

# RESEARCH BRIEF

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## 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%.<sup>1</sup> 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 key populations 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, and emerging data indicate FSW and MSM are essential populations to integrate into HIV programming regionally.

Thus, this study used the Modified Social Ecological Model (MSEM),<sup>2</sup> 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.

## EXAMINING RISK FACTORS FOR HIV AND ACCESS TO SERVICES AMONG FEMALE SEX WORKERS AND MEN WHO HAVE SEX WITH MEN IN BURKINA FASO, TOGO AND CAMEROON

### KEY FINDINGS

#### POPULATION SIZE ESTIMATES AND CHARACTERISTICS

Multiple population size estimate methods were employed across studies. In Burkina Faso the population size estimates of MSM and FSW between the ages of 15 and 49 years old at the national level were 34,060 (95% Confidence Interval [CI]: 30,018-38,102) and 47,873 (95% CI: 27,431-68,314), respectively. There were an estimated 25,019 MSM (95% CI: 6,677-43,361) and 13,771 FSW (95% CI: 9,634-17,909) between the ages of 15 and 49 years old at the national level in Togo. In cities of more than 50,000 people in Cameroon there were an estimated 28,598 MSM (95% CI: 10,544-46,519) and 38,582 FSW (95% CI: 23,563-53,477) between the ages of 15 and 49.

#### BURKINA FASO

In Ouagadougou 343 MSM and in Bobo-Dioulasso 330 MSM were surveyed. MSM participants in Burkina Faso were generally young, and the vast majority reported being single/never married. There were 51.3% and 55.9% of MSM participants in Ouagadougou and Bobo-Dioulasso, respectively, who identified as gay or homosexual, with another 44.0% and 39.2% identifying as bisexual. In Ouagadougou 349 FSW and in Bobo-Dioulasso 350 FSW were surveyed. FSW participants in Ouagadougou were generally younger than those in Bobo-Dioulasso and had higher levels of education in contrast to Bobo-Dioulasso.

#### TOGO

A total of 354 MSM participated in Lomé, and 329 participated in Kara. Of these, 28.7% in Lomé and 46.8% in Kara were over 25 years old. Education levels of MSM participants were fairly high: 60.0% in Lomé and 80.0% in Kara completed high school or higher. MSM participants were overwhelmingly single, divorced, separated or widowed, with only 8.5% in Lomé and 3.0% in Kara currently married or cohabitating. 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. A total of 354 FSW participated in Lomé, and 330 participated in Kara. Of these, 65.6% in Lomé and 45.8% in Kara were over 25 years old. Education levels among FSW participants were low. FSW participants 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 participants were self-employed.

#### CAMEROON

A total of 1,606 MSM and 1,817 FSW participated in Cameroon across seven cities. The highest proportions of MSM were between the ages of 21 and 29 years in all sites. The lowest proportions of MSM were aged 30



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years and older, except in Bafoussam where 20.2% of participants were 35 years and older. Across cities, 62.5% identified as bisexual, and 36.9% of participants identified as being gay or homosexual, with the remainder who answered this question identifying as heterosexual. The highest proportions of FSW participants were in the 25 to 29 years age group in all sites, except in Bafoussam and Bertoua where those 35 years and older were the largest age group. Employment patterns among FSW were similar across sites: 12.8% of all FSW participants indicated they were unemployed, 37.1% were students and 50.1% had some type of employment other than sex work.

## HIV PREVALENCE AND ASSOCIATED RISK FACTORS

### BURKINA FASO

HIV prevalence among MSM was found to be 4.7% in Ouagadougou and 4.9% in Bobo-Dioulasso. Among individuals living with HIV, 41.8% in Ouagadougou compared to 20.0% in Bobo-Dioulasso had previously been diagnosed with HIV. In Ouagadougou 14.8% and in Bobo-Dioulasso 15.6% of MSM reported ever being forced to have sex; however, among MSM participants living with HIV, 43.8% in Ouagadougou and 20.0% in Bobo-Dioulasso reported ever being forced to have sex. HIV prevalence was higher for FSW surveyed in Bobo-Dioulasso compared to those in Ouagadougou (32.9% vs. 8.9%, respectively). Among FSW living with HIV, 48.4% in Ouagadougou and 65.2% in Bobo-Dioulasso had been tested more than once for HIV, and 36.4% in Ouagadougou and 64.4% in Bobo-Dioulasso had been previously diagnosed with HIV. FSW participants in Burkina Faso reported substantial experiences with sexual violence, with 42.0% in Ouagadougou and 39.7% in Bobo-Dioulasso reporting they were forced to have sex at least once.

### Togo

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 about 30% in both sites had never been tested at all. MSM in both Lomé and Kara were subject to stigma and human rights abuses: 7.1% of MSM in Lomé and 8.2% in Kara were forced to have sex against their will at least once. In addition, a large number reported being verbally harassed, blackmailed, or physically aggressed. HIV prevalence among FSW was found to be 27.1% in Lomé and 10.0% in Kara. More than half of FSW participants

## STUDY METHODS & DESIGN

This study used quantitative and qualitative research methods. In Cameroon, a mapping technique was also employed:

1. **Quantitative component:** Respondent-driven sampling was used in Burkina Faso and Togo to accrue samples of 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. **Qualitative component:** In all three countries, 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, knowledge and practices regarding HIV and sexually transmitted infections prevention, and experiences with stigma and discrimination.
3. **Health service assessment component (Cameroon only):** The Priorities for Local AIDS Control Efforts (PLACE) method<sup>5</sup> was used to recruit MSM and FSW participants and to identify health services accessed by MSM and FSW. The study team then mapped and evaluated the types and quality of those services in each selected city. Seven cities were included in this investigation: Bamenda, Bafoussam, Bertoua, Douala, Kribi, Ngaoundéré and Yaoundé.

had been tested for HIV more than once, while 25.7% in Lomé and 17.6% in Kara had never been tested at all. FSW in both Lomé and Kara were subject to discrimination and harassment. More FSW in Kara reported facing discrimination by family members than in Lomé. Among FSW, 17.2% and 33.3% in Lomé and Kara, respectively, had been forced to have sex against their will at least once. Both groups reported being harassed or intimidated by police. In addition, a large number of FSW reported being verbally harassed, blackmailed or physically aggressed.

