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Additional Content to the National Sexually Transmitted Infections Care and Treatment Course for Health Care Workers

High Transmission Areas:
Key Populations



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High Transmission Areas: Key Populations

“No one is born hating another person because of the colour of his skin, or his background, or his religion. People must learn to hate, and if they can learn to hate, they can be taught to love, for love comes more naturally to the human heart than its opposite.”

— [Nelson Mandela, Long Walk to Freedom](#)

High Transmission Area Programme (1)

- Created by NDoH as a means to control HIV through implementation of targeted interventions for key populations
- Vision of program focuses on:
 - reducing HIV/STI/TB incidence among key populations
 - slowing HIV transmission in general population
 - improving health outcomes of all key populations



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High Transmission Area Programme (2)

- Interventions: increased HIV prevention, care, treatment and support services
- Services include:
 - HCT, STI, and TB screening and treatment
 - Sexual and reproductive health screening and family planning
 - Providing condoms and lubricant
 - Risk reduction counselling, education

High Transmission Area Programme (3)

- Strong focus on peer education
- Integrated approach – combined HIV/STI/TB – because of interacting causes of HIV/STI/TB risk and vulnerability
 - Structural, biological, psychosocial and behavioural dimensions
 - Best way to create change and see improvements in the health of key populations



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Who are Key Populations in the Context of HIV/AIDS?



Key Populations Defined (1)

- Populations at higher risk of HIV exposure – more likely to be exposed to HIV or to transmit it
- Includes both vulnerable populations and most at risk populations
- Engagement of key populations is critical to a successful HIV response



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Key Populations Defined (2)

Vulnerable:

- People who are particularly vulnerable to HIV infection in certain contexts, such as:
 - adolescents
 - orphans
 - street children
 - people in closed settings (e.g. correctional centres)
 - people with disabilities and
 - migrant and mobile workers

Most-at-risk:

- men who have sex with men
- transgender people
- people who inject drugs
- sex workers
- offenders in prison settings
- Carry disproportionate burden of HIV and STIs

Key Populations NSP 2012-2016

- Young girls
- Infants and children under age 15
- Sex workers and their clients
- Men having Sex with Men
- Mobile and migrant populations
- Clientele of taverns and shebeens
- Offenders in correctional facilities
- People living in unstable communities
- Men between ages 12-49
- Sero-discordant couples
- HIV-infected pregnant women
- TB/HIV co-infected patients



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Key Populations: Groups

- In this training, we will focus on the following key populations and issues specific to STIs:
 - Sex workers
 - Men who have sex with men (MSM)
 - Prisoners



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What Makes These Populations Vulnerable?

- Sexual violence
- Drug & substance abuse
- Decreased ability to negotiate safe sex practices
- Increased risk of violence
- Poor living conditions
- Unique needs are ignored
- Stigma and discrimination
- Limited access to medical care
- Legal, political, religious and socio-cultural resistance
- Hostility and intolerance from the community
- Services are denied



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Values, Attitudes and Beliefs

- Our values, attitudes and beliefs are one of the most defining things about each of us. Think about your most important value. On a blank piece of paper, answer the following:
 - *Describe your most important values that make you who you are.*
 - *Identify 3-5 beliefs that you find important.*
 - *Who has influenced your values and beliefs and why?*
 - *Why did you become a healthcare worker?*



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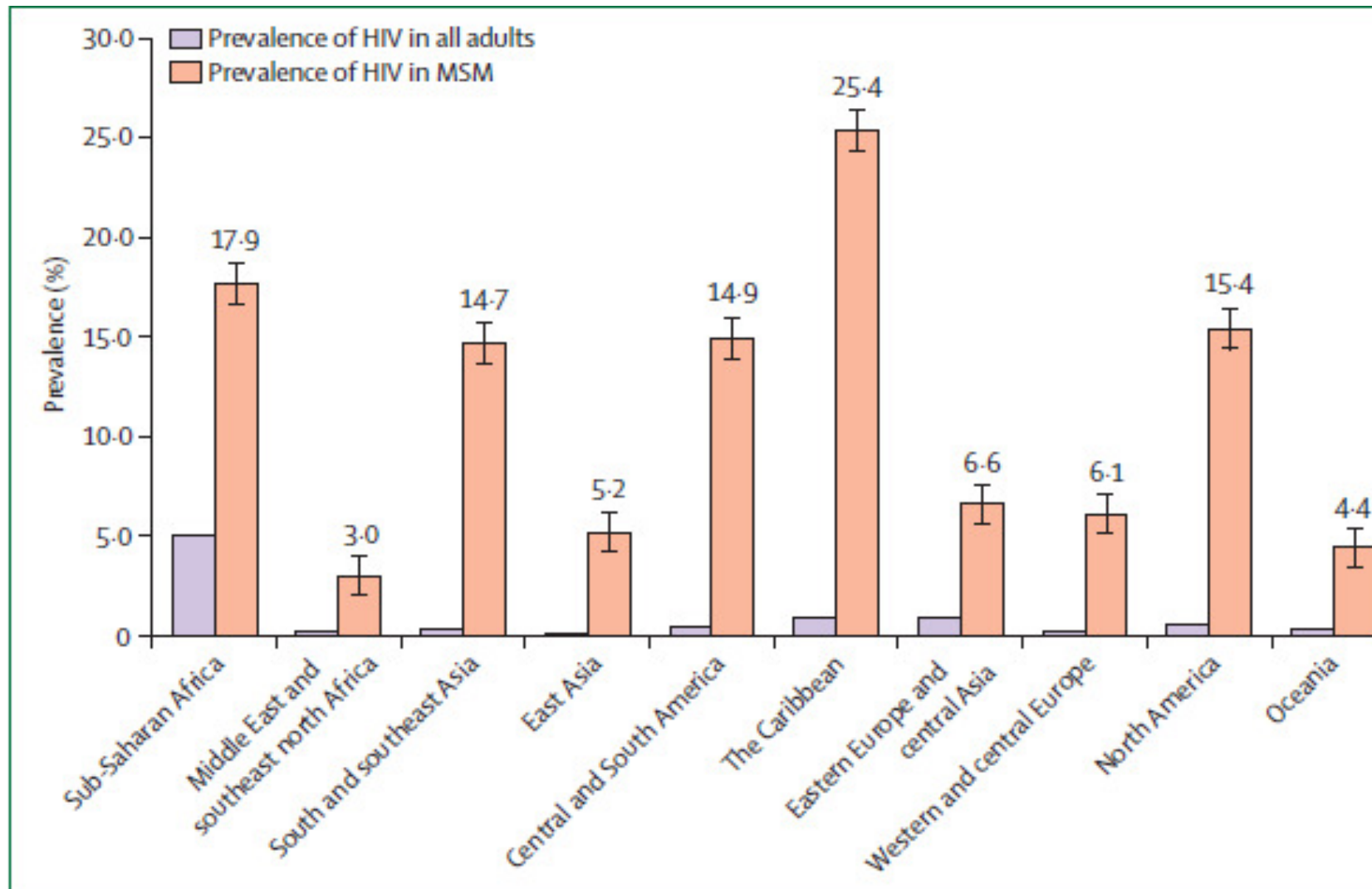
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Discussion

