Delivering Health Services to Key and Vulnerable Populations at Cross-Border Sites in the East African Region

Summary of Research Findings from Uganda

INTRODUCTION AND STUDY OBJECTIVES

In 2016, the Cross-Border Health Integrated Partnership Project (CB-HIPP) conducted a study in Uganda to determine the availability and accessibility of health and HIV services for key and vulnerable populations. The study was conducted in four sites: Majanji (with wet borders) and Malaba, Busia, and Katuna (with land borders). The specific objectives were:

- To describe the readiness (i.e., attitudes, perceptions, training) of health care workers to provide high-quality and friendly health and HIV and AIDS services to the target population
- To describe health-seeking behaviors among key, vulnerable, and migrant populations in the selected study areas
- To assess barriers and facilitators affecting access to health and HIV and AIDS services among members of the target population
- To describe the vulnerability of women from the target population, based on a vulnerability index checklist

The study population was made up of female sex workers (FSWs), vulnerable women and girls (VWG), long-distance truck drivers (LDTDs), men who have sex with men (MSM), people living with HIV (PLHIV), people who inject drugs (PWID), clearing and forwarding agents (CFAs), and fisherfolk (FF). The study also included policy makers, program managers, and providers in the health sector, as well as community opinion leaders and local administrators, officials of local organizations, and business owners. This brief presents the study approach and a summary of the key findings.

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Overview of CB-HIPP

The Cross-Border Health Integrated Partnership Project (CB-HIPP) (September 2014–August 2019) is supported by the U.S. Agency for International Development with funding through the U.S. President's Emergency Plan for AIDS Relief. The project is designed to extend quality integrated health care services in strategic border areas and other transport corridor sites in Eastern, Central, and Southern Africa.

In addition to expanding service delivery for key and vulnerable populations, the project recognizes the need for alternative health-financing models to increase uptake and sustainability of services within an enabling policy environment. In this regard, the region's intergovernmental bodies (i.e., East African Community, Intergovernmental Development Authority, Southern African Development Community) are expected to play a key leadership and partnership role in the project's implementation.

The goal of CB-HIPP is to catalyze and support sustainable and African-led regional health development partnerships to improve health outcomes among mobile populations and vulnerable communities residing along Eastern, Central, and Southern African transport corridors and cross-border sites. This is expected to be achieved through three result areas:

- Increased access to and uptake of integrated health and HIV and AIDS services at strategic cross-border sites and regionally recognized HIV transmission "hot spots" along Eastern, Central, and Southern African transport corridors
- Alternative health-financing models identified, implemented, and tested to strengthen the long-term sustainability of networked health and HIV and AIDS service delivery
- Strengthened leadership and governance by intergovernmental institutions to improve the health of mobile and vulnerable populations

In Uganda, CB-HIPP implemented an integrated approach to engage stakeholders—government officials, community gatekeepers, civil society organizations, and the private sector—to collectively address the unique health problems that face key, vulnerable, and mobile populations along the transport corridors and cross-border towns.

RESEARCH METHODS

This study had two components: a formative qualitative assessment and a quantitative survey. The formative assessment was composed of 57 focus group discussions and 138 in-depth interviews with key and vulnerable populations, as well as 57 key informant interviews with stakeholders and leaders in the health sector. The quantitative survey was administered in April–May 2016 to 2,975 individuals from key and vulnerable population distributed across the four sites (Table 1).

