MAKING ACCESS REAL

Advancing the sexual and health rights of LGBTI persons in Zambia

African Men for Sexual Health and Rights (AMSHeR)
and
Friends of Rainka (FoR)

AMSHeR
African Men for Sexual Health & Rights

"speaking for the voiceless"

Title: **Advancing the sexual and health rights of LGBTI persons in Zambia**

Organisation: **African Men for Sexual Health and Rights (AMSHeR) / Friends of Rainka (FoR)**

Country: **Zambia**

Date: **December 2017**

Who are we?

African Men for Sexual Health and Rights (AMSHeR) is a Pan-African coalition of organisations led by men who have sex with men (MSM) and/or lesbian, gay, bisexual and transgender (LGBT) persons. AMSHeR works to promote non-discrimination, particularly based on sexual orientation and gender identity (SOGI), and to advance access to quality health services for MSM/LGBT persons in Africa. As an advocacy and capacity strengthening organisation, AMSHeR provides a platform for exchange and learning among MSM/LGBT community-based organisations, human rights and HIV service organisations, and other agencies working with and for MSM/LGBT organisations. The organisation also advocates for increased resources, community leadership and strengthening of community structures and capacity to address these issues. In Zambia, AMSHeR has one member, Friends of Rainka (FoR), an LGBTI focused organisation. This study relates to the localisation, in partnership with FoR, of the Robert Carr Network Fund project which AMSHeR was implementing in Southern Africa.

What was the issue?

- The LGBTI community in Zambia had not been exposed to knowledge on sexual health, and so its members were engaging in risky sexual behaviors. This led to high HIV prevalence rates within the community, which worsened the national statistics.
- The problem exists because of the hostile: legal environment; traditional, cultural and religious norms; political environment; and media reporting. The anti-LGBTI rhetoric leads to fear of arrest, making LGBTI people reluctant to seek health services.
- Although grassroots LGBTI organisations existed, they had limited capacity to undertake effective advocacy at community level due to the existing law, limited technical capacity and inadequate financial resources.

What was the change we wanted to see?

Change happens when people become informed, and begin to act on what they have learnt. The change we wanted to see was:

- Sexuality education for the LGBTI community, so that they can make informed choices concerning sexual health
- Members of the community displaying health seeking behaviour as a result

- The community being linked to treatment, prevention and care services from LGBTI friendly health care institutions that would provide these services without stigma and discrimination
- A community informed about human rights and able to advocate for an end to stigma and discrimination.

What did we do?

We took a two-pronged approach – advocacy action and sexual health action.

- Advocacy action:
    - 1-day workshop with 15 lesbian, gay and trans-diverse community leaders drawn from Lusaka, Livingstone and the Copperbelt provinces. There were two focus areas – safety and security training; and human rights and the law regarding same sex acts, with specific focus on the penal code and discrimination based on sexual orientation.
    - The information shared during the workshop was then compiled into an Advocacy Toolkit which also highlighted the human rights violations faced by the LGBTI community, such as discrimination and arbitrary arrests.
    - The Advocacy Toolkit was meant to be used by organisations and community leaders in their advocacy efforts in the three provinces.
- Sexual health action:
    - At a second community engagement a questionnaire was used to identify the pressing health needs of LGBTI persons in Zambia. Some of the issues that arose regarding access to health were:
        - Stigmatization of MSM by health service providers and the lack of MSM-knowledgeable and -friendly services in public health facilities.
        - Use of the media to promote homophobia and transphobia. In Zambia, there is a negative bias in all media reports on sexual minorities, which shuts down any chance of a meaningful debate about LGBTI human rights, including the right to health.
        - Criminalisation of consensual same sex activities is a barrier to accessing services.
        - Lack of privacy and confidentiality of clients' information.
        - Health care and psycho-social support personnel are not educated on the full range of human sexuality, and the particular health needs of LGBTI persons.
        - IEC materials lack information on sexual and reproductive health (SRH) for LGBTI persons and MSMs. In fact, to include information about, for example, ano-rectal intercourse would, according to the current law, amount to promoting immoral acts and spreading or distributing seditious materials. Therefore, even well-meaning health service providers cannot produce IEC materials with this information.

- Lack of psycho-social services.

- From this engagement a sexual and reproductive health and rights (SRHR) Toolkit was developed to specifically address the knowledge gap in health care institutions regarding the needs of LGBTI persons.

- FoR organized a 3-day Community Training in Lusaka with the community leaders, and selected health care providers – identified through a desktop mapping exercise – from the same three provinces. The training was on basic human rights, basic knowledge on sexuality and gender and specific health needs of LGBTI persons. The outcome of this was the design of a system for the community to access, deliver and monitor HIV prevention, treatment, and care and support services.

What did we achieve?

The project primarily created demand for sexual health services and overall uptake of grassroots organisational programming. This is demonstrated through the increase in the number of LGBTI persons reaching out to the local partner organisation for information and services. This project – through provision of the toolkits, which are being used in different LGBTI-friendly health facilities – set the groundwork for current programmes that are aimed at making community health systems inclusive and accommodating of LGBTI health needs. An example of this is the current programme of training for health care institutions on the needs and gaps that exist in health care systems regarding LGBTI persons. The project was a success because of the high level of community engagement through the workshops that surfaced the issues and needs of the community, and ensured that their input is reflected in the toolkits. The community leaders were also instrumental in cascading information down to community members who were not part of the training, through the peer to peer approach, making the project community owned and focused.

What were the key lessons learned?

Community-informed programming: For organisations to design effective interventions and programmes, sustainable community engagement is important so that all programming can be community informed and tailored to the community needs. At the workshops, community members lamented that organisational programming was not speaking to their needs hence the limited demand for the available services.

Awareness raising among health care providers: Health care workers must be sensitised to LGBTI health needs, because their training curriculum does not include that information, leaving them under-equipped to offer services to our community.

Unified Interventions: It is important to have unified interventions that speak to both the community members as well as the critical stakeholders for effective change. Actions that target only community members lack the buy in from health care institutions and the interventions do not result in change at the institutional level.

However, mainstream stakeholders did not participate in this exercise; and – although we did identify and train individual health care

providers who now serve as linkages to institutions – this meant that the interventions were not institutionalised.

It was, as well, difficult to engage all social strata as some classes shunned the activities for fear of being outed. It was also hard to get participation from lesbian, bisexual and transgender women.

Documentation: Organisations need to continuously document violations, as well as the lived realities of the LGBTI community, for more effective, evidence-based and robust advocacy actions. Health care providers at the Community Training interrogated the validity of the issues expressed; it helped that there were community leaders who could speak about their experiences but, in the absence of direct dialogue, documented cases can be presented as evidence of the issues.

For more information, please contact

Besa Chisanga
Outreach Officer
Friends of Rainka
besachisanga20@gmail.com