*When do values or beliefs
become discrimination?*

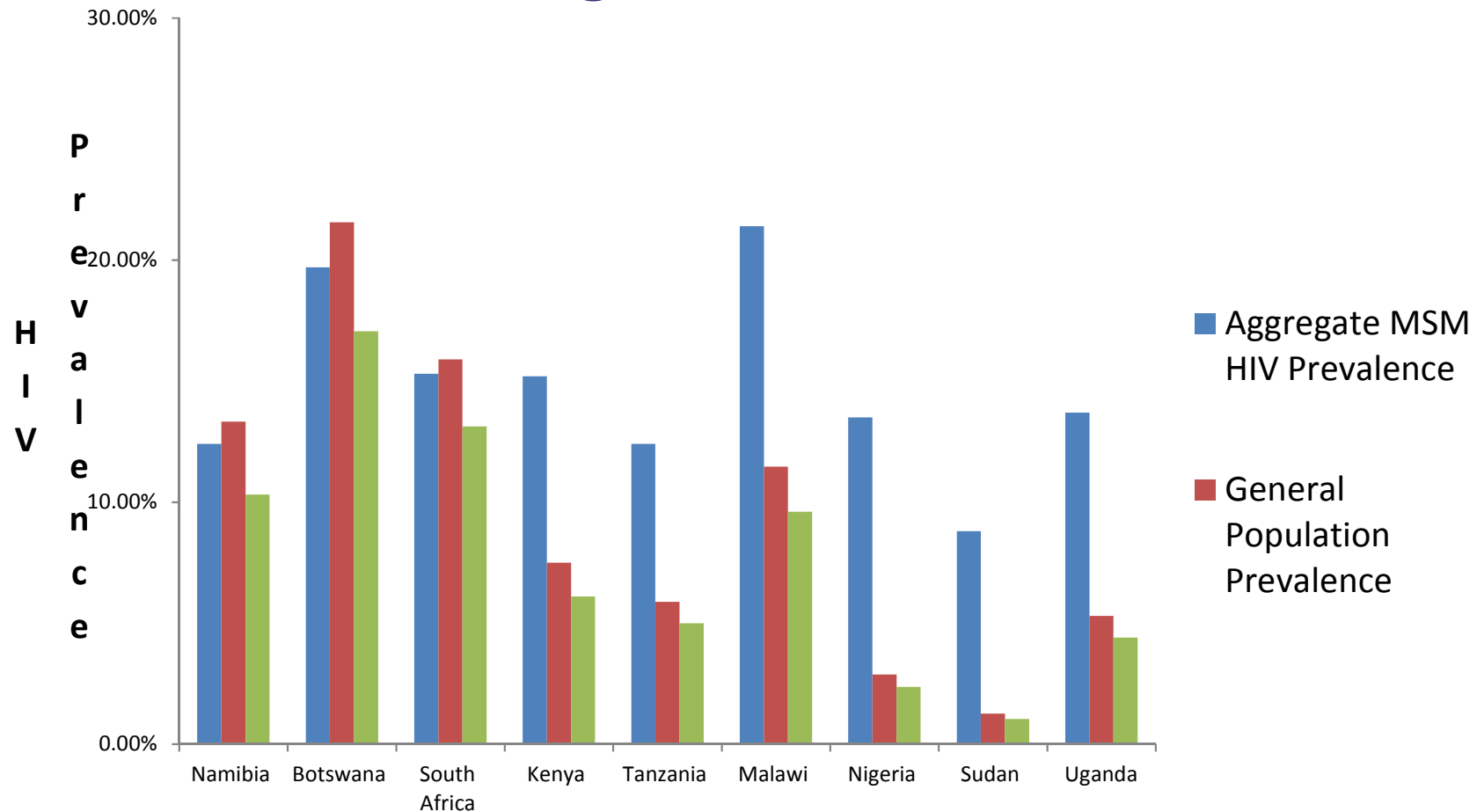
HIV Prevalence Among MSM vs. All Adults



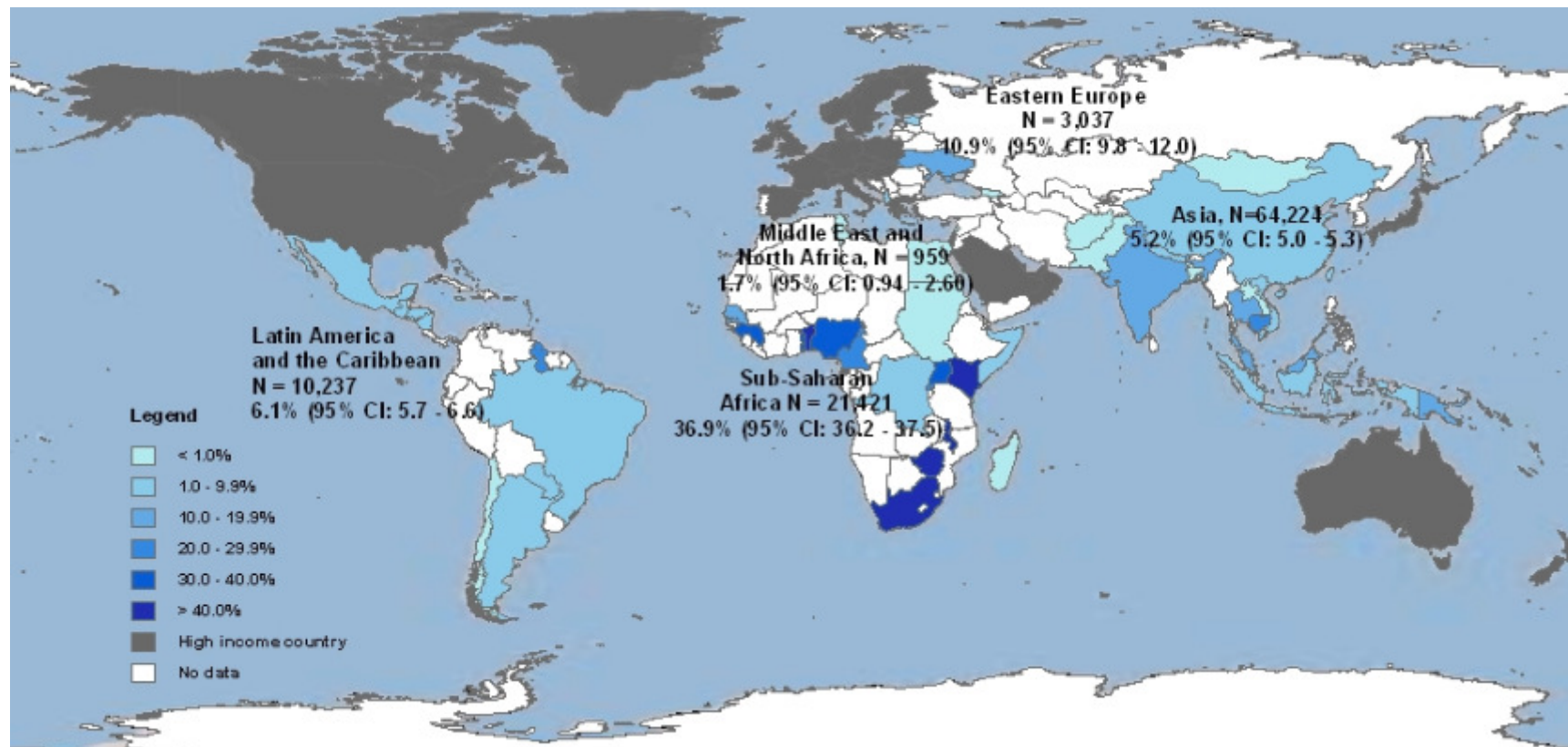
Rising HIV epidemic among MSM in many regions across the world

Source: Beyrer, C., Baral, S. D., Griensven, F. et al. (2012). Global epidemiology of HIV infection in men who have sex with men. *Lancet*, 380(9839), 367-377.

MSM Risks Occur in the Context of Mature and Widespread HIV Epidemics Among Heterosexuals