Table 1: Summary of study population in the quantitative survey

Population	Number in Sample	Study Sites
Female Sex Workers	1,049	Malaba, Busia, Majanji, and Katuna
Fisherfolk	161	Majanji only
Long-distance truck drivers	69	Malaba only
Clearing and forwarding agents	95	Malaba only
Vulnerable women and girls	933	Malaba, Busia, and Katuna
People living with HIV	375	Malaba, Busia, Majanji, and Katuna
People who inject drugs	141	Malaba and Busia
Men who have sex with men	152	Malaba, Busia, and Katuna

KEY FINDINGS

Respondents varied with respect to sociodemographics: Except for LDTDs, 52 percent of whom were foreigners, nearly all survey respondents were Ugandan nationals. Across all groups, most of the respondents had some primary or secondary education, with more CFAs (91 percent) and MSM (83 percent) reporting attainment of some secondary or higher education. FF and LDTDs had the largest proportions of respondents who were married or living in union (76 percent and 86 percent, respectively). Most of the respondents among the key populations (i.e., FSWs, MSM, PWID) reported that they were not married.

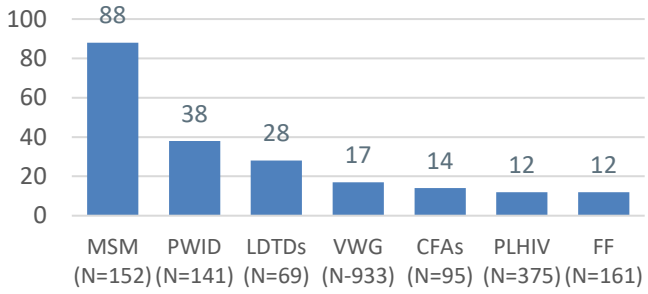
The study population had high levels of mobility: Populations that are highly mobile may face increased risk of infection from HIV and other sexually transmitted infections (STIs) due to their sexual practices while traveling. They also face difficulties accessing health care services or continuing treatment for illnesses. The results of this study show that in addition to LDTDs, who are all highly mobile due to the nature of their work, other groups routinely travel outside their district or across borders. For instance, about two-thirds of the FSWs (67 percent) had travelled outside their home district for sex work in the six months prior to the survey, and about half (49 percent) had practiced sex work outside Uganda. Among MSM, 58 percent reported having travelled outside their district for sex work, while 80 percent of MSM and 97 percent of PWID reported that they planned to travel outside Uganda. Among FF, 79 percent had travelled or slept away from home for work in the six months prior to the survey, with 23 percent staying away for a month or longer.

The in-depth interviews provided information as to how mobility contributes to risky behaviors and how it affects access to health care. Respondents admitted that being away from familiar social support networks and communities for so long leads to loneliness and social disinhibition, which leads to increased sexual risk-taking and alcohol abuse.

Further, LDTDs considered mobility a key barrier to accessing health care, leading to delays in seeking treatment during transit that can turn minor health problems into life-threatening illnesses. In addition, continuity of care was especially problematic for highly mobile populations (especially truck drivers), who might start treatment in one location and continue elsewhere.

Engagement in transactional sex was common among segments of the study population: Besides FSWs, some respondents in the other study populations reported engaging in transactional sex, as illustrated in Figure 1. The highest proportions were reported among MSM (88 percent), PWID (38 percent), and LDTDs (28 percent).

Figure 1: Percentage who engaged in transactional sex in the past three months



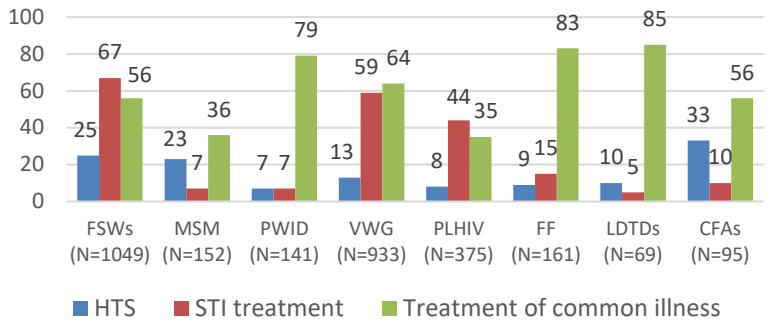
Although there is a wide range of public health care services in the study area, some participants preferred private health services: Most study participants reported that they could access most services at dispensaries and health centers in the study sites, including family planning and tuberculosis screening, HIV diagnosis, and HIV treatment. However, some key populations reported that they preferred private facilities where they spend less time waiting for services than they do at public facilities. MSM also preferred private health facilities because they thought they offered high levels of privacy.