### CAMEROON

Self-reported HIV prevalence among MSM across all sites in Cameroon was 7.0% (including 6.2% in Yaoundé and 18.0% in Douala). In comparison, previous studies that included biological testing found HIV prevalence among MSM to be 44.4% in Yaoundé and 25.5% in Douala.<sup>3</sup> Over half of MSM living with HIV never disclosed their serostatus to partners. Self-reported HIV prevalence among FSW across all sites in Cameroon was 5.1%. In contrast, the most recent HIV prevalence estimate for FSW in Cameroon in 2009 was 36.0%.<sup>4</sup> The mean number of clients in the past month reported by FSW across all sites was 109.5, and the mean number of non-paying partners in the past month was 1.2. Less than half of

all FSW reported using condoms every time they had sex with clients. Almost half of all FSW indicated they had been offered more money for sex without a condom in the past week.

### STRUCTURAL BARRIERS TO HEALTH SERVICES

There were high rates of sexual violence reported by both MSM and FSW across all three countries. Extortion, limited protection or exploitation by police members, and physical aggression were also highly reported by MSM and FSW in all three countries. Barriers to health service use reported by MSM and FSW included confidentiality concerns, discrimination by health providers, inadequate number of medical staff, and geographical distance to services.

### BURKINA FASO

Very few MSM participants reported having been denied healthcare, though 36.0% and 20.1% reported avoiding the health system in Ouagadougou and Bobo-Dioulasso, respectively. Among FSW, 21.0% in Ouagadougou and 14.9% in Bobo-Dioulasso reported fear of seeking health services. Additionally, 15.5% of FSW in Ouagadougou and 9.2% of FSW in Bobo-Dioulasso reported avoiding health services.

### TOGO

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. 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, other FSW 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.

### CAMEROON

Seventy-five percent of MSM who reported they were living with HIV were on treatment, and 78.9% of those on treatment were receiving it from a hospital or pharmacy; the others were receiving treatment from traditional doctors. Just one-quarter of MSM had revealed their sexual orientation to a doctor or nurse. The cities with no specialized clinical services for MSM were the cities with the lowest levels of disclosure to medical personnel. Among FSW who reported they were living with HIV, 64.2% were on treatment, and 78.9% of those on treatment were

### HIV Prevalence in Burkina Faso, Togo and Cameroon

		HIV Prevalence	
		MSM	FSW
Burkina Faso	Ouagadougou	4.7%	8.9%
	Bobo-Dioulasso	4.9%	32.9%
Togo	Lomé	18.5%	27.1%
	Kara	0.6%	10.0%
Cameroon	All 7 sites (self-reported)	7.0%	5.1%

receiving it from a hospital or pharmacy. Limited individual and laboratory resources, such as CD4 testing, were also reported as barriers to services for FSW.

## CONCLUSION

The burden of HIV among FSW and MSM found in this study highlights the need to develop comprehensive and integrated HIV prevention, care and treatment programs in each of these countries and tailor services to address the regional distribution of HIV among key populations. The continuum of HIV care encourages early diagnosis and enrollment into care and treatment, and KP programming in WCA must be designed to overcome barriers to health service delivery, both in the form of stigma and discrimination as well as a lack of specialized service providers in the region.

High levels of sexual and physical violence in both populations must be addressed programmatically and politically. Regional distribution of HIV also implies cross-border migration, and sexual and social networks can be leveraged to better disseminate prevention messages as well as ensure retention in care.

HIV prevalence was less than 5% among MSM in Burkina Faso, but was still higher than HIV prevalence among the general population in the country. Similarly, HIV prevalence was relatively low among MSM in Kara, Togo. MSM in these settings concurrently reported high risk sexual practices, raising the question of whether these populations could have high HIV incidence and low HIV prevalence, similar to what was observed in many other settings in earlier phases of their HIV epidemics among MSM. Alternatively, the populations may have low HIV prevalence and low HIV incidence, and very few individuals within the sexual networks in these settings are people living with HIV. This type of sexual network composition is important, as once introduced, HIV can rapidly expand with or without immediate detection in a similar pattern to what was termed “explosive” HIV transmission among MSM in Russia and Southern India. There has been no part of the world that has been “spared” from expanding HIV epidemics among MSM—and indeed, this represents an important opportunity to prevent further HIV acquisition among these men rather than the constant focus on preventing HIV transmission that takes up the time in so many other places.

The burden of HIV among FSW across countries in this study is noteworthy, but not a new revelation. A heightened burden of disease among FSW in the WCA region has been reported as early as 1987. Ensuing research has consistently shown a heightened risk for HIV among these women of reproductive age across contexts. These results imply that a much broader, standardized and concerted effort towards the prevention of HIV acquisition and transmission is needed among FSW in the region. Offering treatment and other services for FSW living with HIV, as well as addressing the complex reproductive health needs and desires of this population, is warranted.

Structural barriers to health services for KP, including stigma and discrimination, are important deterrents to engagement in the HIV continuum of care. This study found the inability to disclose sexual practices and health needs to health practitioners and economic limitations to seeking services existed in all settings. Some of these barriers seemed to be overcome when specific community-based organizations are developed to potentially provide comprehensive services and create safe spaces for the population to discuss health issues.

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