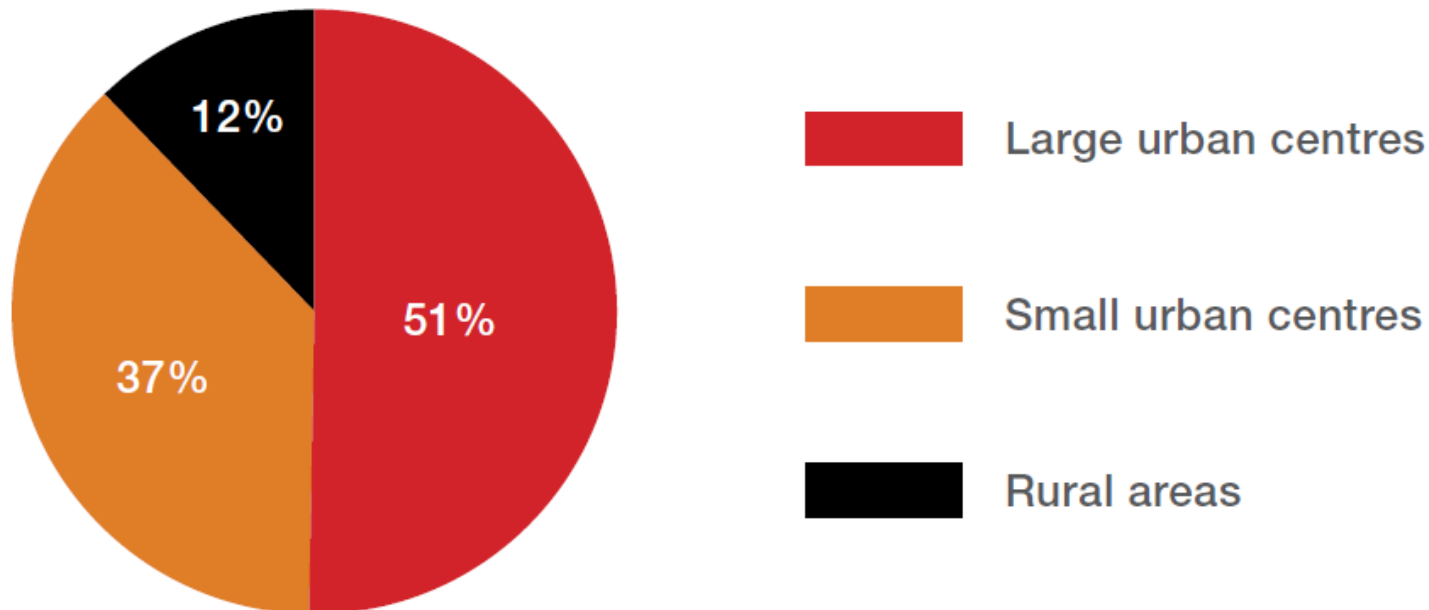


Sex Work Prevalence



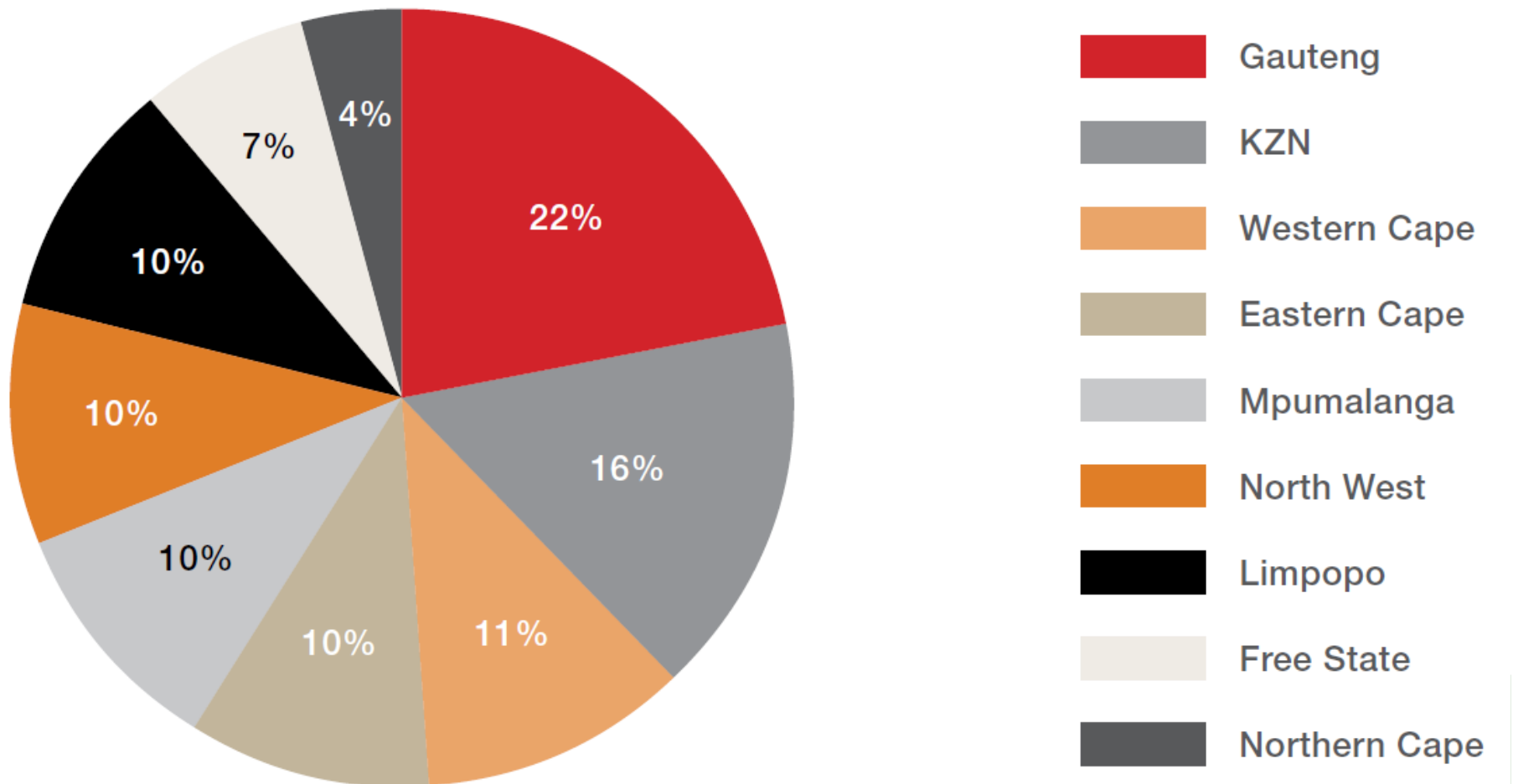
Approximate Number of Sex Workers in South Africa (1)

Female sex workers	138 000
5% Male	7 000
4% Transgender	6 000
NATIONAL TOTAL	153 000
% of adult female population	(0,9%)



Approximate Number of Sex Workers in South Africa (2)

Provincial distribution for intermediate estimate



Systematic Review of HIV Prevalence among Female Sex Workers

	Number of countries	Sample size of sex workers with HIV	Sample size of sex workers	Pooled HIV prevalence (95% CI)	Background prevalence	Pooled odds ratios (95% CI)
Region						
Asia	14	3323	64 224	5.2% (5.0-5.3)	0.18%	29.2 (22.2-38.4)
Eastern Europe	4	331	3037	10.9% (9.8-12.0)	0.20%	NA
Latin America and the Caribbean	11	627	10 237	6.1% (5.7-6.6)	0.38%	12.0 (7.3-19.7)
Middle East and north Africa	5	17	959	1.7% (0.9-2.6)	0.43%	NA
Sub-Saharan Africa	16	7899	21 421	36.9% (36.2-37.5)	7.42%	12.4 (8.9-17.2)
Prevalence level						
Very low or low*	21	3561	69 729	5.1% (4.9-5.3)	0.17%	24.5 (19.1-31.3)
Medium or high†	26	8627	28 075	30.7% (30.2-31.3)	5.47%	11.6 (9.1-14.8)
Total‡	50	12 197	99 878	11.8% (11.6-12.0)	..	13.5 (10.0-18.1)
*Very low (<0.5%), low (0.5-1.0%). †Medium (1.1-5.0%), high (>5.0%). ‡Meta-analysis of prevalence does not include Afghanistan, Laos, and Albania.						

Source: Baral, S et al. Burden of HIV among female sex workers in low-income and middle-income countries: a systematic review and meta-analysis. *The Lancet Infectious Diseases*. 2012

HIV among Offenders in South Africa

- South Africa has the highest number of offenders in southern Africa: 413 / 100 000
- HIV prevalence among offenders in South Africa:

Year	HIV Prevalence	Sample Size
2009-2010	22.8%	HIV testing available to all sentenced offenders on average 360 000 per year
2006	19.8%	8 649 (only 5 299 participated)
2002	41%	Modelled projection

Discussion

- Key populations are estimated to contribute about one quarter of new HIV infections in South Africa*:
 - *How do you feel about this statistic?*
 - *Why are key populations in our communities more at risk of HIV and STIs?*
 - *How do my values or beliefs affect my opinion about this?*
 - *How might my values or beliefs affect the way I deliver care to my clients who I suspect of being a key population?*

*Source: *Getting to zero: HIV in eastern and southern Africa Regional Report. UNAIDS 2013*



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South Africa's Constitution Protects Key Populations

- Section 9: the right to equality before the law and freedom from discrimination. Prohibited grounds of discrimination include race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.
- Section 10: the right to human dignity.



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Discussion

What are Some Interventions that
May Benefit Key Populations?

Recommended Interventions for Key Populations

1. Behavioural interventions
2. Biomedical interventions
3. Structural interventions
4. Additional care and support

What are some examples of each of these types of interventions?



