVENTION FOR SEXUAL MINORITY GROUPS IN ZAMBIA



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# List of Acronyms

<b>AIDS</b>	Acquired immunodeficiency syndrome
<b>ART</b>	Antiretroviral Therapy
<b>FoR</b>	Friends of Rainka
<b>GBV</b>	Gender Based Violence
<b>HIV</b>	Human Immunodeficiency Virus
<b>LGBT</b>	Lesbian, Gay, Bi sexual and Transgender
<b>MARP</b>	Most AT Risk Population
<b>MSM</b>	Men who have Sex with Men
<b>NAC</b>	National HIV/AIDS/STI/TB Council
<b>NGO</b>	Non-Governmental Organization
<b>PEP</b>	Post-Exposure Prophylaxis
<b>PSAf</b>	Panos Institute Southern Africa
<b>PSI</b>	Population Services International
<b>STI</b>	Sexually Transmitted Infection
<b>TDRC</b>	Tropical Diseases Research Centre
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNFPA</b>	United Nations Population Fund
<b>UNGASS</b>	United Nations General Assembly Special Session on HIV and AIDS
<b>VCT</b>	Voluntary Counseling and Testing
<b>WHO</b>	World Health Organization
<b>WSW</b>	Women who have sex with women

# Definition of Key Terms

<b>Bisexual:</b>	A man who is sexually attracted to both men and women.
<b>Coming out:</b>	Telling other people about one's sexual orientation i.e. that one is gay, lesbian or bisexual.
<b>Gay:</b>	A man who is sexually attracted to other men.
<b>Heterosexual:</b>	A man who is sexually attracted to women.
<b>Homophobia:</b>	The disapproval, fear or hatred of homosexual people
<b>Homosexual:</b>	A man or woman who is sexually, emotionally, spiritually and physical attracted to someone of the same sex .
<b>In the closet:</b>	Telling no one that one is a man who is homosexual/gay or that you have sexual feelings for people of the same sex with you.
<b>Lesbian:</b>	A woman who is sexually attracted to other women
<b>Lesbophobic Rape:</b>	Forced sex done to a Lesbian with the hope of transforming her into a heterosexual woman.
<b>Penetrative sex:</b>	Sexual activity that involves penetrating usually with a penis. This can be oral, anal or vaginal penetration.
<b>Safer sex:</b>	Having sexual intercourse that uses methods of reducing the risk of transmitting or contracting HIV or other STIs. Most common way is using a condom.
<b>Sexual orientation:</b>	The biological sex to which a particular person is attracted. For example, a man who is attracted to both women and men is bisexual.
<b>Sexual Practices:</b>	Activities that takes place in the process of a sexual act
<b>Sexual Minority:</b>	people whose sexual orientation composes a minority of the general populations
<b>Sexual Behaviour:</b>	A behavior that depicts one's sexuality or sexual orientation.
<b>Sexual Partnerships:</b>	Relationships between people who are having sex with each other
<b>Sexual Networks:</b>	A group of people who are interlinked through having sex with the same partners.
<b>Sexual Tendency:</b>	behavior that demonstrates a particular sexual orientation even the person may not have that kind of orientation.
<b>Sexuality:</b>	A broad term covering sexual identity (e.g. whether you call yourself 'gay' or 'straight'), sexual orientation (i.e. who they are attracted to), sexual behavior (e.g. some may describe themselves as 'gay' but be bisexual in their behavior), and sexual preferences (e.g. with older or younger people).
<b>Orgy:</b>	Group sex (a sexual act involving more than two people).



# Introduction

HIV and AIDS remains one of the biggest health problems in Zambia and Southern Africa. In 2007, 14.3 per cent of Zambia's estimated 12.9 million population was infected with HIV, and there are roughly 100,000 new HIV infections and nearly 100,000 AIDS deaths every year (ZDHS 2007).

The existence of HIV high risk groups such as mobile populations, commercial sex workers and sexual minorities makes the epidemic even more complex. While commercial sex workers, mobile populations and other key populations seem to get included in some policy and programming interventions, sexual minority suffer extreme marginalization due to the social and legal landscape of the Zambian Society and Southern Africa as a whole.

Sexual minority people live in fear of being stigmatized, blackmailed, attacked, raped or killed by their workmates, family members, neighbours and other members of the community. This harsh treatment pushes the sexual minority populations to the margins of society where they live double lives so as not to be identified as such. They find themselves in heterosexual relationships as a cover up while they are also in sexual relationships with people of the same sex. This tends to put them, and their partners at even higher risk of contracting HIV while increasing the risk of blackmail and stigma if found out.

A Fay et al (2010)'s study of men who have sex with men (MSM) in Malawi, Namibia, and Botswana found that blackmail was one of the most prevalent human rights abuses they faced, with 18% of them in Malawi, 21.3% in Namibia, and 26.5% in Botswana reporting incidents of blackmail. The study further reveals that across the three countries, the 21.2% of people who had been blackmailed because of their sexuality were afraid to walk in their community (19%), were afraid to seek health services (18.5%), had been beaten up by a government or police official (12.2%), were denied housing (6.9%), or were denied health care (5.1%). Even in South Africa, where same-sex activity has been decriminalised and discrimination on the grounds of sexual orientation outlawed, a worrying 10.5% of MSM respondents reported being blackmailed in peri-urban townships outside of Cape Town.

Due to the fact that in this region same-sex practices are highly stigmatized and in most countries criminalized, HIV among sexual minorities goes undetected as people avoid situations where their sexuality and/or HIV status may be disclosed due to stigmatizing perceptions of their society, (Fay et al 2010). Fay et al (2010) further argues that while the HIV epidemic in this region is mostly driven by hetero-sexual and vertical transmission, data on the disproportionate burden of HIV among sexual minority groups especially MSM continues to emerge. However, data on proportion cases remains unknown.

The illegality and stigma attached to sexual diversity or identities may give victims good reason to value non-disclosure, and to go to great lengths to prevent disclosure from taking place.

In countries where religious or customary laws are accorded recognition alongside state law, blackmailers and abusers targeting sexual minorities often think they are privately enforcing legal and social morals. For a variety of reasons, the human rights framework has been of limited use in addressing the problem of abuse of lesbians, gays, bisexuals and transgender (LGBT). At the bottom of all the hate and abuse of sexual minorities by many African leaders, media and communities lie a deep lack of understanding or ignorance and myths regarding sexual diversity.

The prohibitive legal and social contexts restrict LGBT communities from fully benefiting from their human rights. Furthermore, restrictive environment impedes successful health and HIV related responses for such groups despite emerging evidence of their contributions towards new infections especially in concentrated epidemics as prevailing in the region where HIV rates are above 20% and STIs are rampant and only 17% of the study population reported ever disclosing same sex practice to a professional health worker for comprehensive reproductive health service (Fay et al 2010). In cases where the legal environment is not discriminatory like South Africa and Angola for example, the levels of social stigma are still high making it difficult for LGBT communities to freely access health care. Stigma and intolerance has caused LGBT communities to suffer violence even death. This situation has also isolated LGBT, further denying them adequate access to sexual reproductive health and rights services.

In Zambia, as in many other countries in the region, HIV infection is highly driven by the prevalence of multiple and potentially concurrent sexual partnerships. It is exacerbated by a number of socio-economic factors, including the high levels of poverty especially among women. Estimates show that 69% of Zambians live on less than a dollar per day, contributing to high-risk sexual behaviour (Zambia Demographic and Health Survey 2007).

Despite these documented trends, limited studies have been undertaken on the perception of risk of HIV infection for sexual minorities in Zambia. This makes targeted interventions difficult. Of importance to note is the fact that according to CEDEP (2010), in low-income countries (Zambia inclusive), on average, 20% of men who have sex with men report having sex with women at some time; 16% of men who have sex with men also report having sex with women in the last year; and 16% of men who have sex with men also report being married.

Sexual identity has been largely ignored in HIV prevention efforts, yet it can provide important clues for public health prevention efforts. The different sexual identities and behaviours require different HIV prevention approaches because of the different risk exposures. This can be seen from a policy analysis of various national HIV/AIDS policies in Southern Africa, Mozambique, Zambia, Malawi, Zimbabwe, Lesotho among others, (Panos 2012 Policy analysis for MSM response)

The inclusion of targeted programming for sexual minorities in HIV prevention interventions has potential to address some of these unaddressed dynamics in the HIV response thereby contributing to the reduction in the spread of the virus within and outside the population, and has a high potential HIV prevention benefits for the broader community. There is therefore a need to understand the role that sex between men or women plays in total national HIV epidemics, draw lessons and develop programmes around those. It is expected that the outcomes of this study will stir appropriate shifts in the legal and policy frameworks in order to create an enabling environment for inclusive HIV prevention interventions.

## **1.1 Rationale for the study**

Perceptions of sexual diversity in Zambia are that it is foreign and un-Zambian. As a result, most of the current HIV and AIDS and sexual and reproductive health interventions are developed and rolled out with the assumption of a heterosexual population. In the end, the specific needs of sexual minorities are not adequately provided for; neither are service-providers adequately prepared to offer comprehensive services for this population. The challenge of programming for sexual minorities is also faced with limited availability of data which makes it difficult to determine how much targeted programming would be required and what kind of skills and expertise are required to prepare the health personnel.

This study was an important undertaking for the National HIV/AIDS/STIs/TB Council of Zambia because issues of sexual minorities are part of the Most at risk populations (MARPS) which forms part of the key strategies in HIV Preventions for 2011 to 2016. There is urgent need to learn more about the existence of sexual minorities, their characteristics and their risk to HIV infection and other reproductive health problems. There is also need to appreciate the link between the epidemic in the homosexual communities, and that of the general population in order to develop relevant strategies that will ensure that HIV and AIDS are comprehensively addressed. It is further important to characterize the populations, identify service gaps and document the perspectives of the various sub-groups of sexual minorities.