The majority of individuals who sought services at local facilities received the services they wanted: The results showed that 85 percent to 94 percent of respondents across all groups had sought health care from the facilities in the study sites, except for LDTDs (59 percent) and CFAs (76 percent). The most common services sought were treatment of common illness, HIV testing services (HTS), and STI treatment (Figure 2). Notably, 67 percent of FSWs and 59 percent of VWG sought treatment for STIs. More than 80 percent of all groups who sought treatment said they received all the services that they wanted, except for FF (77 percent).

Proximity/closeness to residence was the most important factor influencing choice of a health facility: The most commonly cited reasons for seeking health care at a particular health facility were distance to the facility, the quality of services provided, the attitude of the health care providers, and the cost of services. MSM, LDTDs, and CFAs most often cited quality of care as the reason for facility choice, and the rest of the population groups cited proximity to their residence as the most common reason. Cost was often a reason for facility choice among PWID (34 percent), FSWs (25 percent), and VWG (20 percent). At least 29 percent of FSWs, MSM, PLHIV, and LDTD also cited "good attitude" of providers as a key consideration. About half of respondents (44 percent to 57 percent across groups) said the waiting period was reasonable.

Participants in the formative assessment identified barriers that key and vulnerable populations face in accessing health care, including cost of accessing medical services (since lack of insurance coverage means that most pay for services out of pocket). Even clients who seek services in public health facilities are sometimes required or advised to buy medicines outside the facility. Other barriers cited included long distances to the health facilities; stigma and discrimination in the health sector against specific sexual identities, orientations, and behaviours;

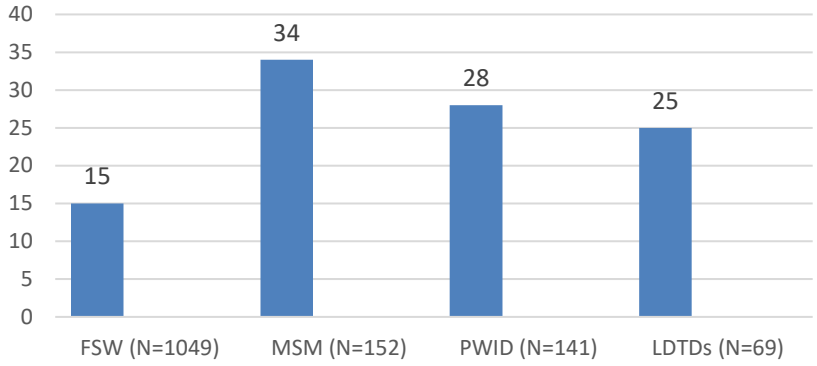
Figure 2: Percentage who sought particular services at last visit to a health facility



criminalization of same- sex sexual activity and sex work in Uganda; and lengthy waiting times at some facilities. Some participants also complained about hurried consultations (which left limited time to discuss problems) and restrictive open hours at some facilities.

Several respondents had sought health care services from facilities located across the border in a neighboring country. Substantial proportions of respondents reported that they had sought health care services across the border in a neighboring country. This included 34 percent of MSM, 15 percent of FSWs, 25 percent of LDTDs, and 28 percent of PWIDs. The service most commonly sought across the border was treatment for common illnesses.

Figure 3: Percentage who sought services across the border



Perceived quality of services offered was cited as the main reason for seeking services in a neighboring country. In the formative assessment, some participants reported that they sought care from other countries because they perceived them to be more accommodating and accepting of non-nationals, and because they could escape perceived stigma at local facilities.