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1. Behavioural Interventions

- Peer education and outreach
- Sexual health screening, risk reduction counselling and skills building
- Promotion, demonstration and distribution of condoms and lubricants
- Screening and referral for drug and alcohol abuse
- Promote utilisation of HIV, STI and TB screening and treatment



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Information, Education and Communication

- Awareness raising, information and education about HIV, STIs, viral hepatitis, and TB with all key populations
 - Especially important in closed settings like correctional centres
- Peer education programmes, developed and implemented by trained key populations
 - Fellow sex workers
 - Fellow offenders



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Counselling for Condoms (1)

- Provision and counselling towards consistent condom use
- Access to lubrication especially for people practicing anal sex
- Female and male condom demonstrations
- Condom negotiation skills for sex workers:
 - Taking client's money prior to sexual encounter so clients cannot refuse to pay if condom is used
 - Taking client to known sex work venue where rules of the venue require use of a condom
 - Negotiating with client to engage in non-penetrative sex, like oral sex
 - If safe, refusal to engage in sex without a condom



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Counselling for Condoms (2)

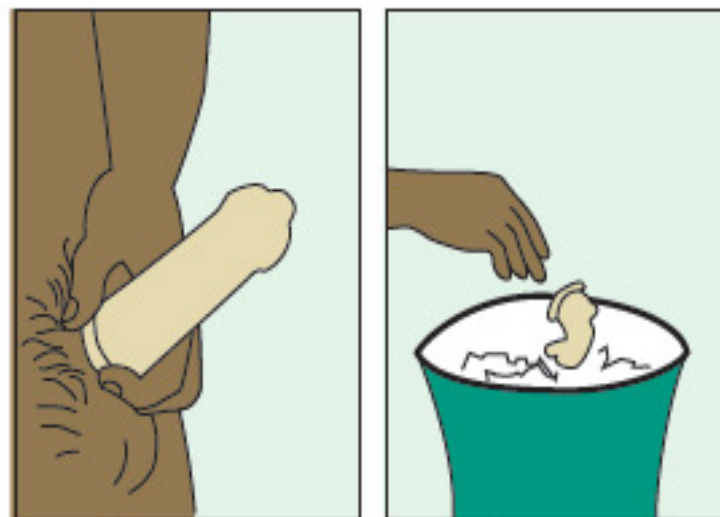
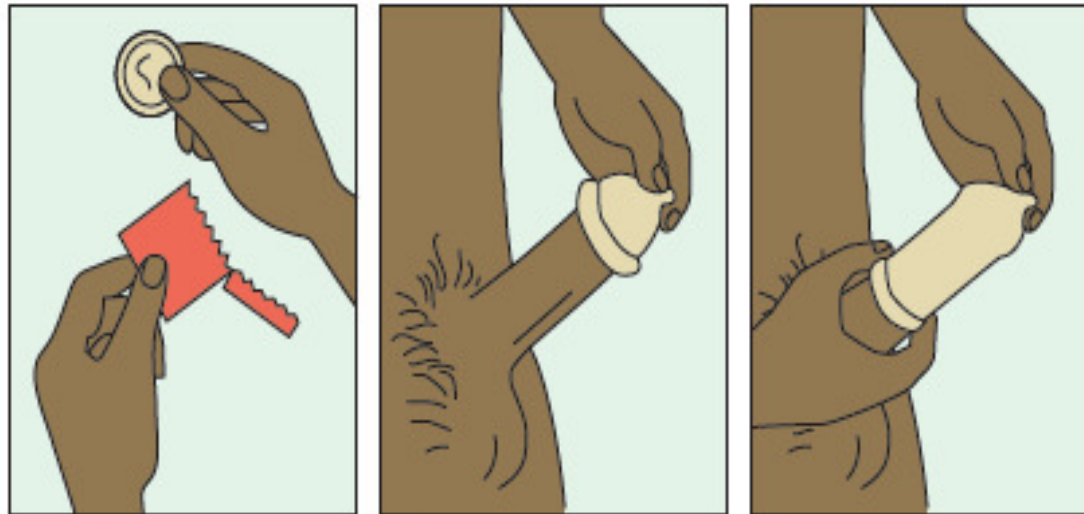
- Widespread condom accessibility
- Condom negotiation skills for other key populations
- Partner notification and partner treatment emphasis!
- Make condoms easily and discreetly accessible to offenders at various locations without having to request them & without them being seen by others
- HCWs should distribute condoms and lubrication to offenders and have condom campaigns



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Male Condoms

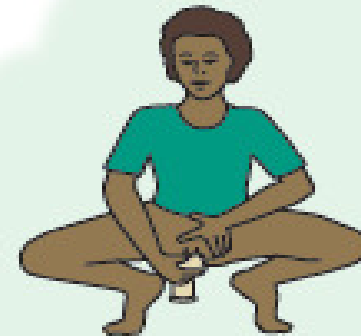
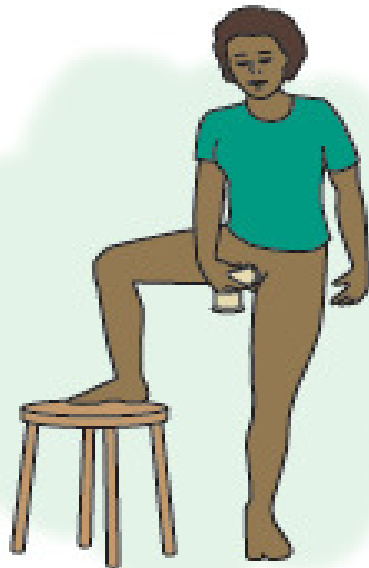
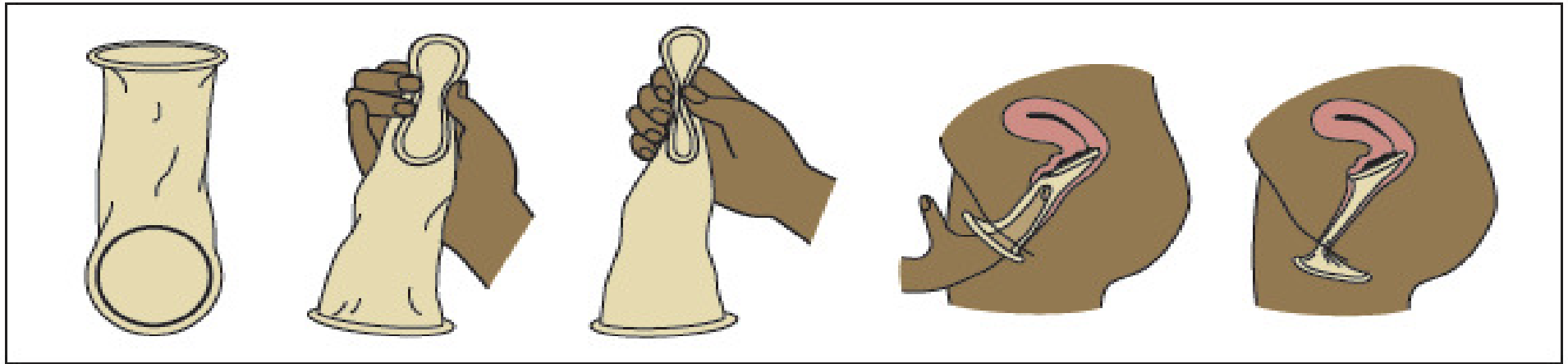


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Female Condoms



MSM: Men who have Sex with Men

- A public health term used to define a risk group by its behaviour
- Different than identity: includes men who are homosexual, gay, bisexual and heterosexual
- Men usually do not identify themselves as 'MSM'
- Sexual behaviours, orientation and identity may change over time for various reasons
 - Identity and terms used to describe oneself may change



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Situational Role in Behaviour

- Some men have male-to-male sex due to the situation they are in and may not have homosexual orientation
 - Single-sex institutions:
 - Military
 - Correctional Centres
 - Boarding schools
 - Work in remote areas
 - Other situations:
 - Sex for money
 - Forced sex
 - Childhood exploration of sex with male peers



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Male to Male Sexual Behaviour Overview

- Male-Male sex
 - Similar to male-female sex
 - Involves feelings and emotions as well as physical pleasure
- How do MSM have sex?
 - No fixed roles (insertive, receptive)
 - Sexual tastes and likes can change over time

Male-Male Sexual Behaviours (1)

- Kissing
- Touching
- Oral sex
 - Also known as 'fellatio,' 'blow job'
 - The most common type of male-male sex, performed by more than 90% of MSM in some studies
 - Easily 'performed,' unobtrusive, easy to stop if interrupted
 - Includes licking the testicles and scrotum
 - Very low risk for HIV infection, but can transmit STIs to the genitalia, oropharynx or face



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Male-Male Sexual Behaviours (2)

- Anal sex
 - Practiced by both men and women
 - Not all MSM enjoy it or engage in it
 - The perianal skin, anal canal and rectum are rich in nerve tissue and can produce pleasurable feelings when stimulated
 - Massaging of the prostate during anal sex:
 - Creates pleasurable sensations
 - Heightens orgasm
 - Increased risk of HIV and STI transmission if no condom and lubrication used