Currently, community and public health programmes do not recognise the increased risks faced by these sub-groups and the need for assisting this population is not adequately appreciated. This study therefore was intended to increase the understanding of this often-overlooked population and the designing of appropriate interventions, and also extending reach of current HIV prevention efforts to high risk groups. Currently in Zambia, programming for sexual minorities is based on the 2009 Modes of Transmission of 2009 which estimated that MSMs contribute to 0.99% to the general incidence of HIV incidence rates (NAC MoT Study 2009). There have been debates to the effect that this could be understated due to difficulties in accessing data for MSM. The study would provide data that can better inform NAC on key challenges of HIV transmission among sexual minorities, gaps in programming and make recommendation for addressing the gaps.

Furthermore the study was meant to help in streamlining the specific intervention needs required for each sub-group. This would make it possible for the country health systems to develop interventions that would



address the needs of this average but diverse population in the most effective ways. The study findings would also be useful in advocacy efforts and promote the implementation of appropriate HIV prevention interventions in the country.

## 1.2 Objectives of the Study

The purpose of the study was to conduct a comprehensive research aimed at characterising high risk populations, their association with total national HIV epidemics in Zambia and identify the opportunities for interventions.

The study answered to the following specific objectives:

1. To describe the characteristics and behaviours of HIV high risk populations.
2. To measure the extent to which high risk populations are being reached with HIV preventive and treatment services
3. To identify inhibiting factors for effective HIV prevention among high risk populations
4. To identify opportunities for inclusive interventions targeting high risk groups
5. To determine HIV prevalence among high risk populations
6. To provide recommendations for inclusive programming in the HIV/AIDS response.

## 1.3 Target Population

The study targeted the sexual minority community, considered to be among the high risk populations in Zambia, specifically men who have sex with men and women who have sex with women, regardless of their sexual orientation or how they identify themselves. This covered the lesbians, gays, bisexuals and transgender people, as long as they had same sex relationships.

### 1.3.1 Inclusion criteria

1. Be a resident of the study site
2. be “MSM or WSW”
3. 18 years of age and above

### 1.3.2 Exclusion criteria

1. Not MSM nor WSW

### **1.3.3 Study Sites:**

The study was conducted in five geographical locations outlined below. The sites were selected because of the size and cosmopolitan nature of the populations. Information from records at Friends of Rainka also indicated that the sites had substantial or huge concentration of the sexual minority population in the country.

#### **Ndola**

Ndola is Zambia's third largest city and the industrial and commercial heart of the Copperbelt province. The city lies about 320km north of Lusaka. The 2010 national census report put the city's population at 455,194 people. Following the collapse of the mining industry at the beginning of the 1990s, many people lost their jobs and have over the years been joined by more in the informal sector due to scarce job opportunities in the formal sector. More than 50 per cent of the labour force is in the civil service.

#### **Kitwe**

Situated about 65 kilometres west of Ndola city, Kitwe is the largest town on the Copperbelt and the country's second city. Its population was 504,194 as of 2010 according to the 2010 national census report. The city's life line is the copper mining industry, which together with the civil service employ most of the labour force.

#### **Chingola**

Chingola is another city on the copper belt with a population of 210,073 people in 2010. The town once renowned for its clean environment is located about 52 kilometres west of Kitwe. Just like Kitwe the town's biggest employer was the mining industry, particularly the Nchanga Open pit mine which is one of the largest open pit mines in Africa. Chingola site also covered Chililabombwe as some of the respondents travelled from Chililabombwe to be interviewed in Chingola.

#### **Lusaka**

Lusaka is the capital city of Zambia. It is home to approximately one in ten Zambians. Its population was 1,742,979 as of 2010. Like any capital city, Lusaka has the problem of unemployment. Most of the employed population in the city work in Government, Non-governmental organizations and the corporate world.

#### **Livingstone**

Livingstone is a historic colonial city and a tourism centre with the world acclaimed Victoria Falls lying 10 km (6.2 miles) away south of the city. The town has road and rail connections to Zimbabwe on the other side of the Zambezi River. Its population was 136,897 in 2010. Majority of people in Livingstone work in the tourism associated businesses and government departments or ministries.

# 2.0 Methodology

The study followed a research plan which outlined how the respondents would be selected, what data gathering techniques would be used and how the data analysis would be done based on the project's assumptions as detailed below.

## 2.1 Study Design

The study was a mixed methods cross-sectional study using mainly quantitative methods for data collection in order to be able to quantify the results as well as make cross references of the variables to create a more definite picture on the sexual minority community in Zambia.

Qualitative data was also collected to compliment the quantitative data and provide descriptions and explanations where necessary. The study was also a case study of sorts because it conducted a systematic enquiry into a set of behaviours, characteristics and practices of the sexual minorities with the aim of explaining how the characteristics and behaviours of this particular group of people affected their risk to HIV infection as well as their ability to access services.

## 2.2 Sampling Method

The study used non-probability and purposive sampling. This was because the study targeted a population that was hard to reach. As such participants were selected based on some defining characteristics that made them holders of some data needed for the study, and the sampling decisions were made for the explicit purpose of obtaining the richest possible source of information to answer the research questions.

### 2.2.1 Snowball Sampling/respondent driven sampling

The snowball method also known as chain referral sampling was used. This method worked by identifying seed respondents who were then used to penetrate their sexual networks to reach out to other participants who could potentially take part in the research. The seed respondents were randomly sampled from the membership register of Friends of Rainka (a Zambian-based sexual minorities membership organisation). The seed respondents would then make contact with people in their sexual networks.

The success of this methodology dwelt so much on the level of trust that the seed respondents instilled in the contacts they recommended, and likewise the level of trust that the seed respondents had in the research team.

### 2.2.2. Sample size calculation

The study did not have a sampling frame because of the secretive or sensitive nature of the study population.

Using snowballing, each of the respondents was expected to lead the study to three (3) other members of his/her network.

The distribution of the start-up groups was as follows:

Lusaka	40 respondents
Livingstone	20 respondents
Kitwe	15 respondents
Ndola	15 respondents
Chingola	10 respondents

## 2.3 Data Collection

As a mixed methods study, both quantitative and qualitative methods of data collection were used as follows:

### 2.3.1 Structured Interviews

Private, face-to-face interviews were conducted using structured questionnaires. There was a questionnaire for MSM and another for WSW.

There were 10 Research Assistants involved in the administration of the questionnaires. A total of 450 interviews were conducted - 80% men and 20% women.

### 2.3.2 Focus Group Discussions

FGDs were used to obtain additional scoping information and experiences at group level. There were two FGDs in Lusaka and another two in Kitwe, (one with men and another with women in each of the towns). A total of four FGDs with an average number of 12 respondents were conducted.

The study did not conduct FGDs in Livingstone because the sexual minority population in Livingstone was mostly commercial sex workers who were reached out in bars and clubs at night. In this case, organising an FGD was not possible.

### 2.3.3 Estimating HIV prevalence

The study also estimated the HIV prevalence of sexual minority groups. This was done through HIV testing of all respondents HIV using Dry Blood Spots (DBS). The DBS were collected by the trained medical personnel from TDRRC as part of the data collection process. The testing was done at the TDRRC laboratory.

### HIV Testing algorithm

- a) Each eluted DBS specimen was first tested with one fourth-generation HIV 1/2/O ELISA test.
- b) All HIV positive samples were then retested with an independent HIV 1/2/O ELISA test.
- c) Any sample testing positive on ELISA test 1 and negative on ELISA test 2 (producing discordant results) will be submitted for tie-breaker testing using a Western Blot assay.

## 2.4 Ethical Considerations

The study ensured that all rules of ethics in research were followed and that the rights of the subjects were protected. In order to do this the study process ensured the following:

### 2.4.1 Confidentiality

The study process ensured that data collected was treated with utmost confidentiality in order to avoid violating the privacy of the subjects. In this regard the study process ensured that data protection and privacy measures were employed. This was done by using codes other than real names of the people.

Data was kept and used only for purpose of this study and was not and will not be shared with unconcerned parties. This was one of the emphasised aspects in the training of research assistants.

### 2.4.2 Consent and Voluntary Participation

The study process ensured that people were given full information about the research and its purpose, and were also given an opportunity to voluntarily give consent to participate in the research.

In order to do this the process ensured that before any activity, people were briefed adequately and were well informed of what they were getting into. Letters of consent were signed by all participants. People who could not read or write were assisted by their colleagues and thumb prints were used to give consent.

### 2.4.3 Getting Clearance from Necessary Authorities

With support of NAC, the study sought and received clearance from the following authorities:

- TDRC Ethics Review Committee to conduct such a biomedical study in the country
- Ministry of Home Affairs gave clearance to conduct the study and assured the research team of security throughout the process. A letter of clearance was offered by the Ministry of Home Affairs. All members of the research carried a copy of this letter as a form of security throughout the research process. which for security assurance that both the respondents and research team would not arrest or interfere with by the security wings pursuant to law that does not permit homosexual practices.
- Ministry of Health provided authority to proceed with the study after obtaining the above two clearances.

### 2.4.4 Protection from Harm

The study process ensured that people participating in the research process were not exposed to any form of harm whether physical, emotional or psychological. The study also ensured that no unrealistic expectations were raised during the research process and that the human rights of all the participants such as the rights to privacy, informed consent, and others were considered seriously and that people were treated with dignity and respect.

