

RESEARCH BRIEF

March 2014



Background

The HIV epidemic in West and Central Africa (WCA) has distinct characteristics compared to other regions of sub-Saharan Africa. National prevalence data over time have shown moderate prevalence in the general population, with no country in the region currently presenting prevalence data over 5%.¹ Limited but emerging data among key populations (KP) at heightened risk of HIV in the WCA region indicate the burden of disease is disproportionately higher among female sex workers (FSW) and men who have sex with men (MSM). Although some data suggest a more concentrated nature of the HIV epidemic in countries where data are available, country-specific studies have either been limited or inconsistent to date for both FSW and MSM in the WCA region. In addition, emerging HIV research indicates that investing and targeting high-risk populations in the cascade or continuum of care for HIV is one long-term solution to address the needs of KP living with HIV as well as to promote population-level HIV prevention and control. However, little is known about the continuum of HIV care for KP in the region.

This study used the Modified Social Ecological Model (MSEM)² as a framework to examine the social-, individual- and policy-level factors contributing to heightened risk of HIV among KP and limited access to health services related to the continuum of HIV care among KP. This study was part of a larger, multi-country study conducted in the WCA region. Findings specific to Togo are presented in this research brief.

EXAMINING RISK FACTORS FOR HIV AND ACCESS TO SERVICES AMONG FEMALE SEX WORKERS AND MEN WHO HAVE SEX WITH MEN IN TOGO

KEY FINDINGS

POPULATION SIZE ESTIMATES AND CHARACTERISTICS

MSM

Using multiple population size estimation methods, this study estimated the proportion of the male population that is MSM in Togo to be 1.65% (95% Confidence Interval [CI]: 0.44-2.86). The population size estimate for MSM between the ages of 15 and 49 in urban areas in Togo is 11,955 (95% CI: 3,191-20,720), and the population size estimate for MSM between the ages of 15 and 49 at the national level is 25,019 (95% CI: 6,677-43,361).

In Lomé 354 and in Kara 329 MSM were surveyed. A majority of MSM participants were under the age of 25 years and single, divorced, separated or widowed. Most of the MSM surveyed had completed secondary school or higher with a higher percentage of MSM in Kara having completed secondary school than MSM in Lomé. When asked sexual orientation, 61.1% and 68.7% in Lomé and Kara respectively identified as gay or homosexual with another 34.9% and 31.3% identifying as bisexual. In Lomé, 0.9% of MSM identified as straight or heterosexual, and 3.1% identified as transgender.

FSW

Using multiple population size estimation methods, this study estimated the proportion

of the female population that is FSW in Togo to be 0.82% (95% CI: 0.57-1.07). The population size estimate for FSW between the ages of 15 and 49 in urban areas in Togo is 6,326 (95% CI: 4,425-8,226), and the population size estimate for FSW between the ages of 15 and 49 at the national level is 13,771 (95% CI: 9,634-17,909).

In Lomé 354 FSW and in Kara 330 FSW were surveyed. FSW in Lomé were generally younger than those in Kara. Educational levels were very low with only 4.3% in Lomé and 24.2% in Kara reporting they completed secondary school or higher. FSW were overwhelmingly single, divorced, separated or widowed. Over half of FSW in Kara had at least one biological child, and over three-quarters of FSW in Lomé had at least one biological child. Outside of sex work, many were self-employed.

HIV PREVALENCE AND ASSOCIATED RISK FACTOR

MSM

HIV prevalence among MSM was found to be 18.5% in Lomé and 0.6% in Kara. About half of MSM participants had been tested for HIV more than once, while less than one-third in both sites had never been tested at all. A small proportion of MSM surveyed reported



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having both male and female regular sexual partners. A higher proportion of MSM in Lomé reported two or more male sexual partners than in Kara. Consistent condom use with casual male partners was higher than consistent condom use with main male partners. Some MSM reported experiencing sexual violence, including being forced to have sex. Sexual violence, including being forced to have sex.

FSW

HIV prevalence among FSW was found to be 27.1% in Lomé and 10.0% in Kara. Most FSW reported having tested for HIV at least once. Condom use with regular and new clients was high in both cities, however condom use with non-paying partners in the past 30 days was reported by only one-quarter of FSW in Lomé and a little over half of FSW in Kara.

STRUCTURAL BARRIERS TO HEALTH SERVICES

MSM

MSM were subject to stigma and human rights abuses. A large number reported experiencing verbal harassment, blackmail, or acts of physical aggression. MSM in both Lomé and Kara reported difficulty in accessing healthcare (17.0% in Lomé; 7.3% in Kara). Some MSM participants reported hiding their sexual identity from providers due to fear of discrimination. Barriers to health service use reported by MSM included confidentiality concerns, discrimination by service providers, an inadequate number of medical staff and the geographic distance to services. MSM interviewed expressed a need for more accessible, affordable, confidential and MSM-specific services.