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Counselling on Anal Sex Practices

- Important with MSM clients and in correctional centre settings
- Practice with fingers or sex toys
- Gradually increase size of toys to train muscles
- Use of different positions and techniques
 - Backing onto penis
 - Sitting on penis
 - Bearing down (abdominal pressure)
 - Deep breathing



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Penile-Anal Penetration

- Use plenty of water-based lubrication and condoms
 - Self-lubrication does not occur
- Water-based lubricant
 - Reduces trauma during penetration
 - Decreases 'openings' for infections, including HIV
 - Oil-based lubricants damage condoms - should be avoided
- Cleanliness
 - Men may be uncomfortable due to fear of faecal matter
 - Gentle cleaning with mild soap and water on the outside is sufficient



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Anal Play

- Use of toys (vibrators, dildos) to stimulate rectum
 - Rub perineum
 - Insert into anus
- Objects should not be shared to avoid pathogen spread
 - People should use their own toys or wash well before exchanging
 - If necessary, condoms can be used on shared toys



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Oral-Anal Sex

- Mouth-anal stimulation
- Sometimes called rimming or anilingus
- Can be foreplay to anal penetration
- Can transmit STI or other infections (Hepatitis A, diarrheal diseases)
- Barriers can be employed to reduce pathogen risk
 - Plastic wrap
 - Dental dams



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Safer Sexual Practices

- When providing counselling to patients about safer sexual practices, the following non-penetrative alternatives may be given
 - Masturbation
 - Thigh-sex
 - Body rubbing, “dry humping,” massage



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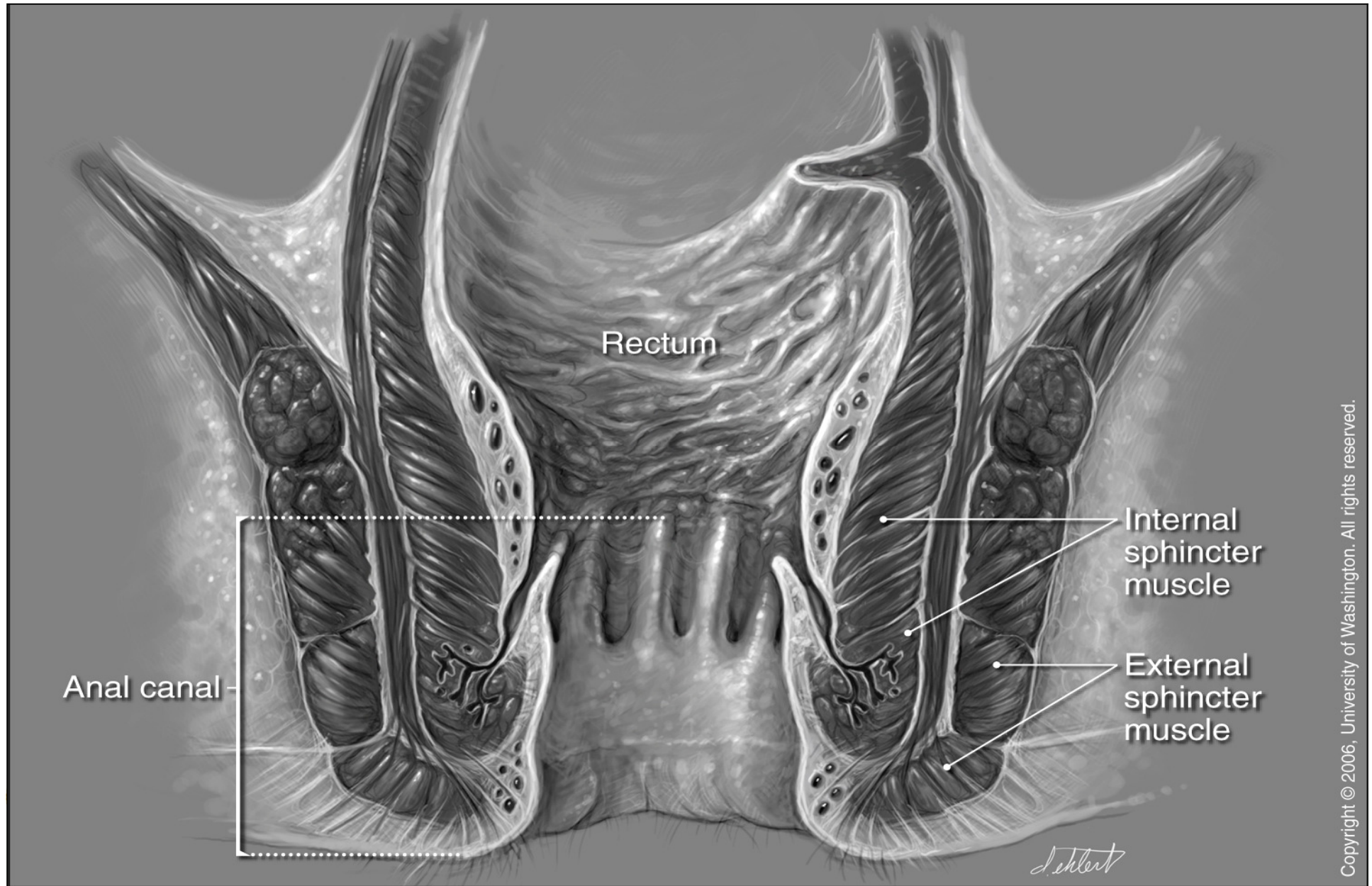


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Clinical Examination of Ano-rectal Region

Anorectal Region: Anatomy



Anorectal Region: Health Issues (1)

- Optimal anal health is important for MSM and transgender people who practice anal sex
- Perianal skin is tough but prone to damage from:
 - Faecal soiling
 - Persistent moisture
 - Toilet tissue abrasion
 - Abrasion from scratching
 - ‘Dry’ anal sex
 - Forced, unlubricated
 - Irritating treatments
 - Over the counter pastes, creams
- Seek help before self-treatment

Anorectal Region: Health Issues (2)

Typical Symptoms

- Pain
- Lumps
- Ulcers
- Rashes
- Discharge
- Bleeding
- Difficulty defecating
- Tenesmus
 - Sensation of needing to pass stool accompanied by pain, cramping, straining

Detection

- STIs can be difficult to detect
 - Asymptomatic
 - Misinterpreted symptoms



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Anorectal Health Care: Perianal Cleansing

- Gently wash with water before/after anal sex
 - May reduce amount of bacteria that could be spread
 - May also remove some of the body's natural protection against infection
- Use water only-- without soap or detergent-- can reduce the loss of this natural protection
- If decide to use soap: advise use of normal soap and water, not strong soap

Anorectal Health Care: Barriers

- Condoms help prevent spread of STIs (including HIV) when worn prior to and during anal contact
 - Male condoms
 - Female condoms, also termed receptive condom
- Oral–anal contact
 - Safest when non-permeable membrane used
 - Can use plastic food wrap
 - Acts as a barrier between the mouth or fingers and the anus

Anorectal Health Care: Lubrication

- Should be used during anal penetrative sex to prevent mucosal tearing
 - Anus does not produce own lubrication
- Use water-based lubricant only
 - Oil-based lubricants can cause irritation and increase the risk of breakage of latex condoms
 - If lubrication not available, saliva can be used
- Avoid spermicides

Anorectal Examination

- Ask patient to roll to left side, facing away from you ('left lateral position')
- Hips and knees flexed towards stomach
- Ask patient to retract right buttock with right hand
- Inspect the perianal region & natal cleft
 - Look for warts, ulcers, rashes, hemorrhoids, bleeding, discharge, fissures



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Digital Rectal Examination (1)

- Ensure patient is comfortable
- Use plenty of water-based lubricant
- Use slow circular motions as you advance
- Valsalva manoeuvre will relax anal sphincters
- As patient does this, slowly advance your middle finger in the anus as far as possible
 - Can take up to 1 minute
 - Gauge their comfort