## 2.5 Limitations of the Study

There were a number of significant limitations that need to be noted as follows:

1. Unknown sampling frame: Owing to the fact that the population of sexual minorities in Zambia is not known, it is not possible to determine the sampling frame. Therefore, the study used snowballing, a non-probabilistic sampling method.
2. Financing: the study had a tight budget especially for the DBS testing. Funds were pooled from elsewhere to cater for the DBS testing. In addition, during the process, it was learned that there were a number of hidden costs attached to snowballing as a sampling technique such as coordination of the respondents, communication and mobilisation required logistical costs that were unforeseen.
3. Unfriendly social and legal environment: The unfriendly social and legal environment in the country made it difficult for the sexual minority community members to easily trust the study and come forth for the interviews. In most cases they would come through in the company of the seed respondent and had to seek approval or consent of the network leaders.

## 2.6 Field-Work

The field work comprised of several steps, starting from the field work preparation phase to the actual data collection process

### **2.6.1 Consultations with key stakeholders**

In preparation for the field work, several consultative meetings were conducted with various stakeholders including Ministry of Home Affairs, Ministry of Health, and some members of the Technical Working Groups of NAC.

The main aim of the consultative meetings was to share the planned study with key stakeholders and get their input to the improvement of the protocol and the process.

### **2.6.2 Identifying and Training research assistants**

Research Assistants were recruited based on a set of prerequisites that included age, previous experience in data collection involving the partner institutions on the study; level of education; willingness to participate on the study without any prejudices; and previous association with the LGBT community. Thus 10 people, i.e. six from the larger population and 4 from the LGBT community, were identified.

Thereafter the research team underwent training which provided in-depth insight into the essence and design of the project; ethical issues; the tools; the respondent consent form; and their responsibilities. The training was conducted in Kitwe and involved both theory and practical sessions especially on how to administer the questionnaire.

### **2.6.3 Identifying and Orienting of seed respondents**

The identification of seed respondents was based on the membership register of Friends of Rainka. Friends of Rainka have over 2000 registered members spread across the country, but mostly in the urban areas of Lusaka, Copper Belt and Livingstone. Friends of Rainka also have focal persons and community coordinators who were used in mobilising the seed respondents in each of the study sites.

Three sensitisation workshops for seed respondents were then conducted in Livingstone, Lusaka and Kitwe. The idea was to establish a cadre of respondents who would understand the study project and then go out to sensitise colleagues in their networks and assure them of security for their participation.

### **2.6.4 Pretesting**

Pretesting of the data collection tools was conducted towards the end of the training for the research team in Kitwe. The identified respondents were given latitude to choose a place they considered appropriate and secure for the interview. The majority preferred to be interviewed from the venue of the training for the research assistants. Twelve respondents were interviewed – Nine MSM and Three WSW. All of them had their blood samples collected.

The tools that were pretested were the respondent consent form, the structured questionnaires and the DBS collection process. This exercise enabled the study to identify and address the gaps in tools and performance of the research assistants. It also helped research assistants to have a hands-on experience in administering the consent form and the questionnaires using the knowledge they were exposed to in the training.

Among the lessons from the pre-test exercise were:

- a. The study needed to be alive to the dynamics of sexual identity and how this affected the respondent-interviewer relationship. Some respondents preferred to be interviewed by the opposite sex by identity or gender.
- b. The input of the respondents was very important in defining the appropriateness of the language to be used in the questionnaires and this was adjusted accordingly.

The lessons drawn from the pretesting exercise were factored into the research process by revising the questionnaires accordingly, and re-strategising on the seed-driven snowballing strategy to ensure that it takes into account the issues of clustering of the sexual minority communities.

### 2.6.5 Data Collection Process

Data was collected in Livingstone, Lusaka, Ndola, Kitwe and Ndola. Below are details of the interviews achieved per site.

Site	MSM		WSW		Total	
	n	%	n	%	n	%
Lusaka	161	48.5	59	50.0	222	49.3
Livingstone	39	11.7	13	15.3	63	14.0
Ndola	42	12.7	8	6.8	50	11.1
Chingola	17	5.1	-	.0	13	2.9
Kitwe	73	22.0	38	28.0	102	22.7
Total	332	100.0	118	100.0	450	100.0

**Table 1: study sites**

Three hundred and thirty two (73.8%) of the 450 people who were interviewed were males while 118 (26.2%) were females. However, this does not necessarily mean that there are more male sexual minorities than females. It is only because it was much easier to reach out to male sexual minorities than females. One of the main reasons for this it is easier to be in a relationship without being identified as lesbian for a long time than it is for gay men, because the society does not frown on women holding hands, hugging or sharing a bed, as such, it was much easier for females to get away without being noticed. But, when found



out, they suffer more intense stigma and hate reactions including such practices as lesbo-phobic rape. In addition, most of the females are also in relationships with males and have so much to protect. As a result, female sexual minorities tend to be more underground than their male counterparts.

In all the study sites, most potential female respondents grew cold feet to participate in the study at the last minute. In Kitwe for instance, a group of about ten women from Mufulira, who apparently were all married, changed their minds on last minute and refused to present themselves for interviews.

The disparities in the distribution of the respondent was mainly due to the fact that in the areas where Friends of Rainka is more grounded, there is high levels of trust among sexual minorities and this encouraged them to come forth. In the other areas where mobilisation was chiefly based on snowballing the sexual networks, some people were uncomfortable to come forth, some would change their minds on last minute.

The study also conducted Four Focus Group Discussions (FGDs) in Lusaka and Kitwe. The table below provides details of the FGDs.

Site	Category of respondents	No. Conducted	No. of people/FGD
Lusaka	MSM	1	10
	WSW	1	9
Kitwe	MSM	1	16
	WSW	1	8
<b>Totals</b>		<b>4</b>	<b>43</b>

**Table 2: Focus group discussion details**

### 2.6.6 Data Analysis

Data entry for quantitative data was done in CSpro 4.0 then exported to STATA 11.0 for data cleaning and validation. Data analysis and tabulation was done in SPSS 17.0

For the qualitative data, content analysis method to interpret the data was used. The process involved looking at data from different angles with a view to identify key themes in the text, and synthesizing the data to understand and develop interpretations.

# 3.0 Research Findings

This section presents the finding per component in detail according to the outcomes of the interviews, FGDs and HIV testing. The findings were classified into five components according to the study objectives. These components are as follows:

1. Characteristics of sexual minorities
2. Sexual Practices
3. HIV Prevalence rates
4. Knowledge levels on HIV Prevention
5. Access to services
6. Inhibiting factors
7. Opportunities for targeted interventions
8. Conclusions and recommendations.

## 3.1 Characteristics of Sexual Minorities

The study identified the characteristics of sexual minorities in Zambia in terms of sexual identity, sexual partners, and practices (including: sexual debut, condom use, type of sexual acts, and presence of transactional sex). These were depicted from the characteristics that the study respondents portrayed in the demographic and sexual behaviour characteristics. The characterisation is as shown in the data sets presented in this section.

### 3.1.1 Demographic Characteristics of the Respondents

The study reflected on a number of demographic characteristics in order to assess if there was any linkage between their demographic characteristics and their sexual behaviour or risk to HIV infection. The demographics presented below will be linked to the findings in the next chapter.

#### (i) Age of respondents

Most of the respondents were less than 26 years old. 44% were of the 21 – 25 year-old age group, and 37.6% were 18- 20 year-old age group; making 18 to 25 year-olds 82% of the total set of respondents. Very few of the respondents were above 26 years of age. This however does not mean that the sexual minority population of Zambia is mostly concentrated within the younger age groups. It only demonstrates that in terms of outreach, it is easier to reach out to the younger groups than the older ones.

The older age groups are more discreet and underground in their behaviour and practices. FGDs indicated that this was the case because most of them would have acquired certain level of social status such as being married, having children and/or working for well-known companies or organisations. This exposes these people to high levels of blackmail and extortion as discussed in FGDs that that levels of black mail especially in Lusaka and Copper-belt were very high for the older age groups. FGDs further indicated that the levels of blackmail among the sexual minorities in Zambia were very high, whereby in most cases younger people blackmailed the older age groups for financial benefits. This has caused the older groups to resort to anonymous commercial sex.

The challenge for the older age groups is that due to the fear of being blackmailed, they are more underground and hence do not come forth for health services. In some cases, these groups have been blackmailed by health workers who have figured out their sexuality.

*“Its is sad that blackmail has reached the level where some people have had to put others on a monthly pay to keep them silent when they have figured out the sexual identity of that person...” an FGD discussant explained.*

The distribution of the respondents by age is as presented in table below:

Age	MSM	%	WSW	%	Total	%
Less than 20 years	127	38.3	42	35.6	169	37.6
20 - 25 years	140	42.2	58	49.2	198	44.0
26-30 years	38	11.4	10	8.5	48	10.7
Above 30 years	27	8.1	8	6.7	35	7.8
<b>Total</b>	<b>332</b>	<b>100.0</b>	<b>118</b>	<b>100.0</b>	<b>450</b>	<b>100.0</b>

**Table 3: Age of Respondents**

#### (ii) Marital Status of Respondents

About 86% of the respondents were not married (88% of the MSM and 77% of the WSW). Some married people who were referred to the study through their networks opted out of the study. The distribution is as shown in the table below:

Marital status	MSM	%	WSW	%	Total	%
Married to a man	5	1.51	2	1.69	7	1.6
Married to a Woman	8	2.41	2	1.69	10	2.2
Single/Never married	294	88.55	91	77.12	385	85.6
Divorced/Separated/Widowed	7	2.11	3	2.54	10	2.2
Cohabiting with a man	16	4.82	1	0.85	17	3.8
<b>Total</b>	<b>332</b>	<b>100</b>	<b>118</b>	<b>100</b>	<b>450</b>	<b>100.0</b>