FSW

FSW reported discrimination and harassment. Among FSW surveyed, 17.2% in Lomé and 33.3% in Kara had been forced to have sex against their will at least once. FSW described being harassed or intimidated by police. In addition, a large number of FSW reported experiencing verbal harassment, blackmail, or acts of physical aggression. About one-quarter of FSW in Lomé and Kara reported difficulty in accessing healthcare, though a smaller proportion of FSW reported being afraid to access healthcare. Though some FSW described receiving good treatment from trusted providers to whom they had previously disclosed their profession, others interviewed reported being reprimanded by health workers as a result of their profession. FSW also reported fear of testing, inability to pay clinic fees and transportation as barriers to accessing health services.

CONCLUSION

The burden of HIV among FSW and MSM found in this study highlights the need to develop comprehensive and

STUDY METHODS & DESIGN

This study used both quantitative and qualitative research methods:

1. **Quantitative component:** Respondent-driven sampling was used to recruit FSW and MSM who were surveyed, tested for HIV, and counseled before and after the HIV test. The survey covered condom use, sexual practices, relationship patterns, access to care, stigma and discrimination, reproductive health, and community dynamics within the given KP group. HIV test results were used to estimate HIV prevalence in each KP.
2. In-depth interviews were conducted with key informants, FSW and MSM. Focus groups were also held with FSW and MSM. The topics for in-depth interviews and focus groups included experiences and practices of the respective KP group, organization and networks of the respective KP, knowledge and practices regarding HIV and sexually transmitted infection (STI) prevention, and experiences with stigma and discrimination.

integrated HIV prevention, care and treatment programs in Togo. Heightened prevalence and associated risk factors among these KP implies integration into the continuum of HIV care and regular testing in order to obtain early diagnosis and enrollment into treatment programs is essential. High levels of sexual and physical violence in both populations must be addressed programmatically and politically.

HIV prevalence among MSM in Kara was lower than in Lomé. Because MSM in Kara have high risk sexual practices, this could be a high HIV incidence, low HIV prevalence population similar to what was observed in many other settings in earlier phases of their HIV epidemics among MSM. Alternatively, MSM in Kara could be a low HIV prevalence and low HIV incidence population, and it is simply that based on the composition of sexual networks, people living with HIV are not part of these networks. The regional disparity of HIV prevalence among both MSM and FSW in Togo is noteworthy and implies diverse programmatic approaches are warranted based on the burden of HIV. Ensuring treatment and service delivery for both populations in Lomé and integrated prevention programming in Kara that includes comprehensive treatment of sexually transmitted infections may be the most effective programming model for Togo.

This study identified structural barriers to health services for KP in Togo, including stigma and discrimination, the inability to disclose sexual practices and health needs to health practitioners, and economic limitations to seeking services. Some of these barriers could be

BARRIERS TO HEALTH SERVICES AMONG MSM AND FSW

I have never revealed my sexual identity to my healthcare providers. But if [the visit] is for an STI, they often know it, and when they know it they say, "A nice guy like this has become an MSM." They neglect MSM. They become very cold, less attentive with them.

- MSM, Kara

To improve prevention services you need more confidentiality and trustworthiness [with providers]. For MSM to use these services requires more awareness of MSM, improved quality of care and nurses. [You should] educate healthcare providers to better accommodate MSM.

- MSM, Kara

References

1. UNAIDS (2013). Global report: UNAIDS report on the global AIDS epidemic 2013. Geneva, Switzerland: UNAIDS.
2. Baral S., Logie C., Grosso A., Wirtz A., and Beyrer C. (2013). Modified social ecological model: a tool to guide the assessment of the risks and risk contexts of HIV epidemics. BMC Public Health, 13: 482.

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overcome through specific community-based organizations (CBOs) providing comprehensive care and creating safe spaces for the population to discuss health issues. The regional disparities of the results also indicate local models should be developed on a city-by-city or region-by-region basis, and community structures should facilitate the relationship between the community and integrated health services.

MSM in Togo: HIV prevalence and risk factors

	Lomé	Kara
HIV prevalence	18.5%	0.6%
Never tested for HIV	30.8%	28.3%
Tested once for HIV	13.3%	24.3%
Male and female sexual regular partners	15.6%	13.7%
Two or more male sexual partners	53.3%	14.9%
Two or more female sexual partners	10.2%	0.9%
Consistent condom use with main male partners	54.4%	45.2%
Consistent condom use with casual male partners	67.2%	64.8%
Consistent condom use with main female partners	46.0%	29.9%
Consistent condom use with casual female partners	64.8%	47.1%
Ever forced to have sex	7.1%	8.2%

FSW in Togo: HIV prevalence and risk factors

	Lomé	Kara
HIV prevalence	27.1%	10.0%
Never tested for HIV	25.7%	17.6%
Tested once for HIV	15.7%	26.4%
Condom use at last sex* with regular client	95.5%	82.6%
Condom use at last sex* with new client	93.7%	86.3%
Condom use at last sex* with non-paying partner	26.4%	57.8%
Ever forced to have sex	17.2%	33.3%
Had an unwanted or unplanned pregnancy	52.1%	45.9%
Has biological child(ren)	78.5%	87.9%
* Vaginal or anal sex		