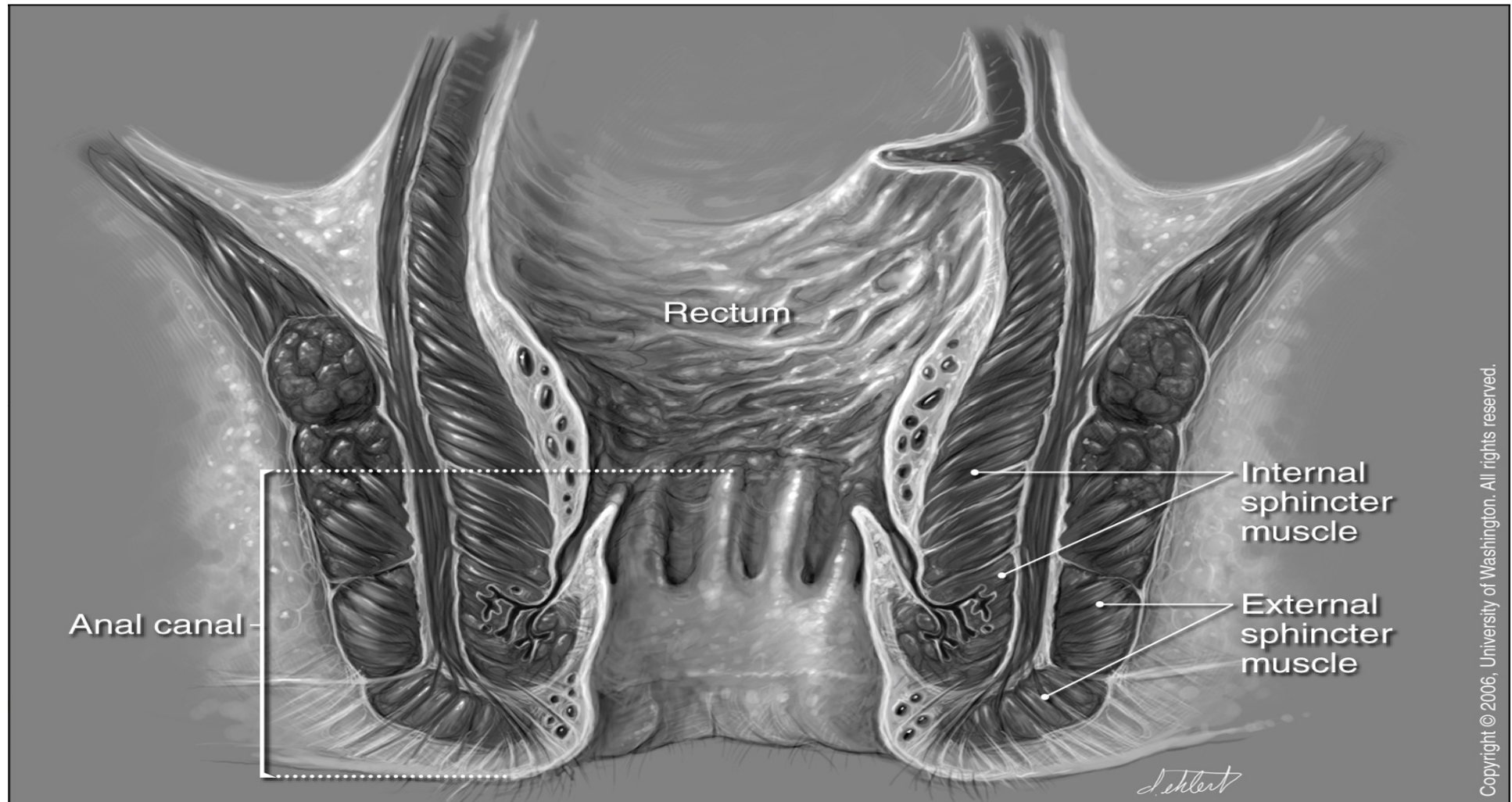


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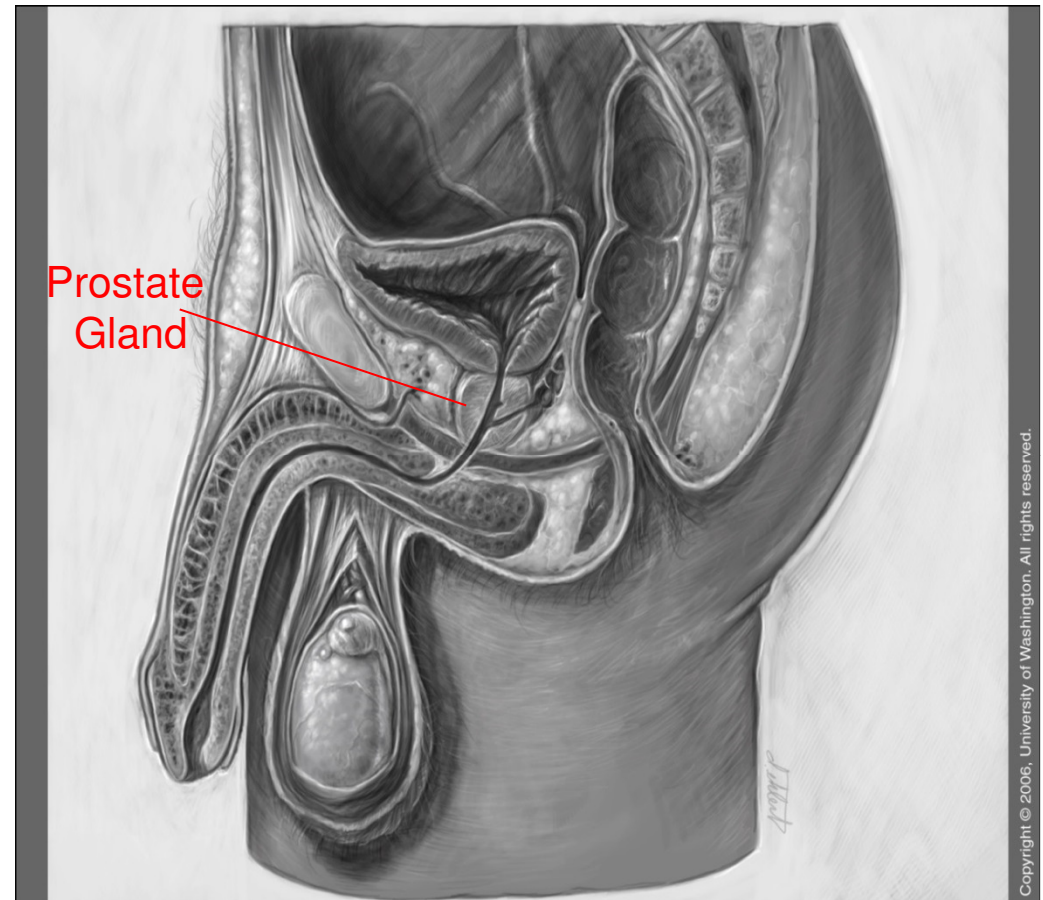
Digital Rectal Examination (2)

Note sphincter tone and any masses or disproportionate tenderness



Digital Rectal Examination (3)

- Palpate the prostate
 - Note shape, consistency, regularity, and any tenderness
- Prostate examination – should be performed in all men over 60
- Examine for symptoms of urinary obstruction (e.g. prostatitis, benign prostate hypertrophy)



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Digital Rectal Examination (4)

- Slowly withdraw your finger
 - Make note of any blood on examination finger
- Perform testing on stool and rectal specimens if indicated



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Completion of Examination and Visit

- Remove & dispose of gloves
- Provide tissue for patient to wipe him/herself
- Ask patient to dress & sit by desk again
- Wash hands with soap and water
- Continue sexual health consultation
 - Collect specimens for diagnostic tests
 - Empiric treatment
 - Prevention counselling, condoms and lubrication
 - Counselling and provision of partner notification slips
 - Follow-up



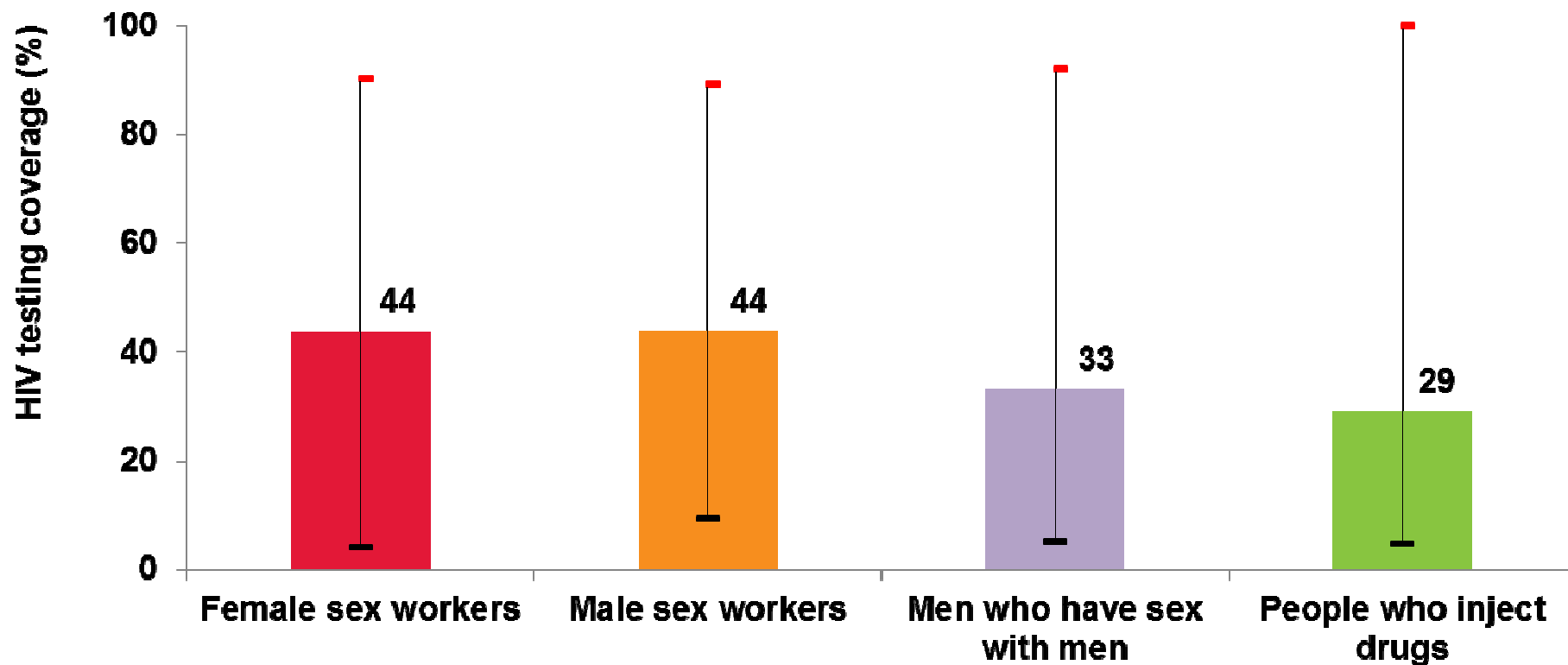
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2. Biomedical Interventions

- HIV counselling and testing (HCT)
- HIV care and treatment (including ART)
- STI and TB screening and treatment
- Sexual and reproductive health services
- Condoms and lubricants
- Post-exposure prophylaxis
- Voluntary male medical circumcision (VMMC)
- Biomedical interventions for PWID

HIV Testing Coverage Among Key Populations, Regional Median, 2011



Though HIV is concentrated among key populations, less than half of them know their HIV status

ART

- Slows replication of HIV (reduces viral load) and stops immune deterioration
- Improves immune system function and prevents opportunistic infections
- Alters/reverses course of existing opportunistic infections
- Decreases hospitalisations
- Increases survival
- Improves quality of life
- Restores hope
- Reduces HIV transmission
- Benefits both adults and children



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ART and HIV Prevention

- ART is a game changer
- When people take their medicine in the correctly

**REDUCES HIV transmission by 96%.
ART is essential to HIV prevention.**



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Discussion

- *What are some challenges related to ART as prevention within key populations?*



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ART in Key Populations

- Provision of services responsive to needs and requests of clients (for example, evening and weekends)
- Community settings or decentralized services through mobile units to take service delivery to clients themselves
- Family-centred
- Patient-held records for mobile populations
- Nutritional supplements for offenders in the prison setting
- Equal access to ART provided to all offenders to ensure continuity of care at all stages, from arrest to release
- Respectful and non-judgmental staff attitudes



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Note that treatment of STIs still follows the NDOH algorithms – does NOT differ for key populations



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TB Screening (1)

- Screening is essential in prison populations and sex workers
 - Access to GeneXpert for timely diagnosis, especially for MDR-TB
- Intensified active case-finding
 - Case finding tracked back to families for new offenders entering prison settings
 - Periodic and systematic screening of entire prison populations
- IPT

TB Screening (2)

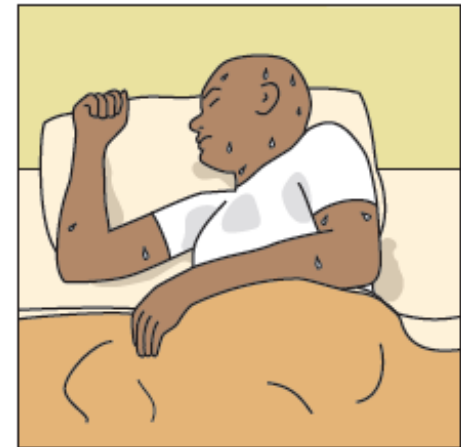
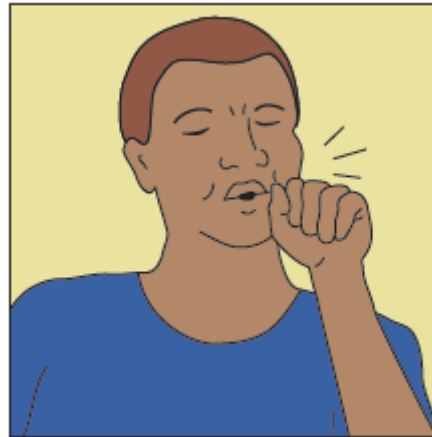
- Segregate offenders in prison setting until they are no longer infectious
- Educate on coughing etiquette and respiratory hygiene
- Continue treatment during all stages of detention, from arrest to release in prisons
- Provide PICT for persons with HIV
- Annually screen healthcare workers and other staff working in prisons and clinics



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TB Screening Questions



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Screening for STIs

- All patients ages 15-49 should be screened for STIs regardless of clinical presentation
- Ask the following 3 questions:
 - Do you have any genital discharge?
 - Do you have any genital ulcers?
 - Has/have your partner(s) been treated for an STI in the last 8 weeks?

STI Clinical Services: Sexual History Taking

- Can be learned with training
- Becomes easier with practice
- Most patients are willing to answer detailed questions about their sexual behaviour if provider is comfortable and professional in approaching sexual history
- Important in all settings including prisons

General Guidelines for Taking a Sexual History (1)

- Normalise sexual history as part of routine care for all patients
- Ensure privacy and confidentiality
- Do not start patient visit with sexual history: discuss easier issues first
- Use an open and non-judgmental attitude, good communication skills

General Guidelines for Taking a Sexual History (2)

- Explain the reasons for taking a sexual history
- Ask less-threatening questions first
 - Genital symptoms, last sexual episodes
- Make no assumptions! Ask all patients about same-sex and opposite-sex partners
- Focus on sexual behaviour rather than orientation



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Privacy and Confidentiality

PRIVACY

- The sexual history should be done in a private room
 - Auditory privacy
 - Only the provider and patient present
 - Request family members and others to leave the room

CONFIDENTIALITY

- Medical information should not be released to anyone without the patient's permission
- Reassure patient about the confidentiality of his/her medical information before taking the sexual history



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Communicating with the Patient

- Encourage patient communication
 - Verbal prompts: *Yes, OK, Thank you...*
 - Reflecting and repeating what the patient said
 - Non-verbal prompts:
 - Face the patient
 - Look the patient in the eye
 - Nod the head
- Do not label or categorise (MSM, gay, sex worker, etc.)
 - Patient may choose to label himself or herself
- Use words that the patient can understand
 - Explain medical terms
 - Use slang words if comfortable with them and used appropriately

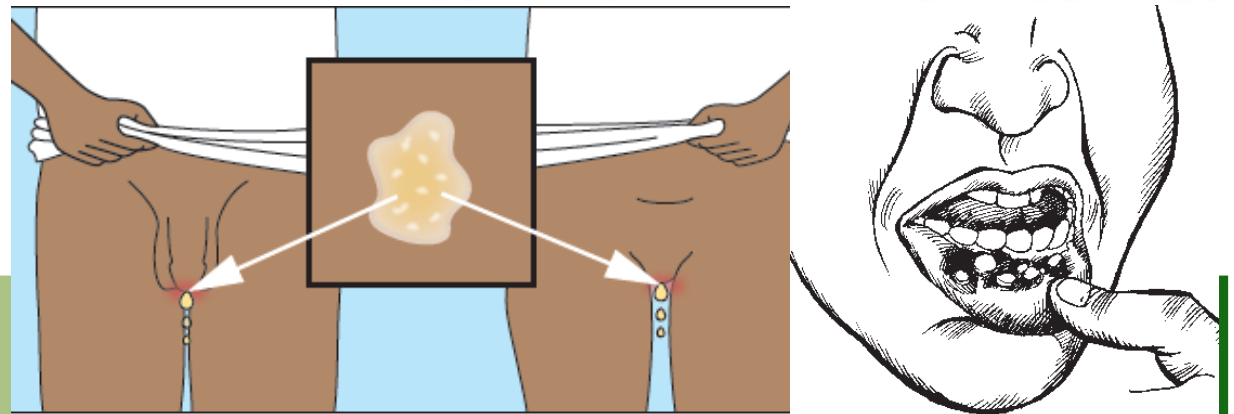
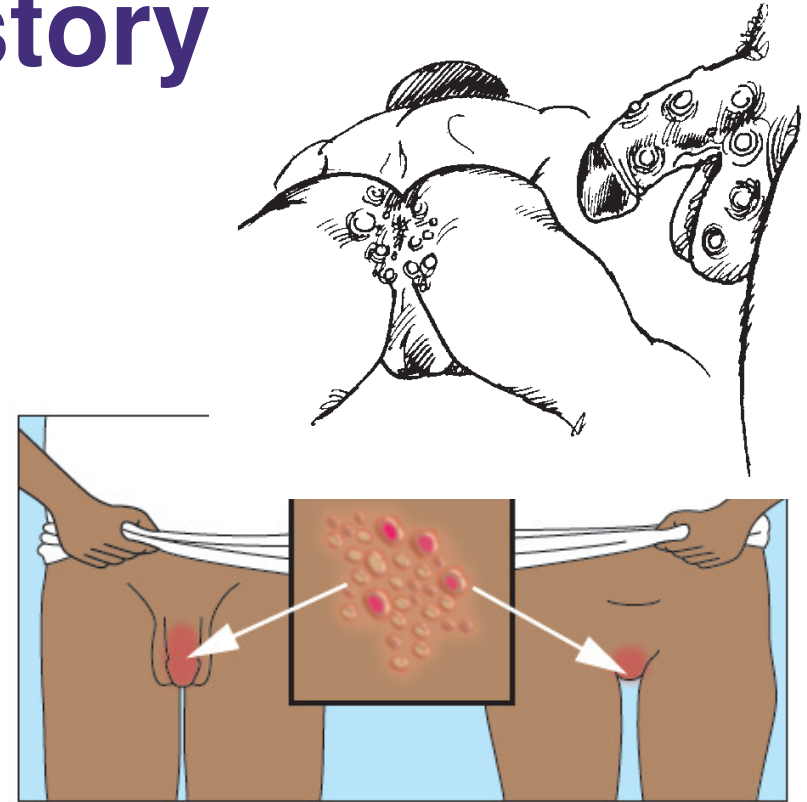


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Prepare the Patient for the Sexual History

- Tell them that you are going to ask sensitive questions
- Give them the option of not answering
- Reassure them the information is confidential
- Explain why you are asking these questions
- Explain that this is part of the examination for all patients



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Sample Script to Prepare the Patient

- Example: *“I’m going to ask you questions about your sexual behaviour. These are questions I ask all my patients. This information will help me to treat you and give you the correct advice on how to protect your health. Everything you tell me is confidential and will not be released to anyone else without your permission. If there are questions that make you uncomfortable or you do not want to answer, just tell me...”*



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Types of Questions

- Ask open-ended questions to get details of sexual behaviour
 - Who, What, Where, How
- Ask the patient to clarify
- In general do not ask ‘why’ questions
 - Usually not necessary to know why in regard to sexual behaviour
 - Asking why implies the behaviour was bad and sounds like a parent scolding a child
- One “Why” question that is OK:
 - “Why did you not use a condom?”

Sexual History: Sample Questions

- Can you tell me a little about your sex (romantic) life?
- When was the last time you had sex?
- Do you ever have sex with men?
- Do you ever have sex with women?
- Do you ever have sex for money or favours?
- When you have sex with men, what kind of sex do you have?
- Do you ever have oral sex? Do you ever have anal sex?
- When was the last time you had anal sex and did not use a condom?
- What got in the way of using a condom that time?
- What prevents you from always using a condom?



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STI Clinical Services

- Symptomatic screening of STIs including cervical and ano-rectal infections
 - Syndromic case management
- Regular screening for asymptomatic infections using lab tests

Type of Screening	Recommended Action
Syphilis screening	<ul style="list-style-type: none">• In MSM offer periodic serological testing for asymptomatic syphilis infection• Offer regular screening to sex workers
Gonorrhoea and chlamydia screening	<ul style="list-style-type: none">• In MSM offer periodic testing for asymptomatic and rectal <i>N. gonorrhoeae</i> and/or <i>C. trachomatis</i> infection• Offer regular screening to sex workers
Periodic presumptive Treatment in sex workers	<ul style="list-style-type: none">• In areas where STIs >15% prevalence of <i>N. gonorrhoeae</i> and/or <i>C. trachomatis</i> infection with counselling and informed consent

STI Drug Resistance (2)

- Consider treatment failure with clients, especially MSM - at increased risk of resistance
 - Aggressively treat suspected resistance cases according to the guidelines
- Take swabs from all exposed anatomical sites which includes urethra, vagina, pharynx and ano-rectum in suspected resistance cases
 - Look specifically for isolated *Neisseria Gonorrhoea*

Partner notification slips and counselling on importance of partner treatment especially important!



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Sexual and Reproductive Health Services (1)

- Pregnancy testing
- Family planning counselling and services
 - Provision of contraception – dual methods
 - Emergency contraception within 5 days/120 hours
 - TOP and post-TOP services
 - Safe pregnancy: ANC, HIV and STI prevention and testing, nutrition and safe delivery
 - Especially important in female offenders prior to release
- Family planning counselling for sex workers
 - Sexual history
 - Menstrual hygiene
 - Promote family planning methods
 - Assess need and counsel on family planning choices



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Sexual and Reproductive Health Services (2)

- Treatment of reproductive tract infections
- Reproductive tract cancer screening (cervical, breast, anorectal and prostatic)
- Care for unintended pregnancies (post abortion care)
- Partner notification slips and counselling on importance of partner treatment
- EMTCT services in prisons for HIV-positive pregnant women, with ensured continuity

3. Structural Interventions

- Services to mitigate sexual violence
- Sensitisation of healthcare workers, police, correctional staff
- Capacity building of Key Population support groups and individuals
- Implementation of existing policies that safeguard health rights of Key Populations



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Gender Based Violence/Sexual Assault Support Services (1)

- Complete history and physical exam to determine appropriate care
- Emergency contraception for women presenting within 5 days of sexual assault
- HIV post-exposure prophylaxis for women presenting within 72 hours of assault
- STI post-exposure prophylaxis

Gender Based Violence/Sexual Assault Support Services (2)

- Psychological support and care
 - Crisis centres
 - Other community resources
- Vulnerable prisoners, such as people with different sexual orientation, young offenders and women should be held separately from adult or male offenders
- Appropriate measures to report and address instances of violence in prison settings



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4. Additional Care and Support

- Psycho-social support
- Family and social services
- Substance abuse services



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Key Populations Require a Tailored Counselling Approach

- Due to risk factors like increased stigma and gender based violence, counselling should be tailored to specific needs of each key population e.g.:

Population	Counselling Needs
Prisoners	<ul style="list-style-type: none">• condom negotiation• HIV and TB counselling and testing
Sex workers	<ul style="list-style-type: none">• gender based violence, negotiating safer sex• prevention interventions (e.g. condoms, HCT, early treatment and TB screening)
MSM	<ul style="list-style-type: none">• condom negotiation• safe sex practices• early treatment

Crisis Counselling

- *What are some strategies you have used to counsel clients who have experienced gender based violence or sexual assault?*



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Steps in Crisis Counselling

1. Intervene immediately
2. Determine facts of crisis
3. Focus on short-term goals
4. Foster hope and positive expectations
5. Provide support
6. Focus on problem solving



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Mental Health

- Key populations are vulnerable to mental health problems because of:
 - Poverty
 - Marginalization
 - Discrimination
 - Violence
- Screen and provide treatment for depression, alcohol-use disorders, self harm, suicidal ideation, & other emotional or medically unexplained conditions



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Group Activity

- *If a client feels she/he is being judged for lifestyle choices, what will happen?*
- *How can I ensure that my clients don't feel judged?*
- *What is my role as a HCW in protecting the rights of key populations?*
- *What will I do to improve my clinical practices with key populations?*
- *How will I personally contribute to improving the quality of life of key populations in my community?*



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For to be free is not merely to cast off one's chains, but to live in a way that respects and enhances the freedom of others.

- Nelson Mandela



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