**Table 4: Marital Status of Respondents**

**(iii) Education level of respondents**

The study assessed the education status of the respondents, by asking the highest level of education attained by each of them. Most of the respondents secondary level as the highest education level they attained (60% MSM and 57% WSW). The distribution of education level of the respondents is as presented in the table below:

Highest education level	MSM		WSW		Total	
	n	%	n	%	N	%
Primary	57	17.17	12	10.17	69	15.3
Secondary	198	59.64	57	48.31	255	56.7
Non-degreed Tertiary	34	10.24	27	22.88	61	13.6
Undergraduate	26	7.83	14	11.86	40	8.9
Post Graduate	17	5.12	8	6.78	25	5.6
<b>Total</b>	<b>332</b>	<b>100</b>	<b>118</b>	<b>100</b>	<b>450</b>	<b>100.0</b>

**Table 5: Level of education of respondents**

**(iv) Employment status of respondents**

The study also highlighted the employment status of the respondents to determine if there was any link between employment status of sexual minorities and their sexual behaviours as well as link to HIV infection. For MSM the highest proportion of the respondents were unemployed at 31% followed by students at 28%. For WSW the highest proportion of the respondents were students at 42% followed by unemployed at 21%. The employment status of the sample was as distributed below:

Employment status	MSM		WSW		Total	
	n	%	n	%	N	%
Partner/girlfriend goes to work	2	0.6	7	5.93	9	2.0
Employed full time	50	15.06	15	12.71	65	14.4
Unemployed	104	31.33	25	21.19	129	28.7
Employed part time	37	11.14	9	7.63	46	10.2
Self-employed	45	13.55	9	7.63	54	12.0
Student	93	28.01	49	41.53	142	31.6
Other	1	0.3	4	3.39	5	1.1
<b>Total</b>	<b>332</b>	<b>100.0</b>	<b>118</b>	<b>100.0</b>	<b>450</b>	<b>100.0</b>

**Table 6: Employment status of respondents**

### 3.1.2 Characterisation by Sexual Behaviour

The study identified a number of factors that characterise sexual behaviour of the sexual minorities which were relevant to the objectives of this study. These were: sexual identity (self-identified), sexual debut, age of partner at sexual debut, location of first sexual encounter and relationship with partner at sexual debut. These characteristics of their sexual behaviour inform the study of any risk factors related to HIV prevention that should be taken into account in targeted programming for these groups.

#### (i) Sexual Identity

The study found that there were three main sub-categories of sexual minorities according to self-identified sexual orientation which are: homosexuals (Gays/lesbians), Bisexuals and transgender. As shown in the table above, the majority of the sexual minority population (54.2%) were bisexual, (57% of the bisexuals were MSM and 48% were WSW).

The categories of sexual minorities as depicted by the respondents of this study based on their self-identified sexual orientation as shown in the table below:

**Table 1: Categories of Sexual Minorities by sexual identity**

Sexual Identity	MSM		WSW		Total	
	n	%	n	%	n	%
Bisexual	188	56.6	56	47.5	244	54.2
Transgender	7	2.1	4	3.4	11	2.4
Homosexual	137	41.3	58	49.2	141	43.3
<b>Total</b>	<b>332</b>	<b>100</b>	<b>118</b>	<b>100</b>	<b>450</b>	<b>100</b>

**Table 7: Categories of sexual minorities by self-identified sexual orientation**

**Bisexuals:** Respondents that self-identified as bisexual indicated that they have sexual relations with both men and women and sexual attractions to both men and women.

**Transgender:** Transgendered respondents indicated that their inner gender identity conflicted with their sexual presentation and while the society expects them to act and behave following the gender determined by their physical sexual presentation; they feel and behave the opposite. In that case, a person who presents male sexual organs, feels feminine and is attracted to men identifies themselves as a transwoman and adopts a feminine gender.

**Homosexuals:** respondents who identified as homosexuals were those who identify their gender equal to the physical presentation of their sexual organs, and are sexually and emotionally attracted to and have sexual relations with people of the same sex. These are also called gay, and females also called Lesbians.

**(ii) Sexual Debut (Age at first sexual encounter)**

Most MSM (41%) had their first encounter with a male between the ages of 18-20 years (20%) and WSW had theirs with another female between the ages of 13-16 years (35.2%). In almost all cases, both males and females will have had their first sexual encounter with the opposite sex before they had their first same-sex encounter. In FGDs consultations, the respondents explained that this was the case because even though they would have sexual attraction to people of the same sex, they tended to conform to what is expected of them, which was to have sexual relations with people of the opposite sex.

The tables below show the ages at first sexual encounter for MSM:

<b>MSM age at first sex with a male</b>	<b>n</b>	<b>%</b>
Below 12 years	20	6.0
13-16 years	107	32.2
18-20 years	136	41.0
Above 20 years	62	18.7
Not sure/Can't remember	7	2.1
<b>Total</b>	<b>332</b>	<b>100.0</b>
<b>Mean age</b>	<b>18</b>	<b>-</b>

**Table 8: MSM age at first sex with a male**

<b>MSM age at first sex with a female</b>	<b>n</b>	<b>%</b>
Below 12 years	30	9.6
13-16 years	82	26.3
18-20 years	81	26.0
Above 20 years	13	4.2
Not sure/Can't remember	106	34.0
<b>Total</b>	<b>312</b>	<b>100.0</b>
<b>Mean age</b>	<b>16</b>	<b>-</b>

**Table 9: MSM age at first sex with a female**

The tables below show the ages at first sexual encounter for WSW:

<b>WSW age at first sex with a male</b>	<b>n</b>	<b>%</b>
Below 12 years	2	1.8
13-16 years	24	22.0
18-20 years	22	20.2
Above 20 years	10	9.2
Not sure/Can't remember	51	46.8
<b>Total</b>	<b>109</b>	<b>100.0</b>
<b>Mean age</b>	<b>18</b>	<b>-</b>

**Table 10 WSW age at first sex with male**

<b>WSW age at first sex with a female</b>	<b>n</b>	<b>%</b>
Below 12 years	13	12.4
13-16 years	37	35.2
18-20 years	36	34.3
Above 20 years	16	15.2
Not sure/Can't remember	3	2.9
<b>Total</b>	<b>105</b>	<b>100.0</b>
<b>Mean age</b>	<b>17</b>	<b>-</b>

**Table 11 WSW age at first sex with a female**

*'I discovered that I was a lesbian when I was 10 years old, but I only started practising lesbianism when I was 18, when I became clear that I was attracted to people of the same sex with me....'* One of the FGD members shared with the research team.

### (iii) Age of partner at first sexual encounter

The respondents indicated that in most cases, the partner that they had the first same-sex sexual encounter with was older than them; (65.7%) for males and (65.2%) for females. The MSM indicated that for their first sexual encounter with females, age was not a significant factor because 33.5% indicated that the partners were younger, 33.0% were same age while 33.5% were older. For their first sexual encounter with a male however, about 66% indicate that the partner was older.

Most WSW indicated an older partner for their first sexual encounter with a male partner as well as their first sexual encounter with a female partner. The following tables (below) show the figures:

Category of respondents	Age of female partner at first sexual encounter					
	Younger		Same age		Older	
	n	%	n	%	n	%
MSM	77	33.5	76	33.0	77	33.5
WSW	15	13.0	25	21.7	75	65.2

**Table 12: Age of female partner at first sexual encounter**

As shown in the table above, age is not a significant factor in the first sexual encounter of MSM with their female partners, for WSW, their first sexual encounter with a female partner was mostly initiated by an older person.

The table below shows the age of male partner at first sexual encounter

Category of respondents	Age of male partner at first sexual encounter					
	Younger		Same age		Older	
	n	%	n	%	n	%
MSM	30	9.0	84	25.3	218	65.7
WSW	2	3.0	10	14.9	55	82.1

**Table 13: Age of male partner at first sexual encounter**

Other factors that characterised first sex encounters were:

- i. **Relationship with partner:** In terms of relationship with partner at first same-sex sexual encounter, most often occurred in relations (boyfriend or girlfriend) or just friends. However there is a significant percentage of sexual encounters occurring with strangers at 7% for MSM and 6% per cent for WSW. There is also occurrence of first sexual encounter between teachers and pupils. Although the level is low, it is significant for youth programming and child protection programmes, especially because there are power relations issues at stake. For MSM the encounters were with male friends (48.2%) and similarly WSW with female friends (42.4%). However the male-with-female encounters were of almost equal frequency while females had sex with older men. However there was also a significant number (40%) of WSW who had their first sex encounters with a friend.

Relationship	MSM		WSW	
	n	%	n	%
Boyfriend/ Girlfriend	83	25.0	50	42.4
Friend	160	48.2	47	39.8
Family member	30	9.0	8	6.8
Another student	10	3.0	3	2.5
Stranger	22	6.6	7	5.9
Teacher	6	1.8	0	0
Other	21	6.3	3	2.5
<b>Total</b>	<b>332</b>	<b>100</b>	<b>118</b>	<b>100</b>

**Table 14: Relationship with partner at first sexual encounter**

- ii. **Location of first same-sex sexual encounter:** Most of their first same-sex sexual encounter occurred at home homes; almost an equal percentage for both MSM (67%) and WSW (68%).

This is in line with the relationship with partner where in most cases it is a family member or a friend. It is however important to take note of the small percentage of the first sexual encounter that takes place on clubs as an important area of intervention especially in terms of use of preventive measures for HIV transmission. Other locations included: church camp meetings for youth, and other social groupings such as wedding parties and family gatherings.