> *"Sometimes there are some people who don't have confidence and fear that if we happen to know that they have HIV they might start talking bad about them so they decide to go to far places, like in Rwanda there is a hospital that side of Rubaaya and keeping going there to get the medicine or getting medicine from Rwanda so that community members may not be able to know."*
>
> – Focus group discussion, PLHIV, Katuna

Rates of screening for noncommunicable diseases were generally low among the study population, but screening for HIV was common: The percentage of respondents who had ever been screened for hypertension was highest among FSWs (26 percent) and lowest among FF (10 percent). The rate of screening for diabetes was generally low among all groups, but highest among LDTDs (13 percent). The rate of screening for cervical cancer was also low, ranging from 21 percent among female FF to 4 percent among VWG. On the other hand, rates of testing for HIV were generally high; more than 80 percent of all the respondent groups except PWID (77 percent) said they had ever been tested for HIV.

The policy environment is supportive of services for key and vulnerable populations: HIV services in Uganda are guided by the Uganda National HIV and AIDS Strategic Plan (2015/16–2019/20), which acknowledges the importance of key populations and suggests scaling up comprehensive HIV interventions for them. The National Most at Risk Populations Priority Action Plan 2015/6–2016/2017 guides the implementation of strategies and indicators to support the scaling up of efficient and effective interventions for these groups. It was also reported that a harmonized HIV/STI treatment protocol exists between Kenya and Uganda, which guides treatment of the cross-border population at facilities on either side of the border at the study sites.

Although most health care workers had been trained in the services offered at the

health facilities, gaps in skills exist for some services: The findings showed that most of the health care service providers had received either basic or refresher training related to the services they were providing at their facilities. However, a proportion of the staff was providing services for which they had not been trained. Services related to sexual and gender-based violence had the highest skills gap (13 percent), followed by family planning (12 percent) and laboratory services (12 percent). Provision of family planning and antiretroviral therapy both had a skills gap of 10 percent.

Health workers saw their facilities as supportive of services for key and vulnerable populations: Most of the health workers interviewed reported that the health facilities where they worked provided services to key populations, although only 13 percent said their facilities provided services for MSM. More than half (55 percent) thought that the health facilities where they worked were very supportive of key populations, and more than 70 percent of the providers said they were comfortable discussing sexual behaviors related to HIV/STIs with clients.

Female respondents supported traditional views and stereotypes that contribute to vulnerability: The results of the vulnerability index showed that a substantial percentage of women supported traditional gender beliefs. For example, among both female PLHIV and VWG, 41 percent and 47 percent believed that men would be justified in beating their wives if they went out without telling them and if the wife neglected their children, respectively. VWG had the highest level of economic vulnerability in terms of ownership of assets, followed by FSWs and PLHIV. Female FF had the lowest level of economic vulnerability.

In the formative assessment, some participants reported having experienced gender-based violence. For instance, FSWs reported that they experienced violence and sexual coercion from their clients, making it difficult for them to negotiate safer sex.

CONCLUSIONS

These results suggest that there are substantial levels of mobility among key and vulnerable populations, including cross-border movements, which could lead to increased vulnerability to HIV infection. Transactional sex, which further increases the risk of HIV infection, was reported in a proportion of each population. Frequent travel also makes adherence to treatment more difficult. Combatting the HIV epidemic in this context will require continued efforts to implement and ensure access to harmonized HIV prevention and treatment services in the cross-border areas, targeted at these populations to reduce risk for themselves and the local host communities.

Although the assessment showed high levels of access to health care services, other factors such as proximity and quality of care emerged as important considerations that influence decisions on when and where to seek health care. These factors, considered together, suggest a potential benefit of adopting and implementing a standardized package of health and HIV and AIDS services, including tuberculosis services, targeted for key and vulnerable populations. Such an effort should also include capacity building for health care workers to ensure that they can provide these services and that they are comfortable and confident in providing them to these populations.

Interventions are also needed to address the social and economic vulnerability of the female members of key and vulnerable populations, and to change societal attitudes that accept violence against women.

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