Location	MSM		WSW	
	n	%	n	%
School/University	42	12.7	24	20.3
In a home	222	66.9	80	67.8
Initiation school	4	1.2	0	0.0
Prison	10	3.0	0	0.0
migrant workers quarters/accommodation	6	1.8	2	1.7
Night club	16	4.8	1	0.8
Bush	6	1.8	0	0.0
Other	26	7.8	11	9.3
<b>Total</b>	<b>332</b>	<b>100</b>	<b>118</b>	<b>100</b>

**Table 15: Location of first sexual encounter**

## 3.2 Use of HIV Preventive Measures

The study assessed the kind of HIV preventive measures that are accessible by the sexual minorities community and those that they use with the aim of identifying how easily accessible HIV Prevention is for the community and identify challenges that require policy or programming redress.

### 3.2.1 Condom Use

Condom use among sexual minorities was highly inconsistent posing a high risk to HIV infection. Generally, most MSM (79%) indicated that they sometimes use condoms for HIV prevention both with their female and male partners. 49% of those who reported using condoms indicated consistent use of condoms with their regular female partners, and 51.3% indicated consistent use of condoms with non-regular female partners.

Condom use with regular male partners was relatively lower, only 32% of MSM reported consistent use of a condom with their regular male partners. In sexual relations with non-regular male partners 67% indicated consistent condom use. Although the consistent use of condoms with non-regular partners seemed fairly high at 67%, 68% of them reported that they did not use a condom at the most recent sexual encounter with their male partners.

**(i) Condom Use for MSM****Table 15: percentage Condom Use for MSM**

Condom use		Bisexual		Gay		Transgender		Total	
		n	%	n	%	n	%	N	%
Ever used a condom	<i>Yes</i>	276	83.0	242	73.0	285	85.7	262	78.9
	<i>No</i>	56	17.0	90	27.0	47	14.3	70	21.1
Frequency of Condom use with regular female partners	<i>Never</i>	17	6.3	0	0.0	0	0.0	17	6.2
	<i>Sometimes</i>	122	44.1	0	0.0	276	100.0	123	44.8
	<i>Always</i>	137	49.7	0	0.0	0	0.0	135	49.0
Frequency of Condom use with non-regular female partners	<i>Never</i>	11	3.9	0	0.0	0	0.0	10	3.8
	<i>Sometimes</i>	121	43.8	0	0.0	276	100.0	124	44.9
	<i>Always</i>	144	52.3	0	0.0	0	0.0	141	51.3
Frequency of Condom use with regular male partners	<i>Never</i>	31	11.4	4	1.5	0	0.0	19	6.9
	<i>Sometimes</i>	143	51.8	196	71.2	276	100.0	169	61.3
	<i>Always</i>	101	36.7	75	27.3	0	0.0	88	31.8
Frequency of Condom use with non-regular male partners	<i>Never</i>	27	9.7	2	0.8	0	0.0	16	5.7
	<i>Sometimes</i>	79	28.6	74	27.0	39	14.3	76	27.6
	<i>Always</i>	170	61.7	199	72.1	236	85.7	184	66.8
Condom use at last Sexual encounter with female partner	<i>Yes</i>	172	62.4	0	0.0	0	0.0	170	61.6
	<i>No</i>	94	34.2	0	0.0	276	100.0	97	35.1
	<i>Cannot remember</i>	9	3.4	0	0.0	0	0.0	9	3.3
Condom use at last Sexual encounter with male partner	<i>Yes</i>	113	41.0	62	22.6	0	0.0	90	32.5
	<i>No</i>	163	59.0	213	77.4	276	100.0	186	67.5

**Table 16: Condom use for MSM**

Condom use was much lower for WSW in both their relations with male and female partners. About 51% of all WSW respondents reported ever having used a condom (as opposed to 79% of their male counterparts). However, a higher number of WSW indicated having used a condom at the last sexual encounter (69.1%).

**(ii) Condom Use for WSW**

Condom use		Bisexual		Lesbian		Transgender		Total	
		n	%	n	%	n	%	N	%
Ever used a condom	<i>Yes</i>	43	36.4	15	12.7	2	1.7	60	50.8
	<i>No</i>	13	11.0	43	36.4	2	1.7	58	49.2
Frequency of Condom use with regular male partners	<i>Never</i>	1	1.0	0	0.0	0	0.0	1	1.0
	<i>Sometimes</i>	13	21.0	0	0.0	0	0.0	13	21.0
	<i>Always</i>	8	14.0	4	6.0	0	0.0	12	20.0
Frequency of Condom use with non-regular male partners	<i>Never</i>	2	3.2	0	0.0	0	0.0	2	3.2
	<i>Sometimes</i>	4	7.4	0	0.0	0	0.0	4	7.4
	<i>Always</i>	14	23.4	3	4.3	0	0.0	17	27.7
Condom use at last Sexual encounter with male partner	<i>Yes</i>	29	49.1	11	18.2	1	1.8	41	69.1
	<i>No</i>	16	27.3	1	1.8	0	0.0	17	29.1
	<i>Cannot remember</i>	1	1.8	0	0.0	0	0.0	1	1.8

**Table 17: Condom Use for WSW****3.2.2 Lubricant Use**

The study found that use of lubricants was common among MSM, during penetrative anal sex, about 72% of the MSM indicated using lubricants. However, lubricants were not used as a means of HIV Prevention. The link between use of extra lubrication during anal penetration and HIV prevention was not clearly understood, lubricants were used make penetration easier. As a result, MSM tended to use any lubricants regardless of whether they increased or reduced risk to HIV infection such as: natural herbs which in some instances cause irritation in the anal region, thereby increasing risk to HIV transmission, or petroleum based lubes such as cooking oil or Vaseline which is used with condom, weaken the condom and increase risk of HIV transmission. The study established that knowledge level on use of lubricants as a preventive method was very low and that MSM used lubricants without condoms.

**(i) MSM Lubricant use**

<b>Lubricants use during penetrative anal sex</b>	<b>Bisexual</b>		<b>Transgender</b>		<b>Gay</b>		<b>Average</b>	
	n	%	n	%	n	%	N	%
<b>Yes</b>	217	65.4	190	57.1	272	81.8	239	72.0
<b>No</b>	115	34.6	142	42.9	60	18.2	93	28.0

**Table 18: Lubricant use by MSM**

**(ii) Types of lubricants used**

Although use of lubricants was not linked to HIV prevention, about 68% of the male respondents indicated that they use petroleum-based lubricants (Vaseline, baby oil and others) and 41% indicated use of water-based lubricants, though this was not consistent. Reasons for inconsistent and low usage of lubricants were highlighted as follows:

- i. Mostly, this is due to limited access to water-based lubricants and lack of knowledge regarding the risks of using petroleum-based lubricants. The FGD revealed that the lubricants are not as readily available as condoms. Some of the respondents saw the commercial lubricants for the first time during the FGD sessions.
- ii. Most receptive partners believed that commercialised water-based lubricants cause irritation, Vaseline seemed to be the best and readily available lubricant.
- iii. The FGDs also highlighted that the knowledge regarding the link between use of lubricants and HIV prevention was low, lubrication is used to facilitate penetration using anything that can make it easier, commonly: saliva, cooking oil, baby oil, or natural herbs. In these cases, condoms are not used.

**(iii) WSW Lubricant use**

Use of lubricants was significantly lower for WSW, mostly because lubricants are used on penetrative anal sex and very few WSW indicated that they engaged in anal sex. Only 13 WSW indicated that they practice anal sex and of those only 7 had ever used lubricants.

Type of Lubricants used	MSM	
<i>Petroleum based products</i>	92	42.2
<i>Water based lubricants such as KY jelly/ glycerin</i>	88	40.7
<i>Yoghurt</i>	8	3.6
<i>Egg albumen</i>	5	2.1
<i>Saliva</i>	35	16.0
<i>Body lotion/baby oil</i>	58	26.8
<i>Soap</i>	7	3.0
<i>Natural herb (Aloe Vera)</i>	3	1.50

**Table 18: Lubricant use by WSW**

### 3.3 Other HIV prevention methods ever used by WSW

The most used HIV prevention methods are finger coat at 13% by Bisexuals; Gloves at 19% by lesbians and the male condom by transgender at 25%. From the FGDs it was established that the other accessories especially dental dam and cling film were not readily available in the country, making oral sex mostly unprotected.

HIV prevention methods	Bisexual		Lesbian		Transgender		Average	
	n	%	n	%	n	%	n	%
<i>Dental dam</i>	4	3.6	6	5.2	0	0.0	5	4.2
<i>Cling film</i>	0	0.0	12	10.3	0	0.0	6	5.1
<i>Finger coat</i>	15	12.5	18	15.5	0	0.0	16	13.6
<i>Gloves</i>	8	7.1	22	19.0	0	0.0	15	12.7

**Table 19:**

### 3.4 Sexual Partners

The study investigated the types of sexual partners that sexual minority people have sexual relations with. These were described in terms of race, marital status, and age.

The study further investigated the sexual behaviour in terms of multiplicity of partners to assess risk due to the interconnectedness of their networks.

#### 3.4.1 Race of Sexual partners

The study also found that in terms of race, most of the sexual partners of the minority groups were black at 97.6% for MSM and 95.8% for WSW. Only 28% and 12.7% of MSM and WSW respectively indicated that they also have white sexual partners. The other significant race was coloured at 35% for MSM and 29% for WSW.

**Table 9: Race of Sexual partners**

Race of Sexual Partners	MSM	(%)	WSW	(%)
Black African	324	97.6	113	95.8
White	92	27.7	15	12.7
Asian	60	18.1	11	9.3
Coloured	117	35.2	35	29.7

**Table 20: Race of sexual partners**

### 3.4.2 Categories of sexual partners

In terms of sexual partnerships, bisexual MSM reported having sexual relations with single men (at 34.7% of their partners) and single women (34.2%). However a significant percentage of bisexual (12%) had sexual relations with married men. Homosexual men on the other hand mostly had sexual relations with single men (62%) and married men (28%).

MSM Category of sexual partners	Bisexual		Transgender		Homosexual	
	n	%	n	%	n	%
Single women	140	34.2	0	0	0	0
Married women	26	6.4	0	0	0	0
Married men	47	11.5	4	36.4	57	27.9
Single men	142	34.7	7	63.6	126	61.8
Male commercial sex workers	25	6.1	0	0	21	10.3
Female commercial sex workers	29	7.1	0	0	0	0

**Table 21: categories of sexual partners for MSM**

Bisexual WSW indicated having sexual relations with single women (40%) and single men (33%). Lesbians on the other hand mostly have sexual relations with single women (80%) and married women (14%).

WSW Category of sexual partners	Bisexual		Transgender		Homosexual	
	n	%	n	%	n	%
Single women	43	39.8	4	100	52	80
Married women	8	7.4	0	0	9	13.8
Married men	10	9.3	0	0	0	0
Single men	36	33.3	0	0	0	0
Male commercial sex workers	2	1.9	0	0	0	0
Female commercial sex workers	9	8.3	0	0	4	6.2

**Table 22: category of sexual partners for WSW**

## 3.5 Sexual Behaviour

The study assessed the sexual behaviour of the sexual minorities specifically looking at what kind of partners they have sexual relations with, types of sexual acts and existence of risky behaviours in order to assess the risks involved in the nature of their sexual behaviour to inform the development of relevant interventions.

### 3.5.1 Multiplicity of Partners

Also important to note is the fact that the sexual minorities portray multiplicity of partners as a significant aspect of their behaviour. The MSM bisexuals for instance indicated that they had more than 1-2 regular female partners in six months (54%) and an equal number of regular male partners within the same period. According to the respondents interviewed, it is difficult for sexual minority people to maintain monogamous relationships due to the scarcity of partners, and difficulty in maintaining committed relationships due to the unfriendly social and legal environment. This culture of multiple partnerships was one of the key findings of the four focus group discussions with the study group, as shown in the short dialogue below (from one of the FGDs):

*Respondent 1: I can't lie to you, we are promiscuous"*

*Respondent 2: "The reason why there is high infidelity in our relationships is because of one thing; you meet the guy today and you want to have sex with him right away, without any relationship, because the bottoms just look for sex, and they can't be trusted. Who can deny sex?"*

*Respondent 3: "I think the only problem I have in our society is the top. Tops experiment, they want to have what's new on the market. Tops always cheat on bottoms; they are all about adventure".*

*Respondent 4: "Ok, it's not a thing you can do away with, because it's in the same case with, you know, male-female thing – [where one is always looking for a new experience]. So you can't avoid that, it's the thing you have to live by. You just have to understand because it's not a thing that you can't change, trust me".*

**Table 23: Extract from FGD discussion on multiplicity of partners**

While each group tends to blame the other for promiscuity, the study concluded that it does not matter whether one is a receptive (bottom) or insertive (top) partner, multiplicity of partners is common place and almost accepted as a norm.

### 3.5.2 Type of sexual acts

The study found that sexual minorities practice the following sexual acts:

1. Oral Sex: About 80% of all respondents indicated that they practice oral sex. In most cases, there is no protection used in the practice of oral sex. Although some of them felt that it is not safe when a partner has STIs such as herpes, oral sex is considered generally safe.

2. Penetrative Vagina Sex: 93% of male bisexuals and 96% of female bisexual indicated the practice of penetrative vagina sex. There is a considerable use of condoms with non-regular partners although it is not consistent.
3. Penetrative anal sex: 100% of the MSM across the categories indicated that they practice penetrative anal sex, only 18% of bisexual WSW and 7% lesbians indicated practice of anal sex. Use of prevention measures in anal sex is minimal because of limited access to lubricants which make condom use easier and less painful.
4. Orgies: about 30% of the respondents indicated that they practice orgies. 32% of the bisexual males, 27% of the bisexual females, 42% of the transgender males, 25% of the transgender female, 28% of the homosexual males and 21% of the lesbians indicated this practice. In most cases, this is done under influence of alcohol and/or drugs.

### 3.5.3 Transactional sex (% of MSM and WSW)

One of the key findings on the sexual behavior of sexual minorities was the existence of transactional sex. Some of the respondent indicated that they have sometimes paid money, alcohol or other things for sex, while other indicated receiving money, alcohol or other favours in return for sex. 50% MSM and 26% WSW indicated paying for sex, while 63% of the MSM and 33% of the WSW indicated receiving money for sex.

## 3.6 HIV Infection Among Sexual Minorities

The study assessed the HIV prevalence rate for sexual minority with the aim of establishing the link between the characteristics of sexual minorities and their risk to HIV infection. According to the findings, HIV rates are highest among homosexual men (24.1% of the self-identified homosexual men tested positive) and bisexual women (23.6% of the self-identified bisexual women tested positive).

### 3.6.1 HIV prevalence by sexual identity

Sexual Identity	Sex	HIV+			Average (%)
		n	N	%	
Bisexual	MSM	24	188	12.8	18.2
	WSW	13	55	23.6	
Homosexual	MSM	33	137	24.1	21.0
	WSW	10	56	17.9	
Transgender	MSM	1	7	14.3	7.2
	WSW	0	4	0	

**Table 24: HIV prevalence rate by sexual identity**



HIV prevalence rate by sex of respondents present a higher rate in WSW because bisexual WSW prevalence rate was almost double that of bisexual MSM. Although the prevalence rate of male homosexuals was significantly higher than that of lesbians (24.1 homosexuals MSM and 17.9% for lesbians), the difference was not as high as that between male and female bisexuals.

### 3.6.2 HIV Prevalence by Sex of respondents

Sex	HIV Results				Total
	HIV Negative	Percent (%)	HIV Positive	Percent (%)	
MSM	275	61.5	58	17.5	332
WSW	91	20.4	23	20.0	115
<b>Total</b>	<b>366</b>	<b>81.9</b>	<b>81</b>	<b>18.1</b>	<b>447</b>

Table 24: HIV Prevalence by sex of respondents

### 3.6.3 HIV prevalence by geographical site

The HIV prevalence was also studied per geographical location. The pattern that came out more or less fits into the geographical spread of the national prevalence. The rates were higher in Livingstone at 28% with the rate higher in WSW at 30% than MSM at 26%. Chingola had the second highest prevalence rate at 23.5% for MSM. There were no WSW HIV tests in Chingola.

This geographical spread requires an understanding the behaviour traits of sexual minorities in these areas to identify risky factors that can inform the development of relevant interventions. The table below shows HIV prevalence rate by study site: Table 25:

Site	Sex	HIV+	Average
Lusaka	MSM	15.5	17.4
	WSW	19.3	
Livingstone	MSM	25.6	28.2
	WSW	30.8	
Ndola	MSM	11.9	12.2
	WSW	12.5	
Chingola	MSM	23.5	23.5
	WSW	-	
Kitwe	MSM	19.2	19.1
	WSW	18.9	

### 3.6.4 HIV prevalence by age

HIV prevalence was highest in the age group above-30-years at 52% for MSM and 50% for WSW.

The prevalence rates were also high in the age groups 21 – 25 years at 16% for MSM and 20% for WSW, and the 26 - 30 years at 29% for MSM and 40% for WSW.

Age	Sex	N		HIV +	Average
				%	
Below 20 years	MSM	11	127	8.7	9.1
	WSW	4	42	9.5	
Between 21-25 years	MSM	22	140	15.7	17.9
	WSW	11	58	20.0	
Between 26-30 years	MSM	11	38	28.9	34.5
	WSW	4	10	40.0	
Above 30	MSM	14	27	51.9	51.4
	WSW	4	8	50.0	

**Table 26: HIV Prevalence by age group**

### 3.6.5 Other Factors Affecting HIV Prevalence Rates

The study also assessed other factors that could influence HIV prevalence rates and these included the following:

#### i. Marital Status

HIV prevalence rate was highest among divorced, separated or widowed MSM at 57.1%, followed by married men at 50%. The two results point to the fact that a section of married men are actively involved in homosexual relations, and exposing their spouses or partners to HIV infection. They also imply that consequential cross infections between the sexual minorities and the heterosexual population are a high possibility in situations where their spouses or partners have extra-marital or multiple relationships.

Of significant importance is the prevalence rate of respondents cohabiting with another woman (27.8%). This could imply inconsistent HIV preventive practices.

#### ii. Education Status

MSM had HIV prevalence rate highest among post-graduates (23.5%) and respondents with primary school level education (24.6%) while for WSW the rate was highest among primary level respondents at 33% and undergraduates at 36%.

### iii. Employment Status

In terms of employment status, the study established that there was no direct causal relationship between employment status and HIV prevalence. This is because HIV prevalence rates were high in both unemployed and full-time employed respondents at 50% and 30% respectively for MSM and the same for WSW at 27% (Employed full-time) and 25% (Unemployed).

## 3.7 Access To And Use Of HIV Prevention Information

The study results show that most of the information the respondents had received in the past 12 months on HIV was for heterosexual relationships. The common source was the mass media (Television, radio and newspapers) at 43% for male respondents and 53% for the females. The other reliable sources were health practitioners, peers/friends and school.

HIV prevention information for same sex relations is almost non-existent. Those that indicated receiving information on HIV prevention in same-sex relations indicated receiving this information from peers or friends at 13% for males and 14% for the female counterparts.

### *HIV information ever received from sexual partner in the past 12 months*

HIV information ever received	MSM		WSW	
	n	%	n	%
Same sex	110	33.1	37	31.4
Opposite sex	289	87.0	108	91.5

**Table 27: HIV information received**

In addition, sources of information on same sex reproductive health issues are very limited. Most of the information on reproductive health issues for heterosexual relationships are from the mass media (63%), friends (36%) and school (33%). However, for same sex relationships, the highest is friends (13%) and then internet and health workers at 8%. This shows that there is a major gap in health communication and access to information for same-sex relationships. The highest source of information being friends, there is no opportunity of verifying whether people are sharing correct information or not.

## Information sources on HIV transmission for MSM

Information sources on HIV transmission	Same sex		Opposite sex	
	n	%	n	%
Health practitioners	9	8.4	125	43.4
Friends of Rainka	9	7.8	19	6.6
Community health worker	3	2.7	65	22.6
Media e.g. TV, Radio, Newspaper	4	3.9	183	63.3
Internet	9	8.1	39	13.6
Sexual partner	1	1.2	20	6.9
Peers/Friends	15	13.3	103	35.5
School	1	1.2	97	33.4
Relatives	2	1.8	51	17.5

Table 28: Information sources for MSM

The sources of information for WSW are the same as those of MSM as shown in the table below:

## WSW Information sources on HIV transmission

Information sources on HIV transmission	Same sex		Opposite sex	
	n	%	n	%
Health practitioners	2	5.1	58	53.4
Friends of Rainka	1	2.5	9	8.5
Community health worker	1	2.5	18	16.9
Media e.g. TV, Radio, Newspaper	1	2.5	77	71.2
Internet	3	7.6	25	22.9
Sexual partner	3	7.6	6	5.9
Peers/Friends	5	14.4	36	33.1
Women's rights groups	0	0	2	1.7
School	1	1.7	97	89.8
Relatives	1	2.5	86	79.7

Table 29: Information sources for WSW

### 3.8 Inhibiting factors for effective HIV prevention for sexual minorities

Having studied and characterised the sexual minorities of Zambia, established their risk to HIV infection and access to prevention services and information, the study made an assessment of potential and existing inhibiting factors to HIV Prevention among this population in order to identify areas for interventions as well as opportunity for entry into this community.

Some of the inhibiting factors to effective HIV prevention among sexual minorities in Zambia that were identified included: highly prevalent socio-legal homophobia, stigma against sexual minorities, unavailability of targeted services for sexual minorities, knowledge levels on HIV prevention and risk reduction methods, perceptions about HIV prevention, sexual violence, alcohol and drug use and limited access to HIV prevention information and services.

#### 3.8.1 Discrimination and Stigma

Stigma and discrimination (induced by the socio-legal homophobia) are a major challenge facing sexual minorities in Zambia. This study found out that incidences of stigma were very high, 52% of the male respondents and 61% of the females indicated that they experienced verbal and physical harassment because of their sexual orientation. This tends to make sexual minority people shy away from seeking health services because they fear being stigmatised by the health providers. In addition, respondents indicated that in times where they have gone to seek medical/health attention that is specific to sexual minorities (such as lubricants, or treatment for anal STIs) health workers have shown inadequate capacity to assist them as required. In some instances, health workers have called in their workmates to discuss the situation they are dealing with, resulting in embarrassment of the client/patient.

In some cases, the stigma is in the perceptions of the clients, but still it is significant in the way that it affects access to services:

‘...Okay, I didn’t tell them that I was a lesbian, but I could tell with the way they looking at me suspiciously, that they suspect I was, you can actually tell when a person is thinking negatively about you, you know. I felt so uncomfortable, I wish they could just ask me so that I tell them the truth about my sexuality, and then, they can ask me questions that are relevant to me rather than assuming...’ FGD participant shared with the research team.

#### 3.8.2 Blackmail

Another significant challenge affecting sexual minorities is high prevalence of blackmail. Blackmail is perpetrated by both other sexual minorities, and/or people from the heterosexual community. The fear of blackmail prevents sexual minorities from accessing health care for fear of being blackmailed by anyone who may discover their sexual orientation, including health workers.

### 3.8.3 Limited access to and low uptake of Risk Reduction Measures for MSM

There were significant knowledge gaps in risk reduction measures particularly with reference to use of lubricants. The link between HIV prevention and use of lubricants is not clearly understood, and access to water-based lubricants is very low, MSM tend to use lubricants like natural herbs that may potentially increase risk of infection due to irritation, or use petroleum based lubricants like cooking oil or Vaseline which when used with a condom compromises their protection.

While the majority of MSM demonstrated high level of knowledge of condoms as an important risk reduction practice, (80% agreed that use of barrier methods like condoms reduces risk), knowledge levels did not match the practice and behaviour. The levels of condom use are much lower, only about 32% reported consistent use of condoms with regular male partners. In FGDs, the participants attested to preferring unprotected sex than otherwise.

#### (i) MSM Knowledge of Risk Reduction Practices

Risk reduction practices	n	%
Oral sex	127	38.3
Sex only in a committed relationship	251	75.6
Availability of protective barrier methods e.g. condoms	265	79.8
Correct and consistent use of protective barrier methods	259	78.0
Reduction number of sexual partners	237	71.4
Thigh sex	126	38.0
Disclosure of sexual identity or Coming out	133	40.1
Maintaining good hygiene	172	51.8
Encourage partners to be tested for HIV	230	69.3
Masturbation	149	44.9

Table 30: knowledge of risk reduction for MSM

#### (ii) Knowledge of Risk Reduction Practices for females

The knowledge levels for WSW respondents were as follows: i) 86% agreeing that consistent and correct use of condom reduces risk, ii) 85% of respondents agreeing that use of barrier methods, iii) 77% indicating that having sex in a committed relation reduces risk. Similarly, just like in their male counterparts, the behaviour and practice did not match the knowledge levels on risk reduction.

<b>Risk reduction practices</b>	<b>n</b>	<b>%</b>
<b>Not engaging licking and sucking of the vagina</b>	50	42.4
<b>Sex only in a committed relationship</b>	91	77.1
<b>Availability of protective barrier methods for WSW e.g.</b>	100	84.7
<b>Correct and consistent use of protective barrier methods</b>	102	86.4
<b>Reduction number of partners</b>	92	78.0
<b>Disclosure of sexual identity or Coming out</b>	47	39.8
<b>Maintaining good hygiene</b>	74	62.7
<b>Encourage partners to be tested for HIV</b>	100	84.7
<b>Non penetrative sex (clit to thigh)</b>	48	40.7

**Table 31: Knowledge of risk reduction for females**

### 3.8.4 Alcohol and Drug Use

Alcohol and drug use were identified as two of the key inhibitors to HIV prevention. Alcohol consumption was reported very high among both male (89%) and female (88%) bisexuals. It was equally high among gays (86%) and lesbians (88%).

Drug use was similarly high among male bisexuals and their female counterparts. Drug use was also reported to be high among WSW and MSM. In FGDs, it was observed that when intoxicated with alcohol and/or other drugs, people tend to forget using safe sex measures to reduce HIV transmission. In addition, people normally engage in orgies when intoxicated.

80% of all the respondents indicated that they had shared a needle for using drugs at least once. This applied even for those respondents that indicated that they don't use drugs. This presents a potential high risk of transmission through needle-sharing.

### 3.8.5 Limited Interpersonal Communication

The level of interpersonal communication on reproductive health issues is very low in same sex relationships as compared to opposite sex relationships. This was confirmed during the FGDs where participants indicated that discussing HIV/AIDS or reproductive health issues with their partner is sensitive, unless the relationship has been on for a very long time because it is considered discriminatory. This limits the opportunity of advancing HIV prevention within couples which has been proved to be most effective in hetero-sexual relationships. There are a gap in addressing HIV/AIDS and reproductive health issues for sexual minorities, interpersonal communication and couple counselling being one of key areas lagging behind.

### 3.8.6 Sexual violence

Some of the respondents indicated ever having sex against their will as indicated in the table below. Most often the perpetrators were friends: 9% for the male victims and 12% for the females. In both cases the victims did not report the abuse to anyone mostly because they wanted to avoid stigmatisation. Instead they opted to hold back the abuse and live with it. This was considered a better option than suffering stigma from the would-be providers of required support.

**Table 30: Sexual violence**

Sex against will	Male				Female			
	Bisexual	Transgender	Gay	Total	Bisexual	Lesbian	Transgender	Total
<i>With man</i>	19.7	71.4	32.1	25.9	41.1	5.2	25.0	22.9
<i>With woman</i>					12.5	24.1	25.0	18.6

In most cases, occurrences of sexual violence go unreported because of the socio-legal environment which does not protect the victims. These cases therefore remain undressed and will pose as an obstacle in efforts to comprehensively address HIV/AIDS among sexual minorities.

## 3.9 Opportunities for inclusive and targeted interventions

It is important that the specific HIV/AIDS epidemic concentrated in the sexual minority groups be addressed comprehensively through targeted interventions that understand and address the vulnerability factors of this population. Despite all the inhibiting factors and challenges identified in this report, the study identified some possible opportunities for inclusive and targeted interventions to address HIV infection among sexual minorities in Zambia.

### 3.9.1 Existence of a well-structured sexual minority community in Zambia

The study found that although the sexual minority community is hidden and mostly on the margins of the society, it is a well-structured in clusters and networks. These clusters work for networking and protection against abuse. These structures create an opportunity for entry points in terms of programming.

The existence of LGBT organisations present an opportunity of entry points into these hidden populations. During the study period, this was verified by the fact that in areas where LGBT organisations are well grounded in Lusaka and on the Copper Belt and mobilisation of sexual minorities was easier in those sites than for example in Livingstone where these organisations as are not as well structured. In terms of vulnerability again, in Livingstone, HIV prevalence rates are much higher and access to information and prevention services is limited because of lack of such outreach organisations.



### **3.9.2 High levels of reported prevalence of HIV and STIs among sexual minorities, low access to preventive measure such as condoms, lubricants and counselling.**

The study has established that the sexual minority community has a concentrated epidemic of HIV/AIDS higher in males homosexuals at 24.1% and female bisexuals at 23.6%. This creates an opportunity to lobby for targeted interventions for this community. Generally, the gaps in service provisions and poor access to targeted services such as counselling, prevention services and others create an opportunity for programming to address the specific needs of sexual minorities regarding HIV prevention.

### **3.9.3 The need for capacity building of medical/health personnel to address sexual and reproductive health needs for sexual minorities in Zambia.**

The study found that the medical/health personnel in Zambia are not trained to address issues of sexual minorities. This creates a problem when sexual minority people need specific services. It also creates a problem for the health workers as they are more often than not expecting to receive clients of sexual diversity. This is an opportunity for programming around capacity building and training of some health workers to specialise in sexual minority issues. The trainings could cover issues around attitude training, understanding sexuality, sexual and reproductive health counselling for sexual minorities, as well as possible health issues that affect people who engage in same sex relations.

### **3.9.4 The need for positive attitudes toward sexual minorities in the Zambia society**

While this is one of the main and key challenges facing sexual minorities in Zambia, it present an opportunity for targeted programming because it is an issue where specific advocacy interventions can be developed. Such advocacy intervention may lead to increased public and policy debate which may increase awareness level and shift attitudes that are negative. Hopefully, such debate may also lead to development of effective policies and laws in addressing issues of sexual minority people in Zambia. The implementation of such policies and laws will translate into effective and targeted programming.

# **Analytical Summary**

The study characterised sexual minorities in Zambia in terms of self-identified sexual orientation, sexual behaviour, risk to HIV infection, access to services and inhibiting factors to effective HIV Prevention.

## **4.1 Sexual Orientation**

The study found that most of the sexual minorities in Zambia were bisexual having sexual relations with both males and females. Some indicated that they have become bisexual in order to conform to society's expectations by engaging in heterosexual relationships when they felt differently, while others just feel bisexual. There were very few who identify as lesbian (3.4%). Mostly, sexual minorities are invisible and underground, but they have well-structured networks which characterise their sexual networks but also act as a form of protection against abuse. In terms of sexual partnerships, bisexual males go out with single men (34.2%) and single women (35%), but also a significant percentage of married men (12%). Other sexual partners for bisexual men are female commercial sex workers, male commercial sex worker and married women in smaller proportions. Female bisexual people have sexual relations with single men (33%) and single women (40%).

## **4.2 Sexual Behaviour**

This study showed that people begin to experience same-sex sexual encounters in their teenage. In most cases, these teenagers will have already experienced sexual relations with the opposite sex. Some of them indicate that they tried sexual relations with the opposite sex to see if the emotional and sexual attraction to the same sex would disappear while others do so to fit in with what everyone else was doing. In most cases, for the first same-sex sexual encounter, the partner is older and more experienced.

As observed in this study, the location of most first same-sex sexual encounter occurred in homes for both MSM and WSW with either a family member or a friend. There is high level of multiplicity of concurrent partners in the sexual minority community, and they explain that this is mostly due to the illegality of their sexuality which makes committed relationship difficult to manage, while others felt that some people are just promiscuous, arguing that it is possible to be committed to one partner regardless of the circumstances.

## **4.3 HIV Prevalence rates among Sexual Minorities**

The study conducted HIV testing using dry blood spots (DBS). The results showed that the HIV prevalence was higher in homosexual men at 24.1% of the sample and for bisexual women at 23.6% of the sample

testing HIV positive. While the study acknowledges that the sampling frame was not clear, the indications from these results are valid to create a picture of what the key issues are.

The fact that most of the sexual minorities portrayed bisexual tendencies poses a challenge in separating the epidemic of the general population from that of the sexual minorities in a way because of the sexual interlinkages and overlaps of the sexual networks between these two communities. This creates an impression that addressing HIV/AIDS holistically for Zambia requires addressing the specific target groups comprehensively.

#### **4.4 Use of HIV Preventive Measures**

The study found that consistent use of condoms and lubricants for HIV Prevention is very low among sexual minorities. In cases of penetrative anal sex, lubricants are used without condoms to facilitate penetration, but the link to HIV prevention is not clearly understood by most MSM. While knowledge levels of the importance of using a condom are very high, negative attitude towards condom-use is equally very high. Access to lubricants is very low and the value of using lubricants for HIV prevention is not appreciated. People tend to use whatever is available or accessible to use as lubricants especially in penetrative anal sex. Common and easily accessible lubricants that MSM use are: Vaseline intensive care lotion (with aloe vera), cooking oil, yoghurt and herbs like aloe vera. In most cases, a condom is not used when these lubricants are used. The risk of using petroleum-based lubricants with condoms is also not clearly understood.

Access to condom did not feature as a major problem. There are numerous unbranded and branded condoms like Maximum, Rough Rider and Kamasutra that can be accessed from pharmacies, grocery shops, health institutions and reproductive health support organisations like Society for Family Health (SFH), Planned Parenthood Association (PPAZ) and Friends of Rainka, among others. However, access to water-based lubricants is almost non-existent except in LGBT organisations like , Friends of Rainka and Transbantu Zambia.

In terms of access to other services such as treatment for STIs, counselling and other, the study found that sexual minorities are not adequately covered owing to the fact that the medical personnel are not trained to deal with cases of sexual minorities, hence they are unprepared to do so. When confronted with a case of sexual minorities, medical personnel react in shock or surprise that end up embarrassing the client who leaves never to come back. In addition, services such as couple-counselling are tailored for a heterosexual community and not provided for same sex clients, thereby marginalising sexual minorities.

#### **4.5 Inhibiting Factors to HIV Prevention**

The study identified a number of factors that act as barriers to increased access to services by sexual minorities. These range from stigma and discrimination which is caused by the unfavourable policy and legal environment as well as high levels of institutionalised homophobia in the Zambian society. The fear of

being stigmatised leads sexual minority people to shun medical services even where the health personnel are not interested in knowing their sexual orientation. This becomes a cause for concern because self-stigma starts and ends with the self, and where there are no services such as counselling, people are left of services with no way of communicating their suffering.

The study also found that in most cases, medical personnel are not trained or prepared to deal with cases of sexual minorities, for example in cases where a man presents an anal STI, or indicates in their personal history that they have been having sex with another man, the medical personnel react either in shock, are not sure how to deal with it. Stigma and discrimination also causes high levels of blackmail, fear, and anxiety because when people identify a sexual minority person, they know that he wouldn't disclose his orientation for fear of stigma, and they use that to blackmail the person. Sexual minority people do not trust even medical workers knowing that any one has potential to blackmail them. This equally causes them to shun comprehensive medical services.

Other inhibiting factors include limited access to preventive services such as condoms and lubricants and perceptions of the risks involved with certain behaviours such as anal sex, lack of lubricants and use of petroleum-based lubricants. This affects HIV prevention negatively because even in situations where people want to use protection, they are challenged by limited access. Lubricants are the most inaccessible preventive measures yet one of the most important subjecting people to using herbs and other unsafe lubricants.

The study also found that there are high levels of drugs and alcohol use which leads to high risk sexual behaviours such as orgies, and unprotected sex and also perpetrates sexual violence. There is also reported high levels of needle-sharing in injecting drug use which increases the risk of HIV transmission.

## **4.6 Opportunities for targeted Interventions**

The study also identified opportunities for targeted interventions. These include existence of a well-structured sexual minority community, reported high levels of HIV and STIs, the need for capacity building for health worker, need for positive attitudes of members of the society including politicians, community leaders and others alike, and the need for a favourable legal and policy landscape. While these sound as challenges, they provide an entry point for programming at various levels in developing and implementing targeted interventions for sexual minorities. Targeted interventions should also include access to VCT and ART programs.



## Recommendations

With the foregoing, the study makes a number of recommendations for programming as follows:

- 5.1** Sexual diversity is a reality in Zambia, and not only in confined environments. It is important to acknowledge their existence in policy planning and implementation to ensure equality in service provision. Although it is still unclear what proportion of the population makes sexual minorities, the human rights approach demands an inclusive approach to programming that should be inclusive of everyone. Understanding the size of the sexual minorities will be important to guide budget allocation and financing of programmes in understanding the magnitude of the need.
- 5.2** There is need to update the Modes of Transmission (MoT) study, in the wake of the new information on sexual minorities in Zambia.
- 5.3** There is need for targeted HIV prevention interventions among sexual minorities ranging from behaviour change communication to access to prevention measures and services such as condoms and lubrication. There is also need to other support services such as counselling to address issues of drugs and alcohol, sexual violence, self-stigma and blackmail.
- 5.4** There is need for targeted reproductive health services for sexual minorities. However, for this to be effective, there is need to train health professionals on issues of sexual minorities and also target attitudes of health workers in dealing positively with sexual minority to enhance access to services for this population. Otherwise, they will remain a hard to reach and marginalised population.
- 5.5** There is need to support and nurture sexual minorities membership organisations and networks because they are key entry-points in addressing reproductive health issues for sexual minorities.
- 5.6** Considering the level of sexual violence and the difference in age between partners during the first sexual encounter, there is need for boys counselling to allow boys to be able to deal with the trauma in case of sexual violence. Boys need to know it is okay to seek help if they have been violated.
- 5.7** There is need to advocate for political will and financing of sexual minority programmes to ensure effective programming and programme delivery.
- 5.8** There is need for multi-pronged approaches targeting attitudes of policy makers, service providers, sexual minority communities themselves and the broader community in order to effectively address the barriers.



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**Vision:** A Southern African community  
that